DOWNLOAD PDF THE TOP 15 POLICIES AND PROCEDURES TO REDUCE LIABILITY FOR PHYSICIAN PRACTICES

Chapter 1 : Types of Medical Practices | ACP

Identification procedures of pilgrims in case of any emergency Evacuation de migrants Ã Paris: "Il faut rÃ©former complÃ©tement les procÃ©dures du droit d'asile".

These features address traditional well-known requirements for documentation principles while supporting expansive new technologies. Use of these features without appropriate management and guidelines, however, may create information integrity concerns such as invalid auto-population of data fields and manufactured documentation aimed to enhance expected reimbursement. Processes must be in place to ensure the documentation for the health information used in care, research, and health management is valid, accurate, complete, trustworthy, and timely. There are a number of existing rules and regulations on documentation principles and guidelines that primarily address documentation authorship principles, auditing, and forms development in a paper health record. New guidelines are being sought by the healthcare industry that ensure and preserve documentation integrity in an age of electronic exchange and changes in the legal evidentiary requirements for electronic business and health records. With the continued advancement of electronic health records EHRs , there is increasing concern that a potential loss of documentation integrity could lead to compromised patient care, care coordination, and quality reporting and research as well as fraud and abuse. This practice brief provides guidance for maintaining documentation integrity while using automated EHR functions. Ensuring Documentation Integrity Documentation integrity involves the accuracy of the complete health record. It encompasses information governance, patient identification, authorship validation, amendments and record corrections as well as auditing the record for documentation validity when submitting reimbursement claims. EHRs have customizable documentation applications that allow the use of templates and smart phrases to assist with documentation. Unless these tools are used appropriately, however, the integrity of the data may be questioned and the information deemed inaccurateâ€”or possibly even perceived as fraudulent activity. Established policies and procedures such as audit functions must be in place to ensure compliant billing. The provider must understand the necessity of reviewing and editing all defaulted data to ensure that only patient-specific data for that visit is recorded, while all other irrelevant data pulled in by the default template is removed. For example, the automatic generation of common negative findings within a review of systems for each body area or organ system may result in a higher level of service delivered, unless the provider documents any pertinent positive results and deletes the incorrect auto-generated entries. Appendix B , available in the online version of this practice brief in the AHIMA Body of Knowledge, illustrates examples of worst and best case scenarios observed in documentation practices for healthcare delivery. These scenarios show how the ability to copy previous entries and paste into a current entry can lead to a record where a provider may, upon signing the documentation, unwittingly attest to the accuracy and comprehensiveness of substantial amounts of duplicated or inapplicable information, as well as the incorporation of misleading or erroneous documentation. The scenarios further illustrate that while helping to improve apparent timeliness and legibility of documentation, additional adverse effects were created by the inability to verify actual authors or to authenticate services provided at any given time. Providers must recognize each encounter as a standalone record, and ensure the documentation within that encounter reflects the level of service actually provided and meets payer requirements for appropriate reimbursement. The integrity of this information is vital. Poor data quality will be amplified with HIE if erroneous, incomplete, redundant, or untrustworthy data and records are allowed to cascade across the healthcare system. Healthcare organizations must manage information as an asset and adopt proactive decision making and oversight through information asset management, information governance, and enterprise information management EIM to achieve data trustworthiness. EIM is defined as the infrastructure and processes that ensure information is trustworthy and actionable. These practices contribute to data quality and information integrity issues. Risky documentation practices that create the potential for patient safety, quality of care, and compliance

concernsâ€”such as those described belowâ€”may leave an organization vulnerable to patient safety errors and medical liability. Template Documentation Challenges Documentation templates can play an important role in improving the efficiency of data collection, ensuring all relevant elements are collected in a structured format. However, these templates also have limitations: Templates may not exist for a specific problem or visit type. Atypical patients may have multiple problems or extensive interventions that must be documented in detail. Templates designed to meet reimbursement criteria may miss relevant clinical information. Templates may also encourage over-documentation to meet reimbursement requirements even when services are not medically necessary or are never delivered. Automated insertion of previous or outdated information through EHR tools, when not modified to be patient-specific and pertinent to the visit, may raise significant quality of care and compliance concernsâ€”creating a potential for medical liability issues. Organizations must develop policies designed to address inappropriate use of these tools to minimize non-compliance. Common documentation risks that can result from cloning features include: Dictation Errors without Validation Organizations using voice recognition without a validation step in place are experiencing significant data quality problems and documentation errors. Organizations should have in place a process to ensure providers review, edit, and approve dictated information in a timely manner. Since these documents are often used and exchanged, the importance of accurate and quality documentation in EHR systems is critical. Best practices for documentation that ensures quality have not been well defined for EHRs and are not well understood by providers. Innovations are needed to improve documentation tools and techniques; a back-to-the-basics focus on the importance of data accuracy and quality must take priority before widespread deployment of interoperable health information exchange occurs. Healthcare fraud has signalled sharper focus on specific avenues for improper claims or billing, including EHRs. Patient Identification Errors Documentation integrity is at risk when the wrong information is documented on the wrong patient health record. Patient identification errors can grow exponentially within the EHR, personal health record, and HIE network s as the information proliferates. Failure of organizations to employ front end solutions that include measures like sophisticated matching algorithms or other methods such as use of biometrics, photography, or fingerprinting can put the organizations at risk. Organizations must have a patient identity integrity program that includes performance improvement measurements that monitor the percentage of error rates and duplicate records within its electronic master patient index. Policies and procedures must ensure that key demographic data are accurate and used to link records within and across systems. Policies must address the initial point of capture as a key front end verification. Authorship Integrity Issues Authorship attributes the origin or creation of a particular unit of information to a specific individual or entity acting at a particular time. If the EHR does not have functionality to enable both providers to document and sign, it may be impossible to verify the actual service provider or the amount of work performed by each provider. In order to support the integrity of the health record, EHR systems need to allow providers to make amendments, have the ability to track corrections, and identify that an original entry has been changed. The functionality to do this can be a combination of EHR applications along with policies and procedures that outline when changes need to be made, what changes can be made, who can make the changes, and how these changes will be tracked and monitored. The original entry must be viewable, along with a date and time stamp, the name of the person making the change, and the reason s for the change. Without this information, the date sequence may be impossible to followâ€”adversely affecting appropriate patient care and resulting in questionable supporting documentation for reported services. See case study 2 in Appendix B for examples of best and worst case scenarios and discussion questions related to data integrity. The EHR functionality may also determine whether or not an original note or amendment includes the correct date and time. Some systems automatically assign the date that the entry was made, while others allow authorized users to revise the date of entry to the date of the visit or service. All users are responsible for ensuring that documentation authorship is accurately recorded in all approved uses of the available documentation tools, and for making sure that any changes or deletions made outside of routine record use are maintained in the EHR system. Healthcare abuse describes incidents or practices which are not

usually fraudulent but are not consistent with accepted medical or business practices that may result in unnecessary costs to payers. These unintentional practices may involve repeated billing and coding errors that over time may be considered fraudulent if patterns of continued practice are found upon external review. When misrepresentation occursâ€"whether it is intentional or unintentionalâ€"the staff member that has responsibility for ensuring an accurate claim has the obligation to proactively identify and prevent fraud. Audit trails must include the name of the user, the application triggering the audit, the workstation, the specific document, a description of the event being audited i. The audit trail must capture what is amended including deletions within the health record and provide auditors with a starting point for compliance audits. EHRs that lack adequate audit trail functionality create uncertainty in the integrity of health record documentation, and may create legal liability for the organization while inadvertently making or protecting criminal activity. There may also be no way to determine if and when corrections or amendments were made to the documentation, who made the changes, or the nature of the changes. In addition to the normal unintentional errors that may occur in documentation, audit trail functionality can help to detect situations where an alteration of records is meant to prevent the discovery of damaging information. Organizations may utilize the audit trail functionality of the EHR system to identify and trend utilization of health records. Compliance Education Organizations may need to devote more strategy to ensure providers are well-informed about compliance and legal risks. This starts in the EHR training process. Organizations may need to develop initiatives in EHR education to make sure they do not risk compliance problems. Staff education on best practices for documentation should focus on the integrity of the health record. The education program must be monitored, maintained, and offered quarterly or annually. Answering questions of who, what, why, and how will help to ensure individuals have a solid understanding of the organizational practices and measures that maintain individual best practices. Education geared toward understanding who, what, why, and how must include: At minimum, organizations should consider these four primary conditions: Desire and commitment to conduct business and provide care in an ethical manner Purchasing systems that include functions and capabilities to prevent or discourage fraudulent activity Implementing and using policies, procedures, and system functions and capabilities to prevent fraud Inclusion of an HIM professional such as a record content expert on the IT design and EHR implementation team to ensure the end product is compliant with all billing, coding, documentation, regulatory, and payer guidelines Ensuring documentation integrity in the record is a fundamental practice. Organizations should use the guidelines and checklists in Appendices C and D to assess their compliance. Steps organizations can take to prevent falsification of EHRs Guidelines for selecting EHR system features to reduce the likelihood for falsification Guidelines for implementing EHR systems features designed to reduce the likelihood of falsification Fraud prevention education programs training requirements, security and integrity requirements, violation of EHR policy and procedure consequences Recommendations for establishing a process for logging all activity on EHR systems audits and audit trails recommended Sample business rules for EHR systems Appendices Four appendices are available in this online version of this practice brief. Role of Clinical Documentation for Legal Purposes. Available online at www. The Federal Rules of Civil Procedure. Record of Care, Treatment and Services section. December, Realizing the full potential of health information technology to improve healthcare for Americans: Public Law th Congress. Health Insurance Portability and Accountability Act. Public Law , th Congress. Health Information Technology Section Patient Protection and Affordable Care Act. Office of Inspector General. Failure to build in technical or policy and procedural safeguards creates an environment in which documentation manufacturing is encouraged and fraudulent entries are possibleâ€"thereby compromising data integrity. There also are instances in which borrowed documentation cannot be tracked to the original source, creating both legal and quality of care concerns. The scenarios below illustrate how technology may be used effectively to achieve either positive results illustrated in the best case example or undesirable outcomes illustrated in the worst case examples. Health record documentation elements can be repetitive because some conditions and situations are frequently encountered and similar processes are followed. Health interventions also follow a

standard course. However, each patient is unique, making each health service distinct from all others. Documentation created for one patient or a specific visit is most often not suitable for others, and copying text entries from one record to another should be carefully controlled. Worst Case Examples Professional Services While Patient A was a patient at Medical Center A, a number of medical tests and diagnostic evaluations were performed in an outpatient clinic over a two-week period. Concern arose about the health plan claim, so Patient A requested a copy of his medical records along with the bill for services. The statement included evaluation and management codes consistently reported at the highest level of service level 5. Because Patient A is a retired auditor for health plans, he examined the documentation and discovered that the medical history was pulled through within departments, between departments, and in subsequent visits with the same provider using the electronic health record EHR system, even when the visits did not include the clinician taking a history. The health plan was billed for a high level of service of history for each hospital outpatient clinic visit. Patient A is concerned that the EHR does not have the functionality or it is not used to show that the history or any documentation component obtained during a previous encounter was copied and reused as documentation for subsequent visits to support physician intensity of service.

Chapter 2 : 7 Best Practices for Avoiding a Malpractice Lawsuit

The 15 policies and procedures contained in The Top 15 Policies and Procedures to Reduce Liability for Physician Practices offer the best of both worldsâ€"comprehensive advice and strategies and written in easy-to-understand language.

They also expect to be treated with true concern, kindness and respect. Respect and empathy go a long way in helping patients be forthcoming about their overall health, specific ailments and how they feel about treatments that may be necessary. Open and honest communication, rooted in kindness and respect, is vital to fostering positive patient-caregiver relationships. It also helps you get to know your patients better, and helps their family members gain a good understanding of care and procedures. It all adds up to earning the trust of your patients. Illustrations can be useful tools to help a patient visualize their diagnosis or show how a medication or treatment will improve a condition. Being consistent in your care is equally important. The same level of care and protocol should be administered to each patient you see. Informed consent means you discussed the advantages and the risks of the care you will provide and gives the patient the opportunity to discuss alternatives. Most health care facilities obtain the informed consent of their patients by way of a signed agreement that is completed with enrollment paperwork. Accurate and Complete Documentation Making and keeping accurate records and documentation of patient visits is vital to a successful practice. In fact, documentation can make or break a malpractice lawsuit. In a case of negligence where no documentation is presented to back up the provider, a jury is very likely to side with a patient. Poorly-kept documentation fares no better. Good documentationâ€"charts and records that are current, thorough and specific to the exact care given at every visitâ€"can be very helpful in supporting a health care worker during a malpractice case. Make sure to stay informed about the health care industry as a whole. Be Prepared Doctors and health care professionals are often seen as distant and rushed. However true that may be of your practice, you should never compromise the time you give to preparing for appointments. Again, showing that level of consideration really is meaningful to your patients. Policies are set for a reason, and they must be followed to ensure the best possible care is provided. This must be the case each and every time you see each and every patient. And again, consistency in your procedures is of utmost importance. The smallest infraction against a set policy or procedure can cause devastating effectsâ€"in the treatment outcome for the patient, and possibly, a subsequent malpractice lawsuit. Avoiding a malpractice lawsuit should be of utmost importance to you.

Chapter 3 : Integrity of the Healthcare Record: Best Practices for EHR Documentation (update)

Top 15 Policies and Procedures to Reduce Liability for Physician Practices by James W Saxton starting at $ Top 15 Policies and Procedures to Reduce Liability for Physician Practices has 1 available editions to buy at Alibris.

There are five sections to the act, known as titles. Title I requires the coverage of and also limits restrictions that a group health plan can place on benefits for preexisting conditions. Group health plans may refuse to provide benefits in relation to preexisting conditions for either 12 months following enrollment in the plan or 18 months in the case of late enrollment. Title I [10] also requires insurers to issue policies without exclusion to those leaving group health plans with creditable coverage see above exceeding 18 months, and [11] renew individual policies for as long as they are offered or provide alternatives to discontinued plans for as long as the insurer stays in the market without exclusion regardless of health condition. Some health care plans are exempted from Title I requirements, such as long-term health plans and limited-scope plans like dental or vision plans offered separately from the general health plan. However, if such benefits are part of the general health plan, then HIPAA still applies to such benefits. For example, if the new plan offers dental benefits, then it must count creditable continuous coverage under the old health plan towards any of its exclusion periods for dental benefits. An alternate method of calculating creditable continuous coverage is available to the health plan under Title I. That is, 5 categories of health coverage can be considered separately, including dental and vision coverage. Anything not under those 5 categories must use the general calculation e. Since limited-coverage plans are exempt from HIPAA requirements, the odd case exists in which the applicant to a general group health plan cannot obtain certificates of creditable continuous coverage for independent limited-scope plans, such as dental to apply towards exclusion periods of the new plan that does include those coverages. Hidden exclusion periods are not valid under Title I e. Such clauses must not be acted upon by the health plan. Please help improve this article by adding citations to reliable sources. Unsourced material may be challenged and removed. April Learn how and when to remove this template message Title II of HIPAA establishes policies and procedures for maintaining the privacy and the security of individually identifiable health information, outlines numerous offenses relating to health care, and establishes civil and criminal penalties for violations. It also creates several programs to control fraud and abuse within the health-care system. Title II requires the Department of Health and Human Services HHS to increase the efficiency of the health-care system by creating standards for the use and dissemination of health-care information. Covered entities include health plans, health care clearinghouses such as billing services and community health information systems , and health care providers that transmit health care data in a way regulated by HIPAA. The HIPAA Privacy Rule regulates the use and disclosure of protected health information PHI held by "covered entities" generally, health care clearinghouses, employer-sponsored health plans, health insurers, and medical service providers that engage in certain transactions. Covered entities must disclose PHI to the individual within 30 days upon request. Between April of and November , the agency fielded 23, complaints related to medical-privacy rules, but it has not yet taken any enforcement actions against hospitals, doctors, insurers or anyone else for rule violations. A spokesman for the agency says it has closed three-quarters of the complaints, typically because it found no violation or after it provided informal guidance to the parties involved. An HHS Office for Civil Rights investigation showed that from to , unauthorized employees repeatedly and without legitimate cause looked at the electronic protected health information of numerous UCLAHS patients. The most significant changes related to the expansion of requirements to include business associates, where only covered entities had originally been held to uphold these sections of the law. Previously, an organization needed proof that harm had occurred whereas now organizations must prove that harm had not occurred. Protection of PHI was changed from indefinite to 50 years after death. More severe penalties for violation of PHI privacy requirements were also approved. This was the case with Hurricane Harvey in An individual may request the information in electronic form or hard-copy, and the provider is

obligated to attempt to conform to the requested format. Providers are encouraged to provide the information expediently, especially in the case of electronic record requests. Individuals have the right to access all health-related information, including health condition, treatment plan, notes, images, lab results, and billing information. Explicitly excluded are the private psychotherapy notes of a provider, and information gathered by a provider to defend against a lawsuit. Providers can charge a reasonable amount that relates to their cost of providing the copy, however, no charge is allowable when providing data electronically from a certified EHR using the "view, download, and transfer" feature which is required for certification. When delivered to the individual in electronic form, the individual may authorize delivery using either encrypted or un-encrypted email, delivery using media USB drive, CD, etc. When using un-encrypted email, the individual must understand and accept the risks to privacy using this technology the information may be intercepted and examined by others. Regardless of delivery technology, a provider must continue to fully secure the PHI while in their system and can deny the delivery method if it poses additional risk to PHI while in their system. An individual may also request in writing that their PHI is delivered to a designated third party such as a family care provider. An individual may also request in writing that the provider send PHI to a designated service used to collect or manage their records, such as a Personal Health Record application. For example, a patient can request in writing that her ob-gyn provider digitally transmit records of her latest pre-natal visit to a pregnancy self-care app that she has on her mobile phone. Disclosure to relatives[edit] According to their interpretations of HIPAA, hospitals will not reveal information over the phone to relatives of admitted patients. This has in some instances impeded the location of missing persons. After the Asiana Airlines Flight San Francisco crash, some hospitals were reluctant to disclose the identities of passengers that they were treating, making it difficult for Asiana and the relatives to locate them. Suburban Hospital in Bethesda, Md. As a result, if a patient is unconscious or otherwise unable to choose to be included in the directory, relatives and friends might not be able to find them, Goldman said. However, due to widespread confusion and difficulty in implementing the rule, CMS granted a one-year extension to all parties. After July 1, most medical providers that file electronically had to file their electronic claims using the HIPAA standards in order to be paid. It can be sent from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. For example, a state mental health agency may mandate all healthcare claims, Providers and health plans who trade professional medical health care claims electronically must use the Health Care Claim: Professional standard to send in claims. As there are many different business applications for the Health Care claim, there can be slight derivations to cover off claims involving unique claims such as for institutions, professionals, chiropractors, and dentists etc. EDI Benefit Enrollment and Maintenance Set can be used by employers, unions, government agencies, associations or insurance agencies to enroll members to a payer. The payer is a healthcare organization that pays claims, administers insurance or benefit or product. Examples of payers include an insurance company, healthcare professional HMO , preferred provider organization PPO , government agency Medicaid, Medicare etc. EDI Payroll Deducted and another group Premium Payment for Insurance Products is a transaction set for making a premium payment for insurance products. It can be used to order a financial institution to make a payment to a payee. EDI Health Care Claim Status Request This transaction set can be used by a provider, recipient of health care products or services or their authorized agent to request the status of a health care claim. EDI Health Care Claim Status Notification This transaction set can be used by a healthcare payer or authorized agent to notify a provider, recipient or authorized agent regarding the status of a health care claim or encounter, or to request additional information from the provider regarding a health care claim or encounter. The notification is at a summary or service line detail level. The notification may be solicited or unsolicited. EDI Health Care Service Review Information This transaction set can be used to transmit health care service information, such as subscriber, patient, demographic, diagnosis or treatment data for the purpose of the request for review, certification, notification or reporting the outcome of a health care services review. EDI Functional Acknowledgement Transaction Set this transaction set can be used to define the control structures for a set of acknowledgments to

indicate the results of the syntactical analysis of the electronically encoded documents. The encoded documents are the transaction sets, which are grouped in functional groups, used in defining transactions for business data interchange. This standard does not cover the semantic meaning of the information encoded in the transaction sets. Some segments have been removed from existing Transaction Sets. Many segments have been added to existing Transaction Sets allowing greater tracking and reporting of cost and patient encounters. It took effect on April 21, , with a compliance date of April 21, , for most covered entities and April 21, , for "small plans". It lays out three types of security safeguards required for compliance: For each of these types, the Rule identifies various security standards, and for each standard, it names both required and addressable implementation specifications. Required specifications must be adopted and administered as dictated by the Rule. Addressable specifications are more flexible. Individual covered entities can evaluate their own situation and determine the best way to implement addressable specifications. Some privacy advocates have argued that this "flexibility" may provide too much latitude to covered entities. Administrative Safeguards â€" policies and procedures designed to clearly show how the entity will comply with the act Covered entities entities that must comply with HIPAA requirements must adopt a written set of privacy procedures and designate a privacy officer to be responsible for developing and implementing all required policies and procedures. The policies and procedures must reference management oversight and organizational buy-in to compliance with the documented security controls. Procedures should clearly identify employees or classes of employees who have access to electronic protected health information EPHI. Access to EPHI must be restricted to only those employees who have a need for it to complete their job function. The procedures must address access authorization, establishment, modification, and termination. Entities must show that an appropriate ongoing training program regarding the handling of PHI is provided to employees performing health plan administrative functions. Covered entities that out-source some of their business processes to a third party must ensure that their vendors also have a framework in place to comply with HIPAA requirements. Companies typically gain this assurance through clauses in the contracts stating that the vendor will meet the same data protection requirements that apply to the covered entity. Care must be taken to determine if the vendor further out-sources any data handling functions to other vendors and monitor whether appropriate contracts and controls are in place. A contingency plan should be in place for responding to emergencies. Covered entities are responsible for backing up their data and having disaster recovery procedures in place. The plan should document data priority and failure analysis, testing activities, and change control procedures. Internal audits play a key role in HIPAA compliance by reviewing operations with the goal of identifying potential security violations. Policies and procedures should specifically document the scope, frequency, and procedures of audits. Audits should be both routine and event-based. Procedures should document instructions for addressing and responding to security breaches that are identified either during the audit or the normal course of operations. Physical Safeguards â€" controlling physical access to protect against inappropriate access to protected data Controls must govern the introduction and removal of hardware and software from the network. When equipment is retired it must be disposed of properly to ensure that PHI is not compromised. Access to equipment containing health information should be carefully controlled and monitored. Access to hardware and software must be limited to properly authorized individuals. Required access controls consist of facility security plans, maintenance records, and visitor sign-in and escorts. Policies are required to address proper workstation use. Workstations should be removed from high traffic areas and monitor screens should not be in direct view of the public. If the covered entities utilize contractors or agents, they too must be fully trained on their physical access responsibilities. Technical Safeguards â€" controlling access to computer systems and enabling covered entities to protect communications containing PHI transmitted electronically over open networks from being intercepted by anyone other than the intended recipient. Information systems housing PHI must be protected from intrusion.

Chapter 4 : Medical Liability/Medical Malpractice Laws

Top 15 Policies And Procedures to Reduce Liability for Physician Practices, by Saxton (Pap/Cdr Edition) by James W. Saxton, Maggie M. Finkelstein, Patricia Mary Kearney, R. N. Kearney Paperback, 73 Pages, Published

Patient Compensation or Injury Fund None provided. An additional five percent of any recovery after institution of any appellate proceeding is filed or post-judgment relief or action is required for recovery on the judgment. In any action for damages based on personal injury or wrongful death arising out of medical malpractice, whether in tort or contract, in which the trier of fact makes an award to compensate the claimant for future economic losses, payment of amounts intended to compensate the claimant for these losses shall be made by one of the following means: The defendant may make a lump-sum payment for all damages so assessed, with future economic losses and expenses reduced to present value; or 2. Limits on Attorney Fees No limitations. Any exemplary damages awarded to a client in a tort suit based on health care or professional services shall be placed in a special fund that may be expended at the discretion of the administrator, Guam Memorial Hospital, for the improvement of medical services within the territory of Guam. Proceedings and records of peer review committees and quality assurance committees. All judgments payable by periodic payments, as provided in this section, shall constitute a property right of the judgment creditor entitled to receive the payments, shall survive the death, disability or incapacity of the judgment creditor, and shall be inheritable, devisable, assignable and otherwise subject to disposition by the judgment creditor as any other form of intangible personal property; provided that nothing contained herein is intended to amend, modify or in any way alter any federal, state or local laws pertaining to taxes which may or may not be assessed against all or any portion of the judgment. Punitive damages not recoverable in medical malpractice cases. A party to the action must elect not less than 60 days before commencement of a trial involving issues of future damages unless leave of court is obtained. Notwithstanding IC , the commissioner may: However, the amount provided by the commissioner may not exceed 80 percent of the total amount expended for the agreement. Any party may petition the court for a determination of the appropriate payment method of such judgment or award. If so petitioned the court may order that the payment method for all or part of the judgment or award be by structured, periodic, or other nonlump-sum payments. However, the court shall not order a structured, periodic, or other nonlump-sum payment method if it finds that any of the following are true: The payment method would be inequitable. The payment method provides insufficient guarantees of future collectibility of the judgment or award. No award of exemplary or punitive shall exceed the lesser of: Compensation for reasonable attorney fees to be paid by each litigant in the action shall be approved by the judge after an evidentiary hearing and prior to final disposition of the case by the district court. Compensation for reasonable attorney fees for services performed in an appeal of a judgment in any such action to the court of appeals shall be approved after an evidentiary hearing by the chief judge or by the presiding judge of the panel hearing the case. Compensation for reasonable attorney fees for services performed in an appeal of a judgment in any such action to the supreme court shall be approved after an evidentiary hearing by the departmental justice for the department in which the appeal originated. The court may include in such judgment a requirement that the damages awarded be paid in whole or in part by installment or periodic payments, and any installment or periodic payment upon becoming due and payable under the terms of any such judgment shall constitute a separate judgment upon which execution may issue. The General Assembly shall have no power to limit the amount to be recovered for injuries resulting in death, or for injuries to person or property. Limits on Attorney Fees.

Chapter 5 : CHAPTER 3: BASIC OFFICE POLICIES, PROCEDURES, AND SYSTEMS

*The Top 15 Policies And Procedures to Reduce Liability for Physician Practices by James W. Saxton () on blog.quintoapp.com *FREE* shipping on qualifying offers. Will be shipped from US. Used books may not include companion materials, may have some shelf wear, may contain highlighting/notes.*

Educational and training programs for staff and physicians? Appropriate disciplinary and corrective action measures? Coding Compliance Program Corporate compliance programs are seen as an effective mechanism to assure compliance with regulations and minimize risk of fraud. A coding compliance program should be a key component of any corporate program -- complementing, not conflicting with, the corporate compliance program. Even if your organization has not yet begun to develop a corporate program, you can still establish a coding compliance program. In developing a coding compliance program, you need to be proactive to prevent someone less qualified from taking the initiative and creating a program for you. Begin with a risk assessment according to the target areas outlined above and the process described under Auditing and Monitoring. Include provisions within your compliance plan that specifically address weak areas identified in this assessment. This will assure that special attention is given to functions and processes that are particularly prone to placing your organization at risk. Convene a multidisciplinary team to address areas of the compliance plan that require cooperation from entities outside your department, such as policies and procedures that address physician documentation or updating the chargemaster. The key elements recommended by the government for inclusion in a corporate compliance program can be addressed in a coding program: Code of Conduct Develop a code of conduct for your department which establishes your commitment to ethical, accurate coding in accordance with all regulatory requirements. Data may be obtained from a variety of sources, usually for a charge. Many private companies offer access to giant databases, often in a user-friendly electronic format. Many states, through state data organizations or hospital associations, release claims data for all payers. Peer review organizations often provide comparative data reports. Box Baltimore, MD Telephone: URL no longer accessible; see http: American Hospital Directory www. State Health Data Resource Manual: This list is not all-inclusive. A number of private vendors offer comparative databases for healthcare providers. At least 37 states have been mandated to collect hospital-level data. Depending upon the state, this data may or may not be available to the public. Contact your state hospital association for information concerning the availability of comparative data. Publication of the names of specific vendors does not constitute an endorsement by AHIMA of any particular product or service. Written Policies and Procedures Develop comprehensive internal policies and procedures for coding and billing and make sure these written procedures are kept up to date. What documentation should be available at the time the record is coded? What procedures do you have in place to assure that medical record documentation is adequate and appropriate to support the coded diagnoses and procedures? Your commitment to assigning codes based on physician documentation and to obtaining physician clarification whenever necessary should be explicitly documented in your policies and procedures. You may wish to establish that a physician adviser is available to provide guidance to the coding staff regarding clinical issues affecting code assignment and to serve as a liaison with the medical staff. Submission of a claim to Medicare for a medical item or service which the healthcare provider knows or should know is not medically necessary is considered a fraudulent practice for which civil penalties may be assessed. Services that are not covered by the Medicare program, such as most routine examinations, should not be billed inappropriately so as to appear to be covered services. The appropriate V code should be assigned to indicate a screening examination. Whenever a test is performed that is believed to be reimbursable by Medicare and no waiver of liability has been issued to the beneficiary, the provider furnishing the test must maintain sufficient information in the medical record to support medical necessity of the test. Upon request, a laboratory should be able to provide documentation supporting the medical necessity of a service the laboratory has provided and billed to a federal program. Fiscal intermediaries have the authority to deny a claim that has insufficient

documentation to support it. A pattern of claims submission for medically unnecessary services can be construed as fraud. According to the model plan, laboratories should not: Use diagnostic information provided by the physician from earlier dates of service other than standing orders Use "cheat sheets" that provide diagnostic information that has triggered reimbursement in the past Use computer programs that automatically insert diagnosis codes without receipt of diagnostic information from the physician Make up diagnostic information for claims submission purposes Laboratories should utilize uniform requisition forms that encourage physicians to order only those tests they believe are appropriate and require physicians to document the need for each test. The ordering physician should be contacted to obtain diagnostic information in the event that the physician has failed to provide such information. This is an area where well-trained coding personnel are a definite asset because they are able to readily recognize inappropriate direction provided by the encoding software. Refer encoder issues to the software vendor. Regularly follow up with the vendor until the issue is resolved. If you identify any unequivocal conflicts with official coding rules or guidelines, address them immediately. The coders should be immediately informed of the erroneous instruction and directed to disregard the encoder in this instance. If your encoder allows customized edits, incorporate an edit to remind the coders of the error and the appropriate code assignment. Document the encoder problem-including the date it was detected and how it was handled-in your coding policies and procedures. Maintain a copy of the provider bulletin that addresses this policy with your coding policies and procedures. This will assure that you will be able to provide documentation supporting this coding practice. If your encoder allows customized edits, add a payer-specific edit for the code or codes affected by the policy. Evaluate a consulting firm carefully before signing a contract. There is nothing inherently wrong with utilizing a consultant to review medical record documentation and assure optimal code assignment based on documentation. Many ethical, responsible consulting firms have helped to significantly advance coding quality and coder and physician education. It is, however, important to be aware that if a provider utilizes a consulting firm for revenue optimization reviews, this may draw the scrutiny of fraud investigators, particularly if the consulting firm charges on contingency. In connection with some government investigations, hospitals have received letters informing them they must advise if outside consultants were utilized during the period and matter in question or if the provider was billing in response to any information previously provided by a consultant. An OIG Fraud Alert was issued in after an investigation into laboratory billing irregularities revealed a possible connection between false claims and consultants. The OIG noted that when a consulting firm is paid on contingency, there is little incentive to correct coding errors that do not result in higher reimbursement. The government determined that this type of arrangement between providers and consultants is ripe for upcoding, unbundling, and other manipulation, which increases costs to the Medicare program. The Fraud Alert recommends that government agents investigating hospital practices should determine whether the hospital has this type of consulting contract. Before entering a contractual agreement with a consulting firm, be sure to check references and the qualifications of the personnel responsible for conducting the work described in the contract. Some things to think about ahead of time: Do they possess an HIM credential? Does their experience match the type of work they will be doing for you? Determine their fee structure. Is it a flat, hourly, or per record rate, or is it contingency based? Verify that the firm has quality control mechanisms in place. Find out if they have a corporate compliance plan. If they do, ask to review it. Ask the consulting firm to review and agree to adhere to your compliance program. The consultant should report all errors that result in decreased reimbursement, as well as those that involve increased reimbursement. Claims adjustments for both types of errors should be submitted to the fiscal intermediary. Make sure that for every code change requiring additional physician documentation, this documentation is obtained prior to submission of a claims adjustment. Verify that a recommendation from a consultant or information presented during a seminar does not conflict with official coding guidelines or government regulations. A number of facilities have gotten into trouble because they were coding correctly to begin with, only to change their procedures because of advice obtained from a consultant or seminar. It is particularly important to verify the appropriateness of revising a

coding practice since sudden changes in coding or billing patterns attract attention, which increases the risk of being audited or targeted for a fraud investigation. Make every effort to get the consultant to take responsibility for any action related to his recommendation. Education and Training Stipulate the qualifications and experience expected of the individuals in coding positions. Make sure coding staff have been properly trained and receive ongoing continuing education. Ongoing education is necessary to assure that knowledge of changed rules and regulations is kept up to date. How will employees be educated on issues of relevance to their work processes? How will new employees be educated prior to performing any job responsibilities that could place the organization at risk? How will ongoing education on new issues, coding guidelines, or regulations occur? These are all questions that should be answered in your compliance program. Conduct periodic inservices to reinforce understanding of the procedures. When documentation deficiencies are identified, educate the physicians on improving their documentation. Clarify conflicting or ambiguous information with the physician. When clarification or additional information is obtained from the physician, make sure this information is subsequently documented in the medical record. Thus, the medical record documentation does not support the code assignment. Provide education outside the HIM department. Educate ancillary departments on the importance of documentation to support medical necessity of ordered tests and on the need for annual updating of the chargemaster. Since coding accuracy depends on the quality and completeness of physician documentation, physician education on documentation requirements is especially critical. Educate the business office staff on coding processes and in turn, invite them to educate your department on the billing process, including claims rejections and appeals. Make sure to document all internal and external training, including who was trained, what they were trained on, and the dates of training. Special training programs should be designed to target areas found to be deficient during an internal or external audit. Communication Procedures for communication of changes in regulatory requirements should be established. A procedure needs to be in place to assure that changes or additions to rules and regulations are communicated to all affected staff. This includes changes that may be contained in publications, such as provider bulletins, that have not been regularly disseminated to the coding staff in the past. You will need to establish a mechanism to assure that memoranda or regulatory issues and provider bulletins are disseminated to all affected staff.

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Chapter 6 : Health Insurance Portability and Accountability Act - Wikipedia

Develop comprehensive internal policies and procedures for coding and billing and make sure these written procedures are kept up to date. INTERNAL CODING PRACTICES Describe your internal coding practices, including the course of action coders should take when the coding situation is not addressed in official coding guidelines.

Shutterstock As a small business owner, you face a variety of risks, especially as you begin to work with more clients and hire employees. Your business deals with a certain amount of liability each day and you can reduce some of that liability by having your policies clearly outlined in writing. With so much to do, maintaining an extensive policies and procedures manual can be tricky. Luckily there are many templates available to get you started, especially if your policies are internal. You can refine these templates for your specific needs and update them as your business grows. Here are six basic policies your business should have in place before you add another client or hire additional employees. Workplace Safety Policies Whether your business operates in a factory or a standard office complex, anyone who steps onto your property faces some level of risk. A data entry worker could develop carpal tunnel syndrome while in your employ. Your company vice president could injure himself moving a computer from one office to another. Device Use Policies You may not realize that as an employer, you could be held responsible for the actions of those in your employ. That means if one of your workers conducts illegal activities on one of your systems, you may be answerable for it. Businesses protect themselves against liability in these instances by having a clearly written usage policy that outlines what workers can and cannot do on devices connected to your network. One important first step should relate to your availability, including your working hours. Studies show that customers prefer talking to live customer service representatives. Will you be available for calls or emergency concerns after hours or are you only available during business hours? Set those expectations up front to avoid disappointment on either end. Your turnaround time for each request should also be outlined in the beginning. Whether your business handles graphic design or pest control, you should have a clearly outlined policy regarding response time. If a customer or client asks that you dramatically reduce that response time, you should also have a written policy in place to cover whether this will incur an extra charge. How will you invoice your clients and what forms of payment will be accepted? Set a grace period for payments to be made before a small service charge is added. Many businesses allow 30 days from the time of invoice for the payment to be made before they begin sending late payment notices. If you put a strict return policy in place, ask yourself whether you plan to stand firmly behind that policy or capitulate for those customers who escalate a complaint up the chain of command. Refunds are still a possibility for service-oriented businesses, even though there is no product to resell. Many businesses offer satisfaction guarantees to lure new business in. Written policies are a great way to protect yourself, while also providing a safe, fair working environment for your employees. Oct 2, More from Inc.

Chapter 7 : Coding Compliance: Practical Strategies for Success

State law will prevail if there are provisions of state law, including state procedures for reporting of disease or injury, child abuse, birth, or death, or for the conduct of public health surveillance, investigation, or intervention (45 CFR).

Thousands of people are injured every yearâ€”some very seriouslyâ€”in slip and fall accidents on business premises. Employee training is critical to reducing your slip and fall loss exposure. All employees who are likely to be around third parties on your premises should be trained about what to do should someone suffer a fall. Medical care should be quickly provided to the injured person even if that means calling an ambulance. People who feel they were treated callously or indifferently are more likely to sue. Elimination of slip and fall hazards should be a periodic scheduled activity. Considerations for indoor areas include: All areas should be adequately lighted, including hallways and stairs. Exits should be well marked, well lighted and clear of obstacles. Handrails, steps and landings should be in good condition. Stair treads should be constructed of uniform height and width. General housekeeping should be maintained and storage areas kept neat. Carpeting should be tight and smooth. Any changes in floor level should be clearly marked. Doormats should be flat, slip resistant, cleaned and checked regularly in bad weather. There should be an effective procedure to assure that all spills are immediately cleaned up. Considerations for outdoor areas include: Walkways should be kept in good condition. Lighting should be adequate. Potholes, cracks or uneven areas should be repaired. There should be an effective procedure for assuring ice and snow are removed. If there are treacherous areasâ€”such as an uneven area of the sidewalk or a ripped carpetâ€”consider marking them as such, using signs to warn people away and putting up barriers around them. Employment Practices Liability â€” Federal law restricts employment decisions based on race and national origin, religion and creed, gender, age and disability. The restrictions on race, religion, gender and disability apply to businesses with 15 or more employees. The restrictions on age apply to businesses with 20 or more employees. An employee who feels discriminated against might sue making such charges as extreme emotional distress or wrongful termination. Larger employers typically provide formal training to management and employees on compliance with civil rights laws. There are many lower cost ways of carrying out this training. Hiring Practices and Liability Avoidance â€” Immature, careless and irresponsible people are much more likely to engage in risky behaviorsâ€”from reckless driving, to sexual harassment, to cutting corners on safety rules, to stealing from their employers. Similarly, people who have drug and alcohol addictions are liable to present a variety of workplace dangers. The first step in cutting down on your liability exposure is to be as careful and thorough as possible about whom you hire. Failure to use a reasonable screening process for new hires could even expose you to negligent hiring liability. Clear job descriptions and workplace rules, disseminated to all employees and applied consistently and without favoritism, can be a tremendous help in minimizing the risk of unacceptable behavior. Managing Product Liability Risks One of the most important ways to reduce potential product liability claims is keeping scrupulous records over the entire life of a product, from design to obsolescence. In the event of a product liability lawsuit, those records would be very important to show that you behaved with reasonable concern for the welfare of others. To reduce the possibility of harm, your products should be carefully designed and fully tested to specifically identify possible product hazards all along the way. Provide the customer with thorough and detailed information about the product and appropriate warnings. Identify products for purposes of prompt recall and have a recall plan. Loss control experts also recommend that you investigate, follow-up and document all customer complaints, even those that seem minor. This demonstrates your concern about your customers and shows that you take your duty to be responsible for the safety of your product seriously. Complaints could provide an early warning of a possible safety problem or other risk. Risk Management For Information Technology The greater the role that computers, the Internet and e-commerce play in your business, the more exposure you have to both property and liability risks involving information technology. Digitally stored information is subject to many of the same risks as any other property fire, flood,

tornado, etc. To prevent the loss of your accounts receivables, customer orders, client records or other such data, you should back up the data regularly and often and store the backup copies in a separate, secure location. Prevent data loss or corruption by viruses and hackers by keeping up-to-date antivirus software and firewalls on all your business computers. If you rely on a Web site, either you or your Web site host should back up all critical material at least daily. Digital technology also presents liability risks. You could be sued if there is a breach of your security and sensitive information about others is exposed or stolen. Make sure you use reputable vendors. Some measures that could help control these risks include: Using a "security seal" from a reputable security certification organization to encrypt data Posting a formal privacy policy Having your legal counsel approve your Web site content and your privacy statement Connect With Us.

Chapter 8 : Controlling Liability Risks | III

n Other policies and procedures necessary to safely and competently provide care in the ED. A good orientation program is completed by evidence of: (1) the process by which policies and procedures are distributed to employees, and (2) employee acknowledgment of their receipt of.

For example, calls to patients should be separated from those to nonpatients. Calls requiring back-up information eg, lab reports should be separated from those that do not. Calls requiring immediate attention should be separated from those that are not urgent. Patient Progress and Inquiry Calls You may request patients with acute or rapidly progressing conditions to report their daily progress. In addition, patients of their own volition may call the office to ask a question regarding their condition or care. The majority of practitioners feel that legitimate progress reports and inquiries should be encouraged. Handling several progress reports or inquiries by telephone may dominate lines needed to receive and schedule appointments. When a specific telephone hour is established, it is usually placed at the beginning of the day. If placed at the end, conflict may arise because of an extended schedule to accommodate emergency cases or walk-in patients requesting an immediate appointment. When a telephone hour is formally specified, office policy usually requires that telephone appointments not be scheduled during that time nor are progress reports or inquiries accepted at times other than that specified. This, naturally, takes considerable tact by the assistant in handling calls made at different times. Patients should never feel that they are being "victimized" by an office policy. Referral Calls Primary physicians frequently refer patients to specialists. This will require knowledge of times most convenient to the patient and passing on the same data your office requires in scheduling an appointment. Personal Calls Office staff should be trained to keep personal calls most brief during office hours. Visualize the plight of the mother with a sick child who cannot make contact with your office because the line is busy. Personal calls of staff should be limited to emergencies and made as brief as possible. Telephone Services and Equipment Telephone services and equipment have evolved rapidly during recent years. Services are available today for the small office that were unheard of even for large offices only a few years ago. There are single-line telephones that come in a wide variety of types, colors, and sizes, with either dials or pushbuttons. There are multi-button telephones, hands-free telephones, cordless telephones, remote speaker telephones, automatic dialers, repeat dialers for busy numbers, telephones with privacy buttons, mobile callers and radio pagers. Your local telephone company will be happy to discuss with you all options that are available. Answering Services and Equipment Most chiropractic offices use some type of answering service or device when the office is not attended. Available answering services will be listed in the yellow pages of your telephone directory, and most can be contracted on a month-to-month basis. The services offered vary considerably, from simply relaying messages to electronic paging or two-way radio dispatching. Many local chiropractic organizations also provide answering services as well as referral services for their members. It is an error if your assistant feels she is too busy to respond to all calls, thinking that the service has already told the caller when office hours begin and that the patient will call back. When callers receive an answering service, they have already suffered a let-down in reaching the coolness of the service when they were in need of help. It creates a warm impression when your assistant replies to the call, rather than waiting for the caller to make a second effort to reach your office. Return calls can then be made by the appropriate person. Be alert to the fact that many people become quickly irritated when their call is answered by a machine. Telecommunication Economics A number of methods can be employed to keep telephone costs to a minimum. There are several companies that provided long-distance rates at a lower rate than that of the telephone company if more than 25 long-distance calls are made each month. Other economical procedures to consider are to use direct dialing whenever possible and avoid person-to-person calls. The telephone company is not above error; thus, your monthly toll statement should be reviewed carefully prior to payment. Make sure that all credits are applied. The Reception Area After the telephone contact, the next typical areas of contact the

office has with a patient are the exterior of your building and the reception area. These contacts help to enhance the success or failure in patient impression as they are the first tangible evidence a patient has of the service they will see. In both physical appearance and mental attitude, be sure that your office has a reception room and not a waiting room. A waiting room is usually the result of poor appointment scheduling. Basic Concepts From both a clinical and a profit-producing standpoint, the reception room is a nonproductive area. Yet, it is one of the most important rooms in your office. It is here that both new patients and visitors receive their first close impression of your values in neatness, cleanliness, taste, and consideration for patient comfort. It is also here that returning patients gather their thoughts before they see you. The reception area need not be large, but it should always be cheerful and sunny, if possible. Furnishings should provide a warm, comfortable atmosphere. Soft background music is helpful for relaxation and to disguise conversations in other areas. A small sign eg, bakelite indicating "Please Register" helps to direct a new patient before he or she is greeted by an assistant. Embarrassing situations regarding fee policy, payments for service, or check cashing can often be avoided by an announcement, professionally prepared, posted near the registration area. Conversations between patients and staff should always be kept on a friendly professional level. Excessive socializing should be avoided. It appears to be human for assistants to be attracted to certain patients and not others, especially patients known for a long time. Yet, favoritism to any one patient must be avoided. In addition, patients are there to bring health problems to the office; they do not want to listen to office problems. Because of its initial impact upon an entering patient or visitor and because it is a high-traffic area, the reception area requires constant attention. Its appearance advertises the personality and character of the practice. Periodic service throughout the day is necessary by an assistant to empty wastebaskets and ashtrays, evaluate lighting and air conditioning, and appraise overall cleanliness and tidiness. A messy environment will do much to discourage good will. Receiving the Patient Every patient entering the reception area should be cheerfully greeted and properly registered. This is the first direct human contact the new patient has with your practice. Depending upon the quality of this approach, either positive or negative impressions will be made. Your receptionist holds the responsibility for developing a receptive patient attitude prior to meeting you. In its simplest terms, the goal is to have the patient like the people associated with the practice. As health practice is not a business but a profession, any reference to "salesmanship" here might be in poor taste. However, it is difficult to completely differentiate sales psychology from human relations common sense. Obviously, the approach in a chiropractic office to either a new or continuing patient is important to the success of the practice. When poorly handled through a thoughtless act or tactless word, your skills and professional reputation may be sharply minimized in the mind of the patient affected. Your assistant should greet the entering patient with a smile and cheerful welcome, as if she were the hostess in her own home, being gracious and pleasant and making the patient feel welcomed and at ease. The rules of courtesy, appearance, decorum, hospitality, and tact apply. A kindly smile, never forced, will do much to tell the patient in distress that he or she will be served with consideration. As in any human contact, the choice of words, voice tone, gestures, posture, and grooming are important parts of the approach. They set the stage for all else that follows in the office. First words as first impressions have a lasting effect. It is good policy to always use the name of the patient in the opening statement. Assistants should be taught that phrases such as "Good morning," "Good afternoon," or "May I help you? Such stern expressions as, "What can I do for you? These openings may frighten the timid person. The expression, "How are you today? Special assistance with clothing, walking, and seating should be offered to the elderly, the crippled, the painfully distressed. When new patients to the practice are greeted for the first time, they should be shown where coats can be hung. If a patient enters the receiving area while your receptionist is on the telephone, the patient should at least be recognized with a friendly nod. If the assistant is busy at her desk, she should stop momentarily to greet the patient and exchange a few words. After the patient is made comfortable in the reception room, your assistant should state that "The doctor will be with you directly. The word directly in the first statement implies a short wait, and yet it is noncommittal. Your receptionist should always try to give the patient some idea of when you will be available. All patients deserve

a courteous explanation of why a long delay is necessary. When a patient has been waiting a considerable time beyond the scheduled appointment, your assistant should re-enter the room and graciously apologize for the delay: This would be discourteous. Nothing less than good social conduct should be the guideline of the receptionist-hostess. If the patient is a woman, the number and ages of her children, if any, should be recorded. Necessary forms should be provided with a clipboard and a ballpoint pen Fig. When a patient is interviewed, an interested, reasonably relaxed, politely inquiring attitude will elicit more information than a hurried, tense interrogation. Basic information is usually recorded on an index card and kept on file for administrative reference. In some offices, the doctor may also desire to have an assistant take some of the basic case history. Usually, a standard form or checklist is used. An assistant should then prepare a folder for the entering patient, insert the data obtained plus anticipated forms to be filled out later, then prepare an office visit slip and attach it to the folder. The patient can then be escorted to the consultation room. Receiving Other Visitors Every business or professional office has a steady stream of salesmen and solicitors calling, and how nonprofessional callers will be handled is a matter of office policy. Many of these callers are important to the operation of your practice.