Risk Matters - Informed Consent for Minors

Informed consent is a fundamental ethical and legal requirement in healthcare, ensuring that patients have the autonomy to make decisions about their medical treatments and procedures. But who has the authority to provide such consent? With competent adults, this is rarely an issue. However, with minor patients, the answer can be problematic.

Recently, state legislatures have become more concerned about parents and legal guardians not being aware, let alone involved, in the medical decisions for their children or those entrusted to their care. As a result, laws are being passed to ensure that the decision-making authority is placed back in the hands of the parents and legal guardians. Whether you agree with these laws or not, they can potentially create areas of conflict between the provider, the parent/legal guardian, and the minor patient. They can also serve as a potential basis for an ethics complaint, malpractice action, or possibly criminal penalties, depending on the jurisdiction.

These new laws are frequently drafted very narrowly and with no consideration of the practical impact to the provider's practice. For example, they often do not permit

stepparents, grandparents, caretakers, foster parents, or persons other than the natural or adoptive parent/legal guardian to sign a consent form. Since often it is a stepparent or grandparent who brings the minor patient to the provider's office, these new laws are problematic.

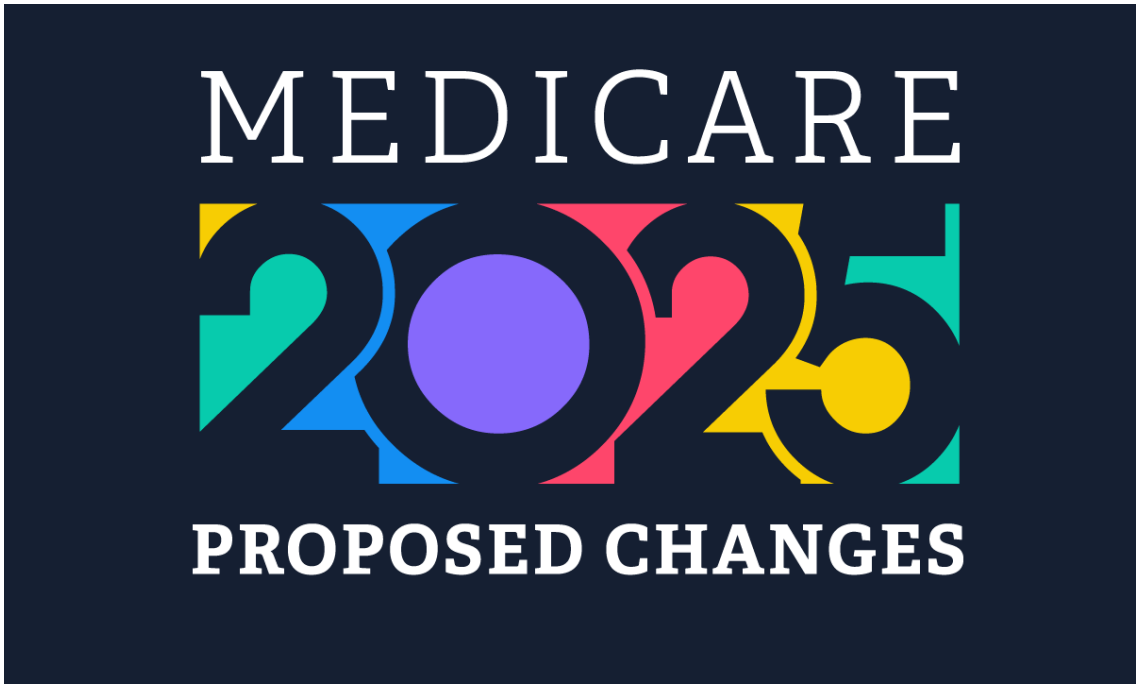
Some statutes require specific documented parental/legal guardian consent when the minor patient's medical decision involves certain types of preventative care, testing, procedures, and treatment, including but not limited to vaccinations (immunizations and COVID), obstetric care, and medications which can appear to conflict with laws that have been on the books for years. Depending on the laws of the jurisdiction, for example, minor patients of a certain age may obtain confidential healthcare testing/treatment in limited circumstances such as reproductive health services or mental health treatment. These existing laws allow minors to consent to their own care without parental/guardian approval. But new laws may require parental or legal guardian consent to such testing/procedures or allow parental/guardian access to the patient's medical records or identification of prescribed medications thereby diminishing the healthcare provider's ability to protect the confidentiality of the minor patient.

Generally, the new laws continue to permit consent documents to be signed for minor's care as follows:

1. **Parents:** Biological or legally adoptive parents usually have the authority to provide informed consent for their minor children. In cases of divorce, it is advisable that the provider obtain a copy of the court's Divorce Decree or Order specifically granting the parent who accompanies the minor patient the authority to make medical decisions (or at least does not restrict such authority).
2. **Legal Guardians:** If a minor is under the care of a legal guardian (ordered or appointed by a court), the guardian has the authority to make medical decisions and execute informed consent documents on behalf of the minor. Healthcare providers should require the guardian to produce for copying and placement in the EHR the document from the court granting such authority.
3. **Emancipated Minors:** In some cases, minors who are legally emancipated (granted adult status by a court or through marriage or military service) can provide their own informed consent. Again, documentation should be requested and copied.
4. **Emergency Situations:** In emergencies where a parent or legal guardian cannot be reached, healthcare providers may be permitted to provide necessary treatment to a minor without prior consent.

The specific laws and regulations regarding who can execute an informed consent document for a minor vary by jurisdiction and given the speed and frequency some of the laws relating to minor consent are being passed, healthcare providers should consult with a SVMIC Claims Attorney (800-342-2239 or ContactSVMIC@svmic.com) or their state medical association to determine the current status of the law in their state.

Release of Proposed Rule Foreshadows Reimbursement Landscape for 2025



On July 10, 2024, the Centers for Medicare & Medicaid Services (CMS) issued its payment proposal for the coming year. Focused on professional services, the Medicare Physician Fee Schedule (PFS) ruling provides a crystal ball into the expected payments for medical practices for the coming year. While it may seem like a broken record, the proposal incorporates a decline in reimbursement for physicians in most settings.

The proposed PFS conversion factor is $32.36, a decrease of $0.93 (2.80%) from the current conversion factor of $33.29. The reimbursement proposed for federally qualified health centers (FQHCs) and rural health clinics (RHCs) is much more positive; the productivity-adjusted market basket* update is an upwards of 3.5%.

The agency's announcement pertains to Medicare reimbursement. Because so many commercial insurance companies base their rates on the formula that drives Medicare rates (the Resource-based Relative Value Scale (RBRVS)), the government's decree has

far-reaching implications.

Let’s unpack the specifics included in the proposed rule:

- Expansion of telemedicine coverage to include International Normalized Ratio (INR) monitoring and caregiver training services.
- Confirmation that audio-only telemedicine may be furnished if, and when, the patient is not capable of using, or does not consent to use, video; supervision requirements for incident-to services provided by telemedicine are clarified to include “immediately available” for the required direct supervision.
- New coding and payment for caregiver training for direct care services and support and caregiver behavior management and modification training, all available to be performed via telehealth.
- Expanded payment for G2211 – the add-on code new in 2024, used for the patient/provider relationship – when an office visit is performed on the same day as an annual wellness visit, vaccine administration, or any Medicare Part B preventive service.
- New code (GCDRA) and payment for the administration of an Atherosclerotic Cardiovascular Disease (ASCVD) risk assessment service, as well as coverage for subsequent risk management services.
- Updated coverage for colorectal cancer screening to remove barium enema and include Computed Tomography (CT) Colonography for Medicare beneficiaries.
- Expansion of payment for services provided by opioid treatment programs, to include payment for social determinants of health (SDOH) risk assessments.
- Migration to general supervision (only) of physical therapy and occupational therapy assistants (PTAs and OTAs, respectively) for private-practice therapists, aimed to improving access in rural areas. Current signature requirements for therapy orders are also proposed to be lessened.
- Direct payment for care coordination services provided by FQHCs and RHCs; continuation of remote audio-visual direct supervision allowance and extension of telemedicine services to incorporate non-behavioral health services payable as provided in these health centers.
- Novel coding and payment for advanced primary care management services via new G-codes, stratified into three levels based on patient medical and social complexity; primary care practices would need to use a specific model of care delivery and a performance measurement requirement as a condition of accessing the new coding scheme.
- For surgeons, an add-on code, GPOC1, when post-operative care services are provided to patients for whom another surgeon performed the surgery, with the federal agency’s pledge to continue to evaluate the payment method for global surgical packages to ensure equitable distribution of payment.
- Expansion of behavioral health services, to include new coding and payment for safety planning interventions for patients in crisis, and coverage of services performed by psychologists, social workers, and other clinicians specializing in mental health.

- Limited, yet important alterations proposed for the Merit-based Incentive Payment System; eligible clinicians and the practice managers supporting them should review the program changes proposed to start on January 1, 2025.

Finally, there is some welcome flexibility added to the overpayment provisions required by the federal government with an outer band of 180 days from the initial discovery of the overpayment under certain circumstances. Expect additional guidance to better understand the proposed requirements regarding reporting and returning overpayments.

If any of these changes may affect your practice in 2025, dig in for more information. The comment period is open for 60 days. The final ruling will be released by the federal government on or about November 1, giving medical practices just two months to absorb the changes.

FOR MORE INFORMATION:
Summary of Changes: PFS Proposed Rule and Rule 1807 Fact Sheet; Full Text of Proposed Rule (2,248 pages)

*An index that measures the change in price, over time, of the same mix of goods and services purchased in the base period.

Closed Claim: When to Hold 'Em and When to Fold 'Em

Most likely you have heard the song, “The Gambler,” written by Don Schlitz and famously sung by Kenny Rogers. The song depicts an interaction between the narrator and a seasoned gambler on an evening train. The gambler notices the narrator’s dejected facial expression and surmises that the narrator is “out of aces.” In exchange for a long draw of whiskey and a light for his cigarette, the gambler dispenses some sage advice:

You've got to know when to hold 'em
Know when to fold 'em
Know when to walk away
And know when to run

Litigation, like cards, can at times feel like a bit of a gamble. There are many moments along the way where the lawyers and parties must decide how to proceed and which cards to play. There are facets to consider – the facts of the case, the standard of care, how the plaintiff and the defendant will be perceived by the jury, the amount of the damages sought, and the policy limits, to name a few. When a case has solid defenses, the defendant

physician supports their care, and defense counsel has procured strong expert support, it makes sense to take an educated risk and defend the case through trial. However, there are situations where the best move may be to resolve a case through settlement, sometimes even before suit has been filed.

The latter scenario occurred involving radiologist Dr. Blanton's care. (Names have been changed). Mack Allan, a 15-year-old male, presented to the ER complaining of right testicular pain. There was some swelling present. Mack reported that he might have hit it against something the night before. A urinalysis showed protein and mucous in his urine.

An ultrasound was ordered, and Dr. Blanton read the image. Dr. Blanton noted that the right testicle was larger than the left, and the right epididymis was enlarged. Her impression was that there was no testicular torsion, mildly enlarged right epididymis and a small right hydrocele that needed to be clinically correlated for epididymo-orchitis. Mack was discharged from the ED with two antibiotics, a topical cream for swelling, and Zofran for nausea. He was told to consult a physician if symptoms worsened and to follow-up in one to two weeks with his primary care physician.

Six days later, Mack presented to a children's hospital with worsening pain, swelling, and redness of the right testicle. He reported that he felt that he had been improving since his first visit to the ER and had been taking his medication as prescribed. Mack's clinical exam by the emergency physician was concerning for testicular torsion. An ultrasound confirmed, showing findings "consistent with acute right testicular torsion." Urology was consulted, and it was determined that there was no significant return of blood flow once the testicle was untwisted. The right testicle was removed.

Mack followed up a month later and appeared to be doing well. He had no other subsequent complications. Later, Mack's parents sought the counsel of an attorney who contacted Dr. Blanton, requesting pre-suit resolution. Dr. Blanton immediately contacted SVMIC.

An expert hired by the claimant opined that Dr. Blanton misread the scrotal ultrasound, noting that there was "clear asymmetry in the blood flow" between the left and right testicle, that there was a lack of attention to the side-by-side comparison study, and that the standard of care required a STAT consult with a urologist and a surgery for orchiopexy could have occurred, thus salvaging the right testicle.

At the time of ultrasound review, Dr. Blanton was focused on the enlarged right epididymis, as noted in the physical exam, which drew her to the conclusion of epididymitis. A quality assurance review of this matter did not conclude any adverse finding, though a preliminary independent expert review was not favorable as to Dr. Blanton's interpretation of the imaging. The sympathetic nature of the plaintiff's injuries was a significant consideration as well.

Prior to filing suit, the parties began discussing the possibility of resolving this matter through settlement. Dr. Blanton was anxious for a speedy resolution and consented to try

to resolve the case. After several months of informal negotiations, the parties mediated, and the claim was reasonably settled pre-suit. Dr. Blanton was relieved to have this matter resolved quickly, and the patient's family was pleased to receive the settlement payment before Mack left for college.

What to do if a patient takes issue with a physician's care?

How physicians behave after learning that their care is being questioned by a patient can have a significant impact on the outcome of the claim. That's why it's important for physicians to know how to act upon learning of a potential issue with a patient's care. **Although every case is different,** the following are some general guidelines to help physicians in this situation.

1. **Notify your insurer as soon as you've received notice, even if a lawsuit has not been filed.**

   Not only does that get your insurer working on your behalf as soon as possible, it also means you may have legal representation faster, depending on the situation. This provides a protective shield for some conversations. Employed physicians should notify their employers immediately as well.

2. **Don't open or alter records.**

   It is very tempting to review or even revise relevant medical records, but doing so can be a costly mistake. Plaintiff attorneys will seize upon EHR data and any alterations. Even looking back at the same record over and over may be an inadvertent flag which highlights potential issues for adverse counsel. Plus, plaintiff's counsel can use a doctor's attempt to conceal or destroy evidence to possibly obtain punitive damages, in addition to compensatory damages. Insurance coverage issues could arise as well.

3. **Don't investigate.**

   It is human nature to want to review the case, talk to other providers and staff about the patient and care, and look for errors. Unfortunately, if done improperly, this can look like an attempt to block the investigation or cover up wrongdoing. The best practice is to consult with an SVMIC Claims attorney who can provide guidance and retain outside counsel when appropriate.

4. **Don't talk to the plaintiff's attorney, if the request seems unusual, before consulting with SVMIC and/or an outside attorney.**

   A plaintiff's attorney may contact the office of the defendant doctor with a request for records or other information. Absent allowing staff to fulfill HIPAA-compliant medical records requests, do not communicate with anyone on the plaintiff's side. The conversation can be used against you. Contact SVMIC and/or your attorney to address any concerns before taking action.

5. **Be kind to yourself.**

   Many physicians feel the public and self-imposed pressures of appearing infallible. Yet, all doctors are humans, and all humans make mistakes. **Even the best doctors make mistakes; even the best care can result in an adverse outcome; sometimes nature wins despite your best efforts.** Even if the physician feels they provided the best possible care, the psychological effect of a claim or lawsuit is not to be ignored, and can include guilt, shame, self-doubt, depression, anger, and physical illnesses. The best methods of working through litigation stress include self-care (exercise, meditation, rest, nutrition, etc.), and seeking professional help (including psychologists, psychiatrists, priests, ministers, or rabbis).

In Dr. Blanton's case, she played her dealt hand appropriately – upon learning of the patient's allegations, she immediately notified SVMIC. During the entire process, she was involved in the investigation and was responsive to her attorney's inquiries and guidance. She did not conduct her own investigation, but rather worked with her counsel and SVMIC. She took care of herself mentally and physically as well. Finally, she had a realistic understanding of her care in this case. Rather than allowing her ego to cloud her judgment, she saw the potential merits of the patient's claim and wanted to resolve the issue expeditiously.

Although it could be said that in this case that Dr. Blanton had very few aces in her hand, she and her legal team made shrewd plays and folded early, avoiding what could have been a very long and costly gamble.
