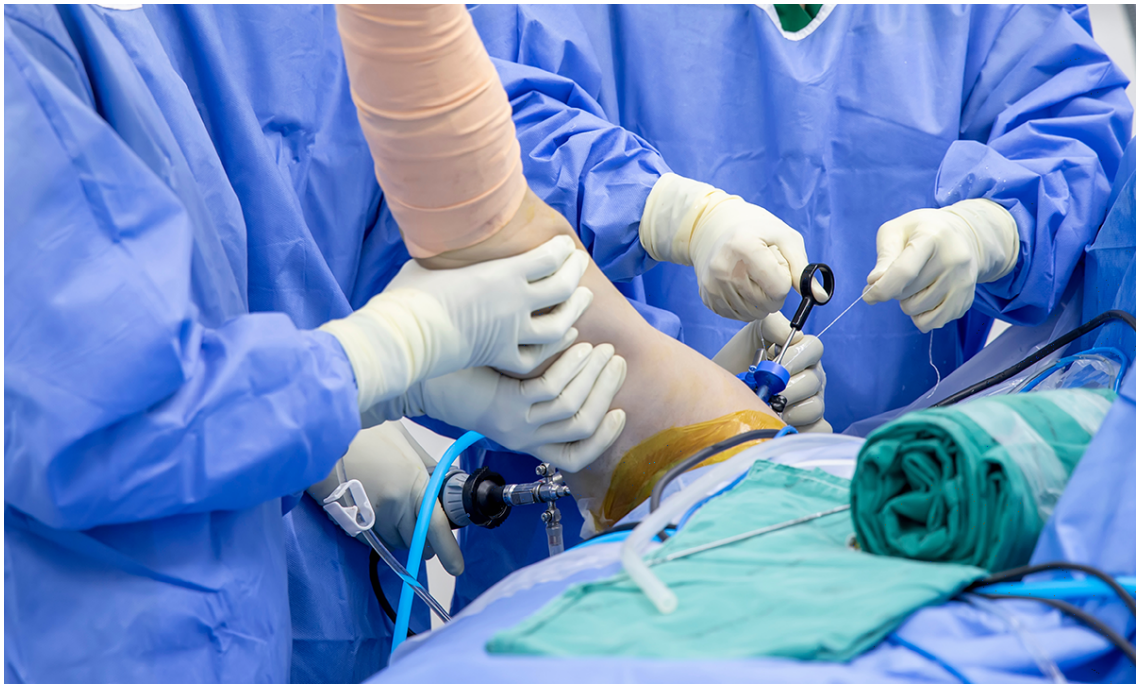
Trust the Process



As an avid sports fan, I routinely hear athletes mention that they need to “trust the process.” The origin of “trust the process,” as used ubiquitously in sports, apparently goes back to 2013 when the Philadelphia 76ers’ new general manager, Sam Hinkie, advocated an emphasis on process over outcome in his first speech with the team. The 76ers’ fans coined the phrase during a rough time for their team and it essentially means, “things may look bad now, but we have a plan in place to make it better.” Dr. Wexler[i] had to be reminded to “trust the process” when he faced his first health care liability action in the same year “trust the process” was coined by the 76ers’ fans.

The patient in Dr. Wexler’s lawsuit was a 75-year-old female who had an MRI that showed a high-grade partial thickness tear of the tendon in the right shoulder. Based on the results of the MRI, Dr. Wexler recommended and performed a right shoulder hemiarthroplasty. Dr. Wexler encountered a bleeding vessel during the surgery, which he chose to tie off with a suture. There was a small amount of blood loss, but the rest of the surgery was uneventful. Dr. Wexler, per his routine, checked the patient’s pulses before he left the operating room. Nursing notes that were charted immediately after the surgery recorded brisk capillary refill and strong pulses. The patient’s radial pulses were also checked by the nursing staff repeatedly throughout her hospital admission following the surgery. The patient was discharged from the hospital three days following the surgery with no circulation issues

documented in the medical chart.

A circulation problem was first documented twenty-eight days later, at which time the patient presented to her primary care physician, Dr. Green. Dr. Green referred the patient to Dr. Sunderland, an interventional radiologist. Dr. Sunderland ordered a CTA and angiography, which showed an occlusion of the axillary artery at the axillo-brachial junction with collaterals. Dr. Sunderland concluded that the patient had a chronic occlusion of the axillo-brachial junction and referred the patient to Dr. Castro, a cardiovascular and thoracic surgeon.

Dr. Castro performed a right axillary exploration on the patient. Dr. Castro's operative note indicated that there was a large amount of scar tissue at the point of transition for the brachial to the axillary artery, and he also noted that a silk stitch was "through the artery" approximately 4 mm proximal to this. The artery was noted to be completely occluded and scarred down for approximately 1 cm. Dr. Castro performed an end-to-end anastomosis and circulation was restored by the graft. Unfortunately, the patient later developed a thrombus.

The patient then had another CTA of her right upper extremity, which showed that the right axillary artery was again occluded. To address this, Dr. Castro performed a thrombectomy of the axillo-brachial, ulnar, and radial arteries by axillary incision, and a brachial-to-brachial bypass with cryopreserved vein. Following the surgery, Dr. Castro described an excellent radial pulse.

The patient later commenced a health care liability action against Dr. Wexler alleging that Dr. Wexler deviated from the standard of care, in part, "by placing a stitch/suture in/through the axillary artery at the axillo/brachial junction with collaterals." The patient claimed she had significant loss of sensation and diminished use of her right arm and hand as a result of the alleged damage to the vessel.

Defense counsel for Dr. Wexler reported that upon first meeting with Dr. Wexler, he seemed to have the impression that he would be automatically liable simply for placing the stitch. Defense counsel discussed with Dr. Wexler that the occurrence of the complication itself does not establish negligence; instead, the circumstances of his placement of the stitch would dictate whether the placement was negligent. In other words, Dr. Wexler needed to "trust the process." Although things looked bad from Dr. Wexler's personal view, his defense counsel was already developing a solid defense plan.

It was apparent, however, that Dr. Wexler was anxious about the litigation process. Upon recommendation of defense counsel, a witness consultant was engaged to assist Dr. Wexler in preparing for his deposition and trial testimony. After first meeting with Dr. Wexler, the witness consultant noted that he was completely "crazed" about the lawsuit and that he had a hard time thinking since he was so anxious about the case. The witness consultant noted that Dr. Wexler, more than anything, needed confidence, hope, and a plan. Again, he needed to "trust the process."

The case eventually proceeded to trial. During trial, the patient's counsel attempted to prove that Dr. Wexler placed the stitch through the lumen of the axillary artery and tied down the stitch, which caused the axillary artery to occlude. Defense counsel argued that had Dr. Wexler placed a stitch through the lumen of the axillary artery and tied down the stitch, the occlusion and patient's circulation problem would have been apparent almost immediately; instead, the first documentation of any circulation problem was twenty-eight days after the patient was discharged from the hospital. The proof offered by the defense showed that Dr. Wexler encountered bleeding from a collateral branch vessel off the axillary artery that was avulsed by use of a retractor during the procedure. Defense counsel argued that Dr. Wexler, consistent with the standard of care, placed a suture around the branch vessel to control the bleeding. Defense counsel conceded that the stitch did, in fact, lead to the occlusion of the axillary artery twenty-eight days later; however, the occlusion was not due to a placement of the stitch through the lumen of the axillary artery as argued by the patient's counsel. Defense counsel argued that although the stitch may have accidentally entered a portion of the axillary artery, doing so was not a deviation from the standard of care. The source of the bleed was deep within the surgical site, visibility was limited, and the suture unfortunately encountered the axillary artery despite the best efforts of Dr. Wexler to avoid doing so. Furthermore, with the assistance of defense counsel and the witness consultant, Dr. Wexler performed admirably and confidently on the stand at trial in defending his care and treatment of the patient. The jury deliberated for one-and-a-half hours and returned a verdict in favor of Dr. Wexler.

Being accused of medical negligence is almost always stressful for a healthcare provider. Although the litigation process is painfully slow, it can quickly wear down a healthcare provider both mentally and physically. For Dr. Wexler, the anxiety from being sued escalated quickly as he believed he was liable simply for placing the stitch. You should be mindful, however, as defense counsel discussed with Dr. Wexler, that an injury alone does not raise a presumption of negligence. Although things seemed bad from Dr. Wexler's perspective when he was served with the patient's Complaint, his defense counsel formulated a defense plan to make things better. Ultimately, defense counsel secured a verdict in favor of Dr. Wexler because Dr. Wexler trusted his defense counsel, trusted his defense counsel's plan, trusted the witness consultant's plan, and trusted his own care and treatment of the patient – the process worked.

[i] All names have been changed.

Phishing by Fax: Do Not Become a Victim

Scenario: It is Friday afternoon, and the physician is working on a stack of documents requesting his signature. Most are routine requests, but one in particular draws his attention. It is seemingly from a national pharmacy requesting the practice confirm an active patient and indicates it is pursuant to 45 CFR 164.508. His initial thought is “great; something else to sign.” Not having received a form like this before, he continues to review it with more scrutiny. The document has all the patient’s correct information as well as all the information for the practice. It then goes on to ask the physician to confirm the patient is/was under their care and to indicate if the patient “changed or switched to another provider”. There are additional grammatical and formatting errors on the form. At the bottom of the form, a request is made for the physician’s confirmation signature and additionally asks for the “clinical/office stamp” and notes this is mandatory. At this point, the physician reaches out to the claims attorneys at SVMIC for guidance.

Was the form legitimate? After the SVMIC claims attorney reviewed the document, the answer was NO. In addition to the other red flags, a Google search of the fax and phone number did not relate to that pharmacy chain, neither local nor national. The physician was

advised that the request was a form of phishing and to not sign or send it back, and that it would be best to destroy it.

While we generally relate phishing to email, we are starting to receive inquiries on similar faxes that follow much of the same tactics that phishing emails do. In Brian Johnson's April 2021 article Don't Take the Bait in 2021, he describes the objective of a phish attack to generally include ransomware, credential theft, fraud, and theft of intellectual property. Phishing relies on "human nature and social tendencies, tricking you into divulging sensitive information, clicking malicious links, downloading malware, and unknowingly enabling fraud." As with phishing emails, these phishing faxes "impersonate brands, companies, people, and processes you trust" … by playing on "emotional triggers that manipulate your social tendencies that include authority, urgency, fear, duty, and a desire to be helpful."[i] The faxes in question look to legitimately be from a trusted source and attempt to additionally give the fax some semblance of authenticity by referencing 45 CFR 164.508, which is a portion of the HIPAA Privacy Rule that addresses when authorizations are required and the general and core requirements for an authorization. Practices can generally trust requests coming from pharmacies for prescription verification, so this attempt utilizes those trusted processes to circumvent suspicion.

What are some red flags to watch for in these faxes? The first to scrutinize is the logo. Does the fax utilize the current logo? The fax referenced earlier does not include a logo, just the name of the pharmacy. Another red flag is that the phone and fax number do not utilize the same area code and no mailing address for the local pharmacy that should be sending the request is included, as would most typically be the case. Grammatical mistakes or strange wording is not as prominent as in the early days of phishing emails; however, it is still a good indicator that something is 'phishy', especially when the correspondence claims to be from a national chain. Watch for additional red flags in information that pharmacies generally do not request, such as requests for stamped signatures.

From a HIPAA standpoint, had this physician sent the fax back, it may have potentially been considered a breach of patient information since he would have disclosed patient information to an unintended party. HIPAA, however, is not the only concern when it comes to phishing faxes.

As we have seen over many years, healthcare is fraught with fraud and a physician signature is gold. Once these fraudsters have a signature and NPI, they can conduct all sorts of insurance fraud. They could potentially write prescriptions for drugs or bill for medical devices or procedures that patients do not actually receive. When the fraud is finally identified, providers who unknowingly provided their signature and NPI may be included in the investigation until they are able to prove they were not part of the fraud.

Just as the physician referenced at the beginning of this article, be on the lookout for anything suspicious or out of the ordinary. In other words, question everything. Look for indicators that something may not be right with the request you are reviewing. Never call the number indicated on the form, but instead, research the number to see if it goes where

you expect. A little bit of research and a lot of suspicion can go a long way in making sure you are not a victim of phishing.

If you experience a potential cybersecurity incident, contact SVMIC as soon as possible by calling 800-342-2239 and asking to speak to the Claims department.

[i] https://www.svmic.com/resources/newsletters/268/dont-take-the-bait-in-2021

2023 Coding Changes: Around the Corner

Each year, the authors of the Current Procedural Terminology (CPT) Manual make changes to the code set. Some years usher in a multitude of changes; others bring few alterations to the table. The 393 changes to the 2023 CPT codes are of importance because they translate your services into billable transactions and ultimately affect your bottom line. Let's break down the key modifications by the CPT authors, the American Medical Association (AMA):

Arguably the biggest difference applies to non-office services; historically, observation services and inpatient services have been reported via separate codes. That changes on January 1, 2023. Observation care discharge services code 99217, initial observation care codes 99218-99220, and subsequent observation care codes 99224-99226 are being deleted. The initial hospital care codes 99221-99223, subsequent hospital care codes 99231-99233, observation or inpatient care services codes 99234-99236, and hospital discharge services codes 99238-99239 are revised to include "inpatient *or observation care*." An admission encompasses observation and inpatient services.

The changes made to the requirements for leveling the office-based evaluation and management codes was extended to the facility setting. The emergency medicine codes 99281-99285, initial and subsequent nursing facility care codes 99304-99310, and home services codes 99341-99342, 99344-99350 are revised to require a medically appropriate history **"and/or"** exam and medical decision making (MDM), instead of all three key components. Time is also a factor, determined by face-to-face and non-face-to-face activities, based on the total time spent on the encounter date. The time in the code's description (displayed in the table below), must be met or exceeded to report.

Category	CPT® Code	Time (Minutes)
Initial	99221	40
	99222	55
	99223	75
Subsequent	99231	25
	99232	35
	99233	50
Same-day	99234	45
	99235	70
	99236	85
Discharge	99238	>30
	99239	≤ 30

Source: American Medical Association (2022). "2023 Evaluation and Management (E/M) Code and Guideline Changes.".

If a service bridges over midnight, the time is applied only to one date of service, according to CPT® guidelines.

The dynamic of new versus established patients is also translated into the facility setting: initial hospital services are for new patients as defined as never having received services from the physician (or qualified health professional [QHP]) in the same specialty in the same group or practice during the stay. Subsequent services are for patients who are established as per receiving services from the same physician (or QHP) in the same specialty, belonging to the same group or practice.

Following last year's elimination of 99201, office consultation code 99241 and inpatient consultation code 99251 are deleted. 99417 – an add-on for prolonged services related to high-complexity office visits – is revised to distinguish the code for use in the outpatient setting; further, the section "on the date of the primary service" is eliminated. Prolonged services add-on codes 99354-99357 are eliminated. The home visit code for new patients, 99343, is also removed.

There were minor revisions in the descriptions for interprofessional, non-face-to-face consultation codes 99446-99449 and 99451; cognitive assessment and care plan services code 99483; and transitional care management codes 99495-99496.

There are a multitude of new codes available on January 1, 2023. A new code 99418 has been created representing inpatient or observation prolonged services. In addition, new codes are being established for the implantation of absorbable mesh and removable of sutures; total disc arthroplasty; diagnostic ultrasound; stent placement (cardiovascular surgery); and prostatectomy. Fifteen new codes have been created for abdominal hernia repair. There are also new codes for vaccines, select ophthalmological services, cardiac catheterization, and group behavior management. Remote therapeutic monitoring gets a boost with a new code for cognitive behavior therapy monitoring (98978). In all, there are 101 new codes.

A new taxonomy for artificial intelligence (AI) applications was added, providing a framework for various AI applications, including virtual reality technology in therapy. The categories include assistive, augmentative, and autonomous. This new appendix signals the future of reimbursement for medical services.

In all, the AMA issued 225 new codes, 75 deletions and 93 revisions. For more information about these 393 changes, please see the AMA's press release, which contains links to educational resources. Click this link, which highlights the E/M changes. Your specialty society is also an excellent resource, particularly if the changes impact services you routinely provide.

Risk Matters: Requirements for Patient Accessing and Posting Results

Practices should be familiar with the general requirements of the HHS ONC Cures Act Final Rule, also known as the ONC Information Blocking Rule, which became effective in 2021. Among other aspects of compliance with the regulation, practices should have documented procedures that outline how both in-house and outside lab results are made available to patients and when an exception to access (such as “Preventing Harm”) may apply.

Clinicians are required to respond without delay to a patient's request for access to lab results when these results are available to the practice. Medical practices should be mindful that outside lab results may be immediately posted to a patient's EHR. Therefore, a policy should be in place that requires prompt review of posted results as well as personal communication with any patient with an abnormal result, sensitive information, or a result requiring immediate action.

If you have confirmed that a patient has accessed the portal previously, it should be sufficient to notify patients of lab/test results via a patient portal provided the patient:

- has been educated on use of the portal
- signed a written consent or electronically agreed to receive information via the portal

If you have not confirmed that the patient has accessed results through the portal, other methods of communication will need to be utilized such as a phone call or First-Class U.S. Mail. ***Any patient with an abnormal result or a result requiring immediate action should be personally notified.***
