The Deposition - Why, When, and How?

Many physicians have had the unfortunate experience of giving a deposition. Many physicians wonder if they have a choice to participate when it comes to a deposition. Whether you are a treating physician, a subsequent treating physician, a defendant in a lawsuit, or an expert hired for the case, you may be required to participate in a deposition. The invitation for this deposition often comes via subpoena. It may also be through a request to your office staff. Should this be something you encounter, there are some rules of the road that can be helpful in navigating the deposition.

Witness testimony under oath constitutes a deposition. A deposition is the life blood of a litigation attorney. The deposition is just the opposite for a practicing physician. Why, when, and how will a physician be found with such a daunting obligation?

There are generally three ways physicians find themselves faced with a deposition:

1) You are a treating physician of a patient who is involved in litigation. As an example, this could be a personal injury case, a worker's compensation case, or a healthcare liability case.

a. Many states have an 'exemption from trial' statute for physicians. However, it is important to remember that you are not exempt from a deposition, so schedule yourself accordingly. You control the time and place; this deposition will occur at your office, if you so choose.

b. You will receive a notice of deposition or a subpoena, **but** you are entitled to schedule the deposition at your convenience and to be paid for your time. If Plaintiff or Defense counsel wants to speak with you first, with a proper medical authorization or qualified protective order, you are entitled to be paid for that as well. And, although it is your choice whether or not to have a pre-deposition meeting, you don't **have** to talk with the lawyers before the deposition.

c. You can ask for assistance from SVMIC - if need be. While you will not routinely be provided counsel if you are merely a witness, they can answer your questions or concerns about the process, including producing medical records and speaking with counsel. From a liability standpoint, it is generally not advisable to meet with a

patient's attorney without your own counsel being present if the subject of the discussion involves the quality of your care.

d. The lawyers seeking to depose you will ask for copies of your medical record.

e. If a fact witness, you are required to testify factually about your care of the patient but are not required to give expert or opinion testimony outside the scope of your care. In short, the law will not allow anyone to force you to be his or her expert. That is your choice, and any expert opinions are yours to give as you see fit.

f. You may fall into the category of a subsequent treating physician in a healthcare liability case. You are not a named defendant, but are being called upon to testify regarding the care the patient received and perhaps any permanent damages or future care required. The opinions formed as a treating physician are routinely discoverable and can be inquired into by counsel of both sides.

g. You do not have to give opinions outside the scope of your care simply because they are asked. For example, you may be asked to comment on the standard of care of others. These types of questions call for your "expert" opinions and are the kind of opinions we seek when we hire medical experts. You are not required to give those opinions unless you have been retained to do so, and you have agreed to do so.

2) You are a Defendant in a Healthcare Liability case.

a. You will already have counsel provided by SVMIC. As such, the deposition and what to expect will not be a surprise. You should know when it will occur, and it will most certainly be scheduled pursuant to your and your counsel's schedule. Prepare for it but more importantly, **let yourself be prepared. Devote adequate time to fully prepare.**

b. How important is this deposition? It is the first impression of **you** in the litigation, and it occurs well before trial. It is often said that the way to do poorly in a deposition is to arrive unprepared. Remember, these litigants are usually represented by savvy attorneys who have met with experts to review the areas of medicine at issue. You will typically **not** get a second chance to correct any mistakes you make in the deposition, and the jury will hear at least some of that testimony.

c. This deposition is nearly always at your counsel's offices. That can give you somewhat of a home field advantage and since you will have already prepared there, it will be familiar to you.

d. In preparing for the deposition, the key is no surprises: you certainly don't want to be surprised by a question about your care or a medical record. Allow your counsel to review with you and prepare you for this process. There really is no substitute for good preparation.

e. In a healthcare liability case, your deposition is nearly always videotaped. This video can and will be used at trial to impeach you. As an example, if you misspeak, "perhaps I did perforate that duct," you can expect that later, after experts are disclosed, this testimony will be used by plaintiff's experts to attack you and then to cross-examine you at trial.

f. Thoroughly read your records and those of others *if instructed*. Your attorney will direct you on what to read and what areas to research.

g. Know the issues of your case - is it a known complication? Was there informed consent? You want to be able to explain, in easy-to-understand terms, why this was a known complication just like you would to a patient prior to a procedure.

h. **Know your standard of care**. In all healthcare liability cases, the standard of care for you and, perhaps your codefendants, is at issue. You should be able to readily define what the applicable standard of care is and then apply it to the facts of the case. While most defendants will not give opinions about the care of others in a case, you most certainly want to be able to articulate why what you did was appropriate and within your standard of care.

i. Perhaps the hardest part of the deposition, when you are a defendant, is the length. It is a long and, yes, sometimes painful process. You have been sued, and thus, you are being accused of negligent care. Many times counsel representing the plaintiffs will be aggressive and argumentative. Your attorney will prepare you for the style, but it can be unsettling. It is an undeniably emotional and nerve-wracking experience. Think of the deposition as a test - one for which you must prepare and endure appropriately. Eat before the deposition and snack during breaks. Take the breaks as needed. Sometimes, physicians will try to outlast the plaintiff attorneys by not requiring breaks. Rest assured that the breaks will not overly lengthen the process, and they will allow you to remain fresh, focused, and refueled for the duration.

j. Always remember that while you are represented, it is important that you advocate for yourself and your care, all the while being empathetic to your patient. Always be professional. Do not engage in an argumentative, condescending, or sarcastic manner.

k. Above all, remember you are the most informed person in the room about the facts and the medicine of the case. Unless there is an expert in the room, no one else went to medical school, trained in residency, and practiced in this field. No one else lived and breathed the process of caring for this patient as did you.

3) You are an expert in a case.

a. You will have help from a competent lawyer. While they do not represent you in the matter, the attorney who has hired you will certainly guide you through the process.

b. This is one of the occasions when you are in charge. Set your fees, and be prepared. It is important to earn your fees, by properly reviewing the medical chart and the opinions of others. Review them prior to the deposition.

c. You have agreed to be attacked, and you can expect it. The opposing counsel for the other side will come after the hired expert in a more aggressive manner than they would a party to the suit. After all, as an expert, you have signed up for this event. Be prepared to stand your ground while maintaining your composure.

d. In maintaining your credibility while being cross examined, it is important to concede points when necessary. In other words, while you have been hired to give an opinion for the defendant in a healthcare liability case, if you are asked a question such as, “Do you agree that the intended result of the operation was not to clip the cystic duct?”, concede that and make your points about known complications. Too often hired experts will take on the mantle of the plaintiff’s or defendant’s case and become argumentative, undermining their credibility in front of a jury. Don’t put yourself, and thus the client for which you are advocating, in an untenable position.

e. Do your homework. The lawyer who has retained you will send you a wealth of information about the case. Your thorough examination of the information and frank discussion with this attorney can equip him or her with what they need to try, and sometimes to settle, a case. Most importantly, you will be sent the disclosures of the other experts. Peruse those closely and be prepared to articulate where you differ and identify their weaknesses.

f. Unless the lawyer who has retained you specifically asks you to do so, do not write down your opinions until, and unless, it is time to disclose them. Your notes will be discoverable, and they will need to be turned over to the other attorney who will use them to question your final opinions.

g. Your financial information, certainly what you earn from expert testimony, may well be discoverable. Some courts are requiring the production of this information on any testifying expert. You will want to anticipate this on the front end.

h. Why would financial information be discoverable? In an attempt to show bias or lack of credibility, the opposing counsel may want to show that you have worked with a particular law firm on many occasions or, for example, “more than half of your income” is derived from expert testimony and not the practice of medicine.

i. Your deposition will most certainly be used to cross examine you, and you will still be required to come live to trial.

It may be that you avoid the deposition process altogether in your practice, and I hope you do. But should you face the deposition, remember to control the setting, charge for your time, be prepared, don’t allow yourself to become a free expert, hold your ground, and breathe.

One last point is that the deposition is rarely, if ever, monitored by a judge, and thus, the actions of the lawyers can be less controlled. While there are Rules that allow a deposition to be terminated for inappropriate behavior of a lawyer or witness, usually the parties (through their attorneys) are fending for themselves, making their objections for the record, and preserving their arguments to be made in front of a judge at a later time. The best advice for you as a deponent is to stay out of the fray. “If you can keep your head when all about you are losing theirs and blaming it on you,” you will survive far better. Rudyard Kipling must have been deposed.

Throwing Stones

Words matter. Words may matter even more in the medical profession. Health care providers work in glass houses. What is said, how it is said, and most importantly, how it is interpreted by the listener, can lead to serious and time-consuming consequences. You may think your words are benign or comforting, but, when a medical event has a poor outcome, those words can lead to years of trouble. Sometimes it's the speaker who suffers. Many times, it is another health care provider who becomes the target. Sometimes it is both. The following case illuminates this point. The physician involved did not intend to cause harm to his peer by his words. However, those hearing the words interpreted them to mean something other than what was intended.

Elliot Smith[1] was 15 years old when he presented to the emergency room at a rural Tennessee hospital. He had been involved in an ATV four-wheeler accident within the previous hour. He complained of left groin pain and of a laceration to the back of the left leg. He may have lost consciousness as well. Elliot was immediately seen by our insured ER physician, Dr. Tom Scott. The initial exam showed that the patient had a bruise on the lateral aspect of his left quadricep and a puncture wound on the posterior aspect of his left leg. He also had superficial cuts to his left forearm and elbow. Dr. Scott performed x-rays to verify that there were no fractures or foreign objects. He noted that there was subcutaneous air reported on the x-ray, which led him to believe that the puncture wound was deep, so he cleaned the wound and then placed a drain. He advised the family to take the patient to see his PCP the next day or to return to the hospital for further evaluation if his condition changed. The patient's vital signs were within normal limits, and the boy was discharged home.

The patient returned to the hospital the next day because the PCP's office was closed. The noted purpose for the return visit was to recheck the puncture wound. The wound was clean, and all looked fine. The bandages were changed, and vital signs were again normal. Dr. Scott told him to change the dressing daily and to see his PCP soon. This was Dr. Scott's last involvement with Elliot, and all still seemed well with him. Four days later, Elliot saw his PCP. At this time, she noted that the patient was running a low-grade fever which caused her to refer him to a surgeon at the hospital who saw Elliot that same day. The surgeon put him on Augmentin, removed the drain, and scheduled exploratory surgery for four days later. During this surgery, he debrided and irrigated the wound. The surgeon noted that Elliot was afebrile but that the swelling and drainage had increased despite the dressing changes and antibiotics, which were continued after surgery. A culture did not grow any bacteria, and Elliot continued to be treated by the surgeon over the next month. His symptoms ebbed and flowed, which resulted in an infectious disease (ID) consult. The ID physician could not identify any bacteria. The surgeon continued to treat the swelling that was occurring as well as drained fluid from the wound, and Elliot appeared to be getting better.

But a few weeks later, the patient was again admitted to the local hospital, this time with complaints of cough, headaches, vomiting, and fever. Shortly after admission, the patient's condition worsened, necessitating a transfer to a children's hospital an hour away. By the time Elliot arrived at the children's hospital, he was in septic shock and disseminated intravascular coagulation (DIC). For the next three months, Elliot was under the care of many different specialties at this institution. Despite all their efforts, Elliot suffered irreversible damage to both his lower legs leading to bilateral below-the-knee amputations.

Fortunately, Elliot eventually recovered enough that no other damage occurred and was released home. Unfortunately, one of the many doctors involved in the care made the comment to Elliot's parents that, "Maybe if Dr. Scott had put Elliot on prophylactic antibiotics at the time of the initial presentation, the likelihood of Elliot losing his lower legs would have decreased." While this was an equivocal statement, the Smiths interpreted it as "Elliot lost his lower legs because Dr. Scott did not put him on antibiotics." This remark led the parents to seek a plaintiff attorney and litigation followed. The medicine was complicated, and the case was vigorously defended. Eventually, the matter was successfully resolved although it caused significant stress for Dr. Scott. The effect of an unsolicited comment by a physician, not in Dr. Scott's specialty, led to years of worry. Due to their son's devastating outcome, the parents may have filed a lawsuit even if this comment had not been made. However, there is no doubt that this one unnecessary comment directly led them to litigation.

This is not an isolated story. It is possible that being critical, either intentionally or unintentionally, can turn the target back onto a fellow physician and bring him or her into a lawsuit. The common theme when this happens is that the interpretation of the physician's words appeared to be critical of another. This is almost never the intent. The doctor who made the offhand comment admitted in his deposition that he did not know the standard of care of ER physicians and was merely speculating. But, how the parents interpreted those words led to the legal events described above. While it is easy to read a medical record from another provider in another specialty with hindsight, it is impossible to know all the facts, circumstances, and communications that led to things that are not in the record, and the standard of care is different for every specialty. Many times, it is a situation of not knowing what you don't know. That's when assumptions take over and come into play, but assumptions are not facts and do not replace being there in the moment when that other health care professional was interacting with the patient. That is why it is important to comment only on what it is known. It is not about ignoring questions about another's care. It is about keeping boundaries firm and commenting only about your role and your care and directing the patient to ask their questions about others to those people. When this happens, the stones that destroy glass houses become rocks that protect them.

[1] All names have been changed

Is a Medicare Appeal Worthwhile?

If you are dissatisfied with a denial of payment by your Medicare contractor, you can appeal the decision. The Centers for Medicare & Medicaid Services (CMS) recently announced attempts to streamline the process by no longer requiring signatures, thus enabling documents to be submitted in a more efficient, streamlined manner. The appeals process continues to feature five levels of appeal, each of which have a deadline. To initiate the first level entitled “Redetermination,” for example, you need to file the appeal within 120 days after receiving the remittance.

Many practices report success related to having denials overturned. For those practices that are still stuck in the appeals process, the third level of appeals is managed by the Medicare Office of Hearing and Appeals. It is so backlogged – the turnaround time in 2018 was a remarkable 1,321 days - that CMS opened a low-volume appeals initiative last year. This featured payment of 62% of billed charges for appeals less than $9,000, just to get them out of the queue. A federal judge recently issued a warning to CMS to reduce the backlog by 2020, so many are projecting another payout soon.

Although the process isn’t easy, if you feel that your claims were not paid fairly, appealing a Medicare claim is possible. For simple, step-by-step instructions, see Medicare’s guide to submitting an appeal.

For more information about the May 2019 changes to the appeals process, visit the Rules and Regulations page here.

MIPS Audits Begin

In June, the Centers for Medicare & Medicaid Services (CMS) announced the commencement of audits for the Merit-based Incentive Payment System (MIPS). The contract was awarded to Guidehouse, formerly known as the US Public Sector of PricewaterhouseCoopers. Guidehouse is transmitting notifications of audits via email or certified mail. The auditors require the requested information be provided within 45 calendar days.

CMS has issued guidance about the requirements to fulfill the audit. For example, the 2017 "Provide Patients Access" criteria, which was a component of the Advancing Care Information category requires: "*Dated report, screenshot, or other information that documents the number of times a patient or patient authorized representative is given access to view, download, or transmit their health information. This could include instructions provided to the patient on how to access their health information including the website address they must visit, the patient's unique and registered username or password, and a record of the patient logging on to show that the patient can use any application of their choice to access the information and meet the API technical specifications*."

The guidance about the audit requirements, which can be accessed in the Quality Payment Program's online resource library, are titled: "MIPS Data Validation Criteria." The 2017 and 2018 versions have been posted here. CMS advises that documentation about the Merit-based Incentive Payment System should be maintained for six years. It's an opportune time to review this newly released guidance to ensure your documentation strategy for program compliance is responsive to the new guidelines. Should you be audited, you'll be ready.

MIPS Scores Are In

If you participated in the Merit-based Incentive Payment System (MIPS) in 2018, you can now view your results. The Centers for Medicare & Medicaid Services (CMS) released the performance feedback, final scores, and payment adjustments for 2018 MIPS program participants. CMS reports that 98% of practices were successful in avoiding penalties.

Log in here to view your results. If you are not satisfied, the deadline for a targeted review is September 30, 2019, at 8:00 pm EST. However, CMS encourages practices to call (1-866-288-8293) or email QPP@cms.hhs.gov before submitting a targeted review to determine if there is an issue that has already been detected. If penalized, you'll see 5% deducted from your Medicare reimbursement in 2020.

For more information, download the 2018 Performance Feedback FAQs and the MIPS 2018 Scoring Guide available under the Quality Payment Program's Resource Library. The Library also contains the 2018 Targeted Review Fact Sheet.

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