Five Key Trends for 2022

2022 is off to a roaring start, and it pays to be mindful of the external pressures on your practice. Start with this checklist of key trends to consider regarding your medical practice.

Keep abreast regarding the dynamic nature of your market. Change abounds in the healthcare delivery system, driven by the pandemic. Retailers, fueled by partnerships with well-funded, early-stage companies like OneMedical, are pushing into the medical practice space. They are joined by companies focused on virtual care -- like Best Buy Health. Dollar General is the latest to jump in, with a focus on so-called “healthcare deserts” in rural communities. Keep an eye out for the new competitive landscape, as care access points and referral patterns are shifting in rapidly.

Recognize forthcoming reimbursement changes. The government halted a nearly 10% cut expected to hit medical practices in 2022; however, Medicare reimbursement is scheduled to decline this spring as sequestration is phased back. *(See Table: Medicare Reimbursement Cuts 2022 below.)* Each quarter this year will bring a small cut to Medicare payments; these reimbursement dips are often mimicked by commercial insurers. Insurance companies like United Healthcare performed well during the pandemic --

premiums were stable, while pay-outs for healthcare services declined substantially with patients putting off care. With Wall Street hungry for sustained profits, commercial insurers will be seeking ways to bring down reimbursement now that demand for services is rising. Watch out for more claims denials; put your business office on the alert to submit appeals to stave off financial losses for your practice at the hands of the insurers.

Automate. It's a message you've been hearing for years now, but the promise of technology is finally being realized today. Self-serve scheduling, registration, and check-in allow your practice to harness your patient's love of new consumer-focused tools and their inevitable convenience. Consider, also, the promise of being able to automate transactions like claims appeals, prescription refills, and prior authorizations for medications. Technology is enabling more and more practices to realize these opportunities.

Consider telemedicine opportunities. The government's recent extension of the public health emergency provides the runway for continued use of the telemedicine CPT codes at the same levels of reimbursement for in-person care. Dozens of codes remain payable by audio only – including psychotherapy, health risk assessments, smoking cessation counseling, and nutrition services. Further, 99441-3 (phone calls with physicians or advanced practice providers, billed based on time) continue to be payable from Medicare for the now. Even better, many of the 200-plus CPT codes are available for Medicare payment through the end of 2023. This list is for Medicare, but many commercial payers have extended reimbursement for virtual care as well.

Show your appreciation. The ongoing pandemic, staffing shortages, and the multitude of other challenges being faced by your practice have had a toll on you and your team. Make a mental note to thank every employee today – and at least once a week. A personal, handwritten note expressing your appreciation for their efforts goes a long way. Perhaps add a gift card, or a coupon for an extra hour of leave (e.g., rotate early departures on a slower afternoon). Many non-profits and school groups are hosting efforts to bring goodies to hospital workers. Consider making a call to such groups and inquire as to whether your team may benefit from their generous efforts.

Table: Medicare Reimbursement Cuts 2022

Cuts	Phase 1 (Q12022)	Phase 2 (Q22022)

MCR Physician Conversion Factor Reduction	-0.82%	-0.82%
MCR Sequestration (2% on Payments)	0%	-1%
PAYGO Sequestration	0%	0%
TOTAL	**-0.82%**	**-1.82%**

Risk Matters: New Course on Litigation

A wise attorney once told me, "The road to serenity is not paved with litigation." How true that is. Unfortunately, litigation is a familiar experience for those of us who practice medicine -- most of us will find our serenity traumatized by a lawsuit during our career. The stress can be overwhelming and even debilitating, but it doesn't have to be. In this article we will discuss the sources of that stress and the ways to cope. I offer two common idioms to remember if you are sued for malpractice: "You are not alone," and "You will survive."

-Michael Baron, MD, MPH

In response to policyholders who have expressed a desire to have had a better understanding of what litigation entailed before they were embroiled in it, SVMIC is now offering an online course entitled, "Anatomy of a Medical Malpractice Lawsuit." This

course identifies the elements of a malpractice lawsuit and outlines the major phases of the litigation process. Significantly, it discusses the physician defendant's role in each phase and what the physician can do to better assist in his or her own defense. Finally, the course identifies the emotional risks associated with a malpractice claim/lawsuit and healthy ways to cope with that stress. The latter topic is discussed by Dr. Michael Baron, Medical Director for the Tennessee Medical Foundation.

This course offers one (1.0) hour of CME credit, 5% premium credit for physicians, and is intended for all areas of practice. As with all our online courses, it is free to SVMIC policyholders.

When Right is Wrong – Lessons from a Wrong Site Surgical Procedure

Since the 1998 introduction of the “Sign Your Site” campaign by the American Academy of Orthopaedic Surgeons, much attention has been directed to preventing wrong site surgical procedures. What resulted was a paradigm shift in pre-operative processes, evolving into the pre-operative procedure that is today generally accepted and implemented in most operative facilities, whether it is a hospital, ambulatory surgery center, or office setting. Today’s pre-operative process involves:

1. Pre-operative verification confirming the right patient, the right surgery, and the right location.
2. Pre-operative marking of the surgical site with the patient or representative in such a way that the mark is visible after the patient is prepped and draped for surgery.

SVMIC recommends marking the surgical site during discussion with the patient or the patient's representative prior to surgery.

3. "Time Out" in the operative suite immediately before beginning surgery, with active and intentional communication among all members of the surgical team. SVMIC recommends having the relevant imaging available in the operating room for the surgeon to consult during the Time Out to verify that the correct level or side of the body is being addressed.

Without a doubt, these procedural changes have succeeded in preventing wrong site surgical errors. However, despite the development of these pre-operative procedures and the industry's overall attention to this problem, wrong site surgical error persists. Surgery involves humans, and humans make mistakes. This article discusses one such wrong site surgical error, the legal claim that followed, and its ultimate resolution.

Ms. Johnson[1], a twenty-year-old female, presented to an ambulatory surgery center for ACL repair of her left knee. CRNA Turner administered a nerve block pre-operatively for post-operative pain control. By his own admission, CRNA Turner went too fast in his care of Ms. Johnson, got distracted, and administered the nerve block to the right (wrong) knee.

CRNA Turner quickly recognized his error. He informed his supervising anesthesiologist, the orthopedic surgeon, and Ms. Johnson what had happened. It was determined that the ACL repair of the left (correct) knee would proceed as scheduled, but without the pre-operative nerve block. Another modality would be used to address Ms. Johnson's post-operative pain. The surgery on the left (correct) knee proceeded uneventfully, and Ms. Johnson was sent home with immobilizers on both knees. She was instructed not to attempt to ambulate on her own. Despite these instructions, Ms. Johnson tried to walk on her own at home and fell, causing pain and swelling in her right knee. Ms. Johnson reported the injury to her orthopedic surgeon, who added the right knee to the physical therapy protocol already planned for the left (operative) knee. Fortunately, the injury to the right knee was mild and resolved with physical therapy and time.

Only a few months after the surgery, Ms. Johnson decided to pursue a legal claim against CRNA Turner. She contacted an attorney, who sent a letter to CRNA Turner. CRNA Turner reported receipt of the letter to SVMIC's Claims Department, and defense counsel was retained to assist him. After investigating the claim, it was decided that by all involved that it would be prudent to engage Ms. Johnson in settlement discussions. These discussions were productive, and a settlement was reached between the parties. The parties thus avoided a lawsuit and resolved the matter fairly quickly.

There are several lessons to consider from this wrong site surgical error claim:

1. Wrong site surgical errors are not limited to surgery itself. A wrong site error can occur at any step in the surgical process, as is demonstrated by this wrong site pre-operative nerve block. Using the three-step procedure (verification, marking, and time out) before administering the nerve block could have prevented CRNA Turner from blocking the incorrect knee.

2. Although inconvenient, it may have been prudent to cancel the surgery after discovering the wrong site nerve block. The surgery could have been rescheduled for a later date and Ms. Johnson would have left the surgery center with only one leg immobilized. More likely than not, this would have avoided her subsequent fall, injury, and eventual legal claim.
3. “It is what it is.” Once the error occurred, the only thing CRNA Turner could do was manage it well. He did this by (1) promptly recognizing the error; (2) frankly and honestly informing the supervising anesthesiologist, orthopedic surgeon, and patient; and (3) factually documenting the event in the record. “Just the facts” was what was needed in the medical record. That is not the place to explain or elaborate or make an excuse.
4. Wrong site surgical procedures are referred to as “never” events, meaning that they should never happen. It is difficult to imagine a scenario where medical negligence is not admitted in these cases. Efforts can be made to place the error in context, but, more likely than not, a defendant in a lawsuit involving a wrong site error ultimately must concede that the error was a deviation from the standard of care. Therefore, with negligence conceded, the parties are left debating what injury resulted from the error and what that injury translates to in terms of monetary damage. Fortunately, Ms. Johnson experienced only a minor injury from this wrong site error and her monetary damages were minimal, making this an easier claim to resolve. Johnson also contributed to her fall and injury by disregarding the discharge instructions, a fact that also aided the claim’s resolution.
5. As to the claim’s resolution, it is important to note that CRNA Turner recognized this situation early for what it was. His prompt report to SVMIC enabled the claim to be addressed, investigated, and positioned for a quick resolution, thus avoiding a lawsuit.

Significant progress has been made over the past two decades to avoid wrong site surgical errors. However, even the three-step pre-operative process is not a guarantee that this medical error will never occur. Despite all precautions, mistakes still happen. Slow down, take the pre-operative process seriously, and do your best. In the end, even if right is wrong, SVMIC is here to help you through it. Members can find extensive resources to assist with questions and issues such as the one discussed here in the Vantage® portal, by emailing us at ContactSVMIC@svmic.com, or by calling us at 800.342.2239.

[1] The names of individuals in this closed claim have been changed.

The No Surprises Act: What You Need to Know Now

Surprise medical bills are a major concern for patients. Visits to the emergency room, and services provided by physicians who are not in the patient's insurance network, have caused patients to incur thousands, and sometimes hundreds of thousands of dollars in medical debt. The No Surprises Act, approved in late 2020 as part of the Consolidated Appropriations Act, is intended to protect patients against surprise medical bills when they receive emergency care or scheduled treatment from doctors and hospitals that are not in their insurance networks. Under the No Surprises Act, consumers are responsible only for their in-network cost-sharing.

Unfortunately, the law is extremely burdensome for providers. Many providers don't understand the depth of their responsibility in complying with the law. The following summary is intended to shed some light on the steps providers must take to comply with the new regulations.

SUMMARY

The No Surprises Act went into effect January 1, 2022 and is designed to protect patients against certain provider balance billing and facilitate a better understanding of the cost of medical services. The regulation has two major components:

Regulations protecting patients from surprise medical bills

- Protects patients who are enrollees in group health plans and group and individual health insurance coverage and receive emergency services, non-emergency services from out-of-network (OON) providers at in-network facilities, and air ambulance services
- Prohibits providers and facilities from directly billing individuals for the difference between the amount they charge and the amount that the individual's plan or coverage will pay plus the individual's cost-sharing amounts (i.e., balance billing)
- With the exception of ancillary providers, certain OON providers at in-network facilities may be eligible to provide notice and receive consent (aka **Notice and Consent**) from the patient to balance bill for their services
- Providers must provide proper public disclosure of patient balance billing protections in their offices and on their website (see Disclosures in Resources)
- These requirements do not apply to beneficiaries or enrollees in federal programs such as Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE

Federal patient transparency protections

- Intended to provide patients with a better understanding of the cost of care, provider networks, and health plan cost sharing amounts
- **ALL** providers must provide self-pay patients (uninsured patients and patients who have insurance but request not to have a claim filed with their insurance) a **Good Faith Estimate (GFE)** upon scheduling care or on request
- Creates a patient-provider dispute resolution process for uninsured (or self-pay) individuals to contest charges that are "substantially in excess" of the good faith estimate
- Limits billed amounts in situations where a provider's network status changes mid-treatment or individuals act on inaccurate provider directory information

KEY COMPONENTS OF THE LAW

Notice and Consent. Except in emergency situations, non-ancillary out-of-network providers may balance bill patients only when notice and consent timing and disclosure requirements are met. The standard notice and consent documents must be given before the service is rendered and be physically separate from and not attached to or incorporated into any other documents. CMS has provided **Standard Notice and Consent Document** for use by providers, which must include a "Good Faith Estimate" (GFE) of each item or service. If a patient schedules an appointment at least 72 hours prior to the date of service, the Notice and Consent documents must be presented at least 72 hours prior to the date the services will be provided. If the appointment is scheduled less than 72 hours prior to the date of service, the documents must be provided on the day of the appointment. In this situation, the documents must be provided no later than 3 hours prior to the relevant services being delivered.

Independent Dispute Resolution (IDR). OON providers and health plans are left to determine the amounts due to the provider for OON services based on the "qualifying payment amount." The qualifying payment amount, or "QPA," is the health plan or issuer's median contracted rate recognized by the plan on January 31, 2019, for the same or similar item or service in the same geographic region, adjusted for inflation. To facilitate this process, Congress established an IDR which may be initiated if a payment arrangement cannot be agreed upon.

Good Faith Estimate (GFE). The GFE is intended to provide transparency regarding the cost of services to enable patients to compare prices across providers. The estimate should reflect the cash price for services and the total cost of expected care furnished by the provider during a "period of care" (defined as the day or multiple days in which the primary service is performed including other additional services that will likely be furnished in conjunction with the primary item or service.) The GFE must also include an itemized list and description of expected services, diagnosis codes, services codes and associated anticipated charges. If the patient service is scheduled more than 10 days in advance, the provider must provide the GFE within 3 business days. If the item or service is scheduled at least 3 business days in advance, the GFE must be provided within 1 business day. If the billed amount is ultimately at least $400 above the GFE, the patient is eligible to start the patient-provider dispute resolution process. Refer to the resource section for links outlining the dispute process.

State Laws: Prior to the No Surprises Act, many states had enacted laws related to the practice of balance billing. It is important to understand whether your state has more protective laws than the No Surprises Act.

Need Assistance? For more information, see the government's resource page at the following link: https://www.cms.gov/nosurprises/policies-and-resources/provider-requirements-and-resources. With so many nuances involved with this issue, consider consulting with your attorney about the No Surprises Act. SVMIC also has experts to assist with your questions. Contact us at ContactSVMIC@svmic.com or 800.342.2239.

RESOURCES

Requirements Related to Surprise Billing: Qualifying Payment Amount, Standard Notice and Consent, Disclosure on Patient Protections Against Balance Billing, and State Law Opt-in: https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780

Independent Dispute Resolution: https://www.cms.gov/nosurprises/help-resolve-payment-disputes/payment-disputes-between-providers-and-health-plans

Good Faith Estimate: https://www.cms.gov/files/document/good-faith-estimate-example.pdf

Patient Provider Disputes: https://www.cms.gov/nosurprises/consumers/medical-bill-disagreements-if-you-are-uninsured; https://www.cms.gov/nosurprises/providers-payment-resolution-with-patients

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