HEALTHCARE
RISK MANAGER

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Closed Claim Abstract

CASE #1

A twenty-six-year-old female patient presented for her annual ob-gyn physical. She complained of periodic tenderness in the right breast unassociated with hormonal cycles. The physician did not appreciate any abnormalities during the manual breast exam. Because guidelines do not recommend routine yearly mammograms for her age group, she was offered the test but declined at that time. During the ensuing year, about six months past her exam, she developed tenderness and dimpling of the upper outer quadrant of her right breast. She called her doctor after the condition persisted for two additional months and was diagnosed with invasive lobular carcinoma with metastasis to lymph and bone tissue. The patient sued the physician for delay in diagnosis and treatment and the case settled for a large amount.

Risk Management recommends that the physician **follow the patient's complaint to conclusion**. Document patient education efforts in regard to the need to follow up should she notice any changes or a lack of disappearance of symptoms. Finally, the physician should have scheduled this patient for follow-up at the time of her original complaint.

CASE #2

A patient was seen in her family practice office for a sore throat and upper respiratory infection. She said she mentioned to her physician she had a small tender breast lump, and he offered no

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Risk Management Looks at Misconceptions

of Early Breast Cancer Diagnosis

by Susan Millar, RN, Risk Management Consultant

In 2002, the Physician's Insurers Association of America (PIAA) presented the results of their 17 year long study to look at the underlying issues in claims alleging a delay in the diagnosis of breast cancer. Four hundred and eighty seven cases were analyzed beginning in January 1985. There were common threads in many of these cases. These similarities lead to risk management recommendations for patient education, tracking systems and improving provider documentation to help increase safety for our patients and reduce physician liability exposures.

The PIAA study found that allegations of misdiagnosis or delay in diagnosis resulted when mammograms were misinterpreted, when a referring physician did not perform necessary follow-up and when physicians did not order baseline and periodic screening mammograms. "Delays" sometimes also occurred when a patient did not follow the physician's recommendations.

In 35 percent of the PIAA cases, the physical finding failed to impress the physician as suspicious, and in 31 percent of the cases the physician failed to follow up with the patient in a timely manner. The delayed diagnosis was caused because 26 percent of positive mammogram results were reported as negative. Radiologists were most frequently involved in these claims, followed by women's primary health providers.[1]

Radiologists have come under intense pressure in regard to mammography liability, and some have chosen not to read mammograms because of the associated high risk. These cases are often difficult to defend. Twenty-twenty hindsight is an obstacle to defensibility, because knowing where the cancer was ultimately diagnosed may influence the plaintiff's expert reviewing the films to conclude there is a suspicious finding at that location. We know that the precursors of breast cancer lesions may be present many years before becoming malignant and would not have raised suspicion. The radiologist must use his/her best judgement to make a definitive diagnosis and yet, this is never an exact science. Heightened concern about liability may encourage physicians to err on the side of recommending additional unnecessary procedures.

What is delay in diagnosis and can all cancers be found early enough for 100

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Risk Management Looks at...
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percent cure? Society's expectation of "early detection = cure" implies that all breast cancers behave alike and can be diagnosed at a curable stage. While the American Cancer Society (ACS) supports that concept, other experts disagree. Current data suggests we can expect good results in about four out of every five women diagnosed with breast cancer if treated at an early stage.[2] The limits of technology and physicians' abilities do not always meet commonly held expectations.

Regular mammography and breast self exam are still considered the most effective method we currently have to diagnose early stages of breast cancer disease according to the ACS.[3] However, a percentage of mammograms will be read as negative when a lesion is present, and a percentage will be read as suspicious leading to unnecessary procedures when no lesion is present. The dilemma lies in deciding whether a finding requires no follow-up other than a routine screening, or is suspicious requiring additional testing and/or whether a repeat mammogram would be beneficial.

The problems with mammography interpretation are not simple, because of many inherent limitations. Interpretation may be influenced by factors such as the patient's age, risk factors, breast density, as well as a host of other variables. Technical limitations, systems errors and inadequate quality of the image further complicate interpretation as do other factors such as the experience and training of the interpreter.[4]

We have learned to rethink the process of informed consent and patient education for breast health. It is important to patient safety that we inform patients of the risks, limitations, accuracy and benefits of mammography. While we don't want to understate the importance of regular screening or give women a sense of hopelessness, we would prefer that no woman think a negative mammogram proves she is free of breast cancer. She should be told that if she suspects a problem or notices a change, she should follow up with her physician.[5]

The ACS guidelines urge physicians to emphasize patient self-awareness. Patients must understand that mammography is not perfect and may not produce a conclusive diagnosis.[6] They should be informed that a persistent or painful lump or elevated concern should be reported to their physician right away. All patients should be told after any screening or diagnostic procedure, "If you don't hear from us within a specified time period call our office."

On the right are some Risk Management recommendations for those who treat patients or read studies in regard to breast health.

Please visit the American Cancer Society's website at the following address (caonline.amcancersoc.org) to review the updated guidelines published in 2003. The updated guidelines focus on patient education and self-awareness.

We know that one in five women diagnosed with breast cancer will die from their disease.[7] We know that some cancers spread while virtually undetectable with conventional means. Is this really a delay in diagnosis or is it a failure of technology? Patients (and jurors) are not always aware of these limitations. The limitations of current detection and treatment methods are seldom discussed with patients or even understood by all physicians. **Discuss these limitations during the informed consent process, and document the patient's understanding.**

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Risk Management Tips for the Primary Healthcare Provider

- All women should be informed that there is a possibility of false-negative and false-positive findings
- Women's health providers should have a tickler system in place to remind women to schedule their routine screening mammograms
- The tickler system should include a step to follow up when no result is received and to communicate findings to other healthcare providers
- Educate women of the importance of self-awareness
- Women should be informed to notify their provider of breast concerns
- Follow every concern to its conclusion
- Document all patient complaints regarding the breast
- Document family history of breast cancer
- Document the results of any previous mammograms
- Document the recommendations for subsequent diagnostic studies and follow-up
- Remember to follow up with other physician consultants regarding test results etc.
- A palpable mass with a negative mammogram may require tissue diagnosis
- Pregnancy should not cause delay of appropriate diagnostic studies
- Do not abandon diagnostic pursuit because you are unimpressed by the physical findings
- If a mass is palpated or suspected, additional studies should be done until a diagnostic conclusion is reached
- Perform regular follow-up exams on patients who present with complications related to the breast
- If the patient does not keep her appointment, a reminder letter should be sent
- If the patient fails to reschedule, then another letter detailing the risks should be sent
- Document all efforts to contact the patient

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no guidance but treated her infection. A year later she was diagnosed with invasive cancer of the breast. She sued her family practice doctor for ignoring her complaint. Since her main complaint had been URI the physician did not pay attention to her secondary complaint. This is a clear case of coning of vision.

From a risk perspective, these issues cause some degree of liability exposure for any physician who discovers a secondary disease process while pursuing diagnosis of another condition. An example would be the orthopedist that sees a soft tissue mass on an x-ray taken in the office to assess pathology in the spine. Any secondary complaint should be addressed and/or referred to the appropriate provider.

Risk Management Looks at...

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Risk Management Tips for Radiology and Surgical Providers

- Repeat mammograms when films are of poor technical quality
- Check film quality while the patient is still in the mammography center if possible
- If the mammogram results are equivocal, recommend a repeat study, additional views, follow-up studies, other imaging modalities etc. as appropriate
- Compare findings to the results of the physical exam when needed
- Compare the results of mammography studies to previous studies
- Promptly report your findings to the referring physician
- The self–referred patient should be advised of any abnormality and referred to her PCP or OB/GYN
- Promptly report consultation and biopsy results to the referring physician
- Remember that the referring physician may not be the only provider who should be notified

Footnotes

1. Physician Insurers Association of America Breast Cancer Study, Third Edition, Spring 2002.
2. www.cancer.org
3. Ibid.
4. www.auntminnie.com
5. www.auntminnie.com, U.K. group accuses breast cancer screening advocates of disinformation 7/11/2003 By: Shalmali Pal
6. www.cancer.org, Differences in Mammography Reading
7. www.cancer.org Cancer, Prevention and Early Detection Facts and Figures 2004

Medicaid Update

By Dan Johnson, Senior Consultant, MAG Mutual Healthcare Solutions, Inc.

Medicaid audit activity is at an all-time high. The following provides some background information and steps physicians can take to safeguard their practice.

Background

Approximately two years ago, Medicaid cancelled its contracts with outside vendors who provided postpayment physician and hospital audits and created an internal audit department. There is little doubt that a goal of this department was to recoup as much money as possible given the extensive budget deficit. One of the internal audit department's first activities was to clean up old case files that had been outstanding for three years or more.

Medicaid began notifying physicians in early 2003 that overpayments had been made for services performed as long ago as 1997. As part of its multi-peril medical practice policy, MAG Mutual provides limited coverage for certain expenses incurred in connection with Medicare/Medicaid audits (but does not cover fines or sums to be reimbursed by the insured physician). Since 2003, Medicaid has demanded more than $550,000 from physicians insured by MAG Mutual, and this figure could easily top $1 million by the end of 2004. It is not unusual to see Medicaid overpayment refund letters demanding as much as $120,000 from physicians for services performed several years ago.

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Medicaid Update

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Medicaid audit findings include, but are not limited to, the following:

- Billing for a higher level of care (Evaluation and Management services) than supported by your documentation
- Physician extenders (Physician Assistants and Nurse Practitioner) providing Medicaid medical services, but being billed under the physician's name and number
- Hospital Services (all services)
- Laboratory Services (medical necessity)
- Providing and billing of medical services without adequate documentation (e.g., Chief Complaints)

What Physicians Can Do

No physician practice is audit proof, but there are steps physicians can take to lessen their audit risk for Medicaid as well as Medicare and other third-party payers who perform post-payment audits.

- Credential all physicians and mid-level providers (Nurse Practitioners, and Physician Assistants) who bill Medicaid under the rendering providers' name and number
- Billing personnel should maintain a high level of proficiency
- Obtain your billing profile at least annually
- Obtain the services of an outside, qualified individual to review your documentation and coding
- Establish a voluntary Fraud and Abuse Compliance Program for your office

For additional information, please contact Dan Johnson at **706-868-6436** or **DJohnson@magmutual.com**.

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