The Quality Tsunami: PPACA, Medical Malpractice Risks, ICD-10 and EMR

PAHCOM Lehigh Valley
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Speakers’ Disclaimer

- **D. Scott Jones, CHC** does not have any financial conflicts to disclose.
- This presentation is not meant to offer medical, legal accounting, regulatory compliance or reimbursement advice and is not intended to establish a standard of care. Please consult professionals in these areas if you have related concerns.
Presentation Goals

● PPACA Hot Topics we will discuss:
● PPACA physician and medical practice implementation:
  ● Quality reporting mandates, timelines, and reimbursement penalties, 2014-2017
  ● PPACA Patient volume and treatment risk issues
● Medical Malpractice and Healthcare Fraud under PPACA
● PPACA Requires ICD-10: When?
● PPACA EMR Risks, Benefits, and Complications
Healthcare Reform

President Obama Signs PPACA
March 23, 2010
Healthcare Reform

- Healthcare Reform Goals
  - Improve Access
  - Universal Coverage
  - Increase quality reporting to include outcomes
  - Increase integration of care through partnerships of physician networks and hospitals
  - Cost control and cost reduction

- What this means to Physicians and Administrators ....
  - Over 70% of healthcare executives surveyed believed that physicians performed inappropriate procedures for monetary benefit
  - Congress is focused on reducing “unnecessary” medical costs

Source: Physician Compliance Network
Healthcare Reform

- Patient Protection and Affordable Care Act (PPACA 2010) amended by the Health Care and Education Affordability Reconciliation Act (HCERA 2012)
  - Quality and Cost Payment (Title III, §§ 3002, 3003, 3007) – Adjusts physician payments based on quality and cost through a value-based modifier, beginning January 1, 2015
  - PQRS and other quality reporting mandates: Penalties for not reporting beginning in 2015, up to 2% of the prevailing fee schedule for each quality report type

Healthcare Reform

- **Fee-for-service → Value-based/Quality-based reimbursement system**
  - Goal: Reward doctors & hospitals for improving quality of care

- **Subsequent trends:**
  - Outcome-based payments
  - Currently, lower than expected patient demand in hospitals
  - Increasing numbers of insured patients
  - Improving patient experience
  - Hospital competition on outcomes and total value
  - Increased physician employment
A Major Intersection: Compliance, Quality, Fraud, & Malpractice

- OIG Work Plan 2014
- PPACA & Quality
- Government Accountability Office (GAO)
  - “...beneficiaries...who receive healthcare from providers who adhere to PPACA...may receive higher quality of care...Conversely, those who receive care from providers who fail to do so may receive lower quality of care.”

www.gao.gov/assets/590/589657.pdf
Intersection: Compliance, Quality, Fraud, & Malpractice

- General Accounting Office (GAO)
  - “...it is possible that, if these (PPACA) standards and guidelines become accepted medical practice, they could impact the standard of care against which provider conduct is assessed in medical malpractice litigation.”

PPACA and Medical Practices: Quality and Reporting
Physician Compare Internet Site

- **Required by the Affordable Care Act**
  - § 10331(a)(1)
- **Provides information regarding:**
  - Physicians enrolled in Medicare Program
  - Other eligible professionals participating in PQRS
- **Information is publically displayed**
Physician Compare

- PPACA § 10331(a)(1)
  - PQRS Measures Reported
  - Assessment of Patient Health Outcomes
  - Assessment of continuity and coordination of care
  - Assessment of efficiency and cost
  - Assessment of patient experience
  - Assessment of safety, effectiveness, and timeliness of care
  - 2014: User Interface; reports published online
  - January 1, 2015: CMS Report to Congress
Physician Compare: Approval

- CMS must allow physicians & other professionals to have reasonable opportunity to review their results before posting
  - 30 day preview period for all measurement data
- CMS will provide details of review process
  - www.cms.gov

§ 10331(a)(1)
Medicare Billing Data

- CMS has released billing data for all doctors, nationally, under the Medicare program.
- Data includes amounts billed, and totals billed the federal payment system.
- Data uncover nation’s top Medicare billers: The Washington Post Peter Whoriskey, Dan Keating and Lena H. Sun,
- “The government insurance program for older people paid nearly 4,000 physicians in excess of $1 million each in 2012, according to the new data. Those figures do not include what the doctors billed private insurance firms”. April 9, 2014
PPACA Section 10331(a)(2): CG-CAHPS

- Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS)
  - Patient surveys begin 2014....individual physician surveys by 2015.
  - Timely care, appointments, information
  - How well doctors communicate
  - Patient ratings of doctors
  - Health promotion and education
  - Shared decision making
  - Health status / functional status as a result of care rendered

- “Certified Survey Vendor” created
PPACA Rule CMS-1600-P
Quality Reporting Measures

● Physician Quality Reporting System (PQRS) 2014:
  ▪ 9 Measures must be reported
  ▪ 3 from National Quality Strategy domains
  ▪ For 50% of the entire Medicare-eligible patient population

● Effect of not reporting PQRS occurs in 2016

● Failure to report a selection of the measures = up to 2% reduction in prevailing Medicare Fee Schedule (FS)

● Qualified Clinical Data Registries created for sub-specialists dealing with specific diagnoses, conditions (§ 1848(m)(3)(E)(ii))
Value Based Modifier (VBS)

- How quality data reported under PQRS equals modification to payments under the Fee Schedule
- VBS use begins 2015; full implementation 2017
- Physician groups of 10 or more must report beginning 2016; expect all physicians to report by 2017
- Quality tier system results in FS reductions of up to 2%
- QRUR (Quality and Resource Use Reports) will report how the value based modifier will impact individual physician reimbursement, beginning 2014
Hospital Value-Based Purchasing

- PPACA Title III, Subtitle A: Transforming the Health Care Delivery System
  - Incentive Payments to Hospitals meeting performance standards in
    - MI, Heart Failure, Pneumonia, Surgery, Infections
    - ED, Readmissions, Children’s Asthma
  - Performance Scores increase/decrease DRG payments
  - Incentives up to 2% of the Medicare FS by 2017
  - Data and Scores on Hospital Compare Internet Site
  - GAO reports October 2015 and January 2016
Hospital Acquired Conditions Payment Reductions

- **PPACA Section 3008**
  - FS Payments for Hospital Acquired Conditions will equal 99% of the FS
  - The Secretary will determine a list of “hospital acquired conditions”
  - Confidential reports to hospitals tracking conditions
  - This program will be expanded to all other types of providers
  - Possible CMS reports on Hospital Compare Internet Site
  - Effective FY 2015
Long Term Care, Rehabilitation, Hospice, PPS Exempt Cancer Hospitals, SNF, HHA

- PPACA Sections 3304-3006
- Quality Reports required 2014 for all types of facilities
- CMS “Compare” Internet sites to post data
- Reduction in the “increase factor” of payments, up to 2%
- Increase Factor can = 0%, resulting in a 2% reduction
Integrated Care Demonstration Project

- PPACA Section 2704
- Project continues through December 31, 2016
- Goal: Establish bundled payments for services and providers involving an episode of care and hospitalization
- Severity of illness adjusted payment
- Data collection monitors outcome, cost, quality
- Report to Congress: December 31, 2017
National Strategy for Quality Improvement in Health Care

- PPACA Part S, Subpart I, Section 399HH(2)(B)(i-iii)
- Establishes Priorities that will:
  - Have the greatest potential for improving health outcomes, efficiency, and patient-centeredness...
  - Identify areas...that have the potential for rapid improvement in the quality and efficiency of patient care...
  - Address gaps in quality...
National Strategy for Quality Improvement

- HHS Annual Report to Congress, 2012
- “Key Measures and Long Term Goals”
  - “...reducing the harm caused in the delivery of care...reduce harm from inappropriate or unnecessary care....”
  - CDC: 5% of hospital patients acquire health care associated infections
  - 145 Health Care Acquired Conditions (HACs) occur per 1,000 admissions
  - AHRQ: Hospital Readmissions occur at a rate of 14.4%
  - Physician Compliance is Quality of Care
“No college junior studies organic chemistry and takes the MCAT planning to devote 4 years to medical school and 3 plus years to residency and fellowship just to cheat Medicare and Medicaid.”

Julie K. Taitsman, M.D., J.D.
CMO for the OIG, DHHS
Educational Resources

- “A Roadmap for New Physicians: Avoiding Medicare & Medicaid Fraud & Abuse”
  - Booklet & companion slide presentation
  - www.oig.hhs.gov/fraud/PhysicianEducation

- Agency for Healthcare Research & Quality

- Medscape Education
EHR/EMR Risks, Benefits, & Complications
January 2014

Objective:
- Describe how CMS & its contractors implemented program integrity practices in light of EHR adoption.
- Concerned that EHRs may make it easier to commit fraud
- 2 Major areas where EHRs c/b used to commit fraud:
  - Copy-Pasting
  - Overdocumentation

EMR Risks

- Adequate EMR record documentation
- Informed consent deficiencies
- Inadequate patient education
- Poor physician-patient communication
- Poor physician-physician/nurse communication
- Lack of documented medical necessity for performed services
- Improper performance of medical services/care
EMR Risks

- Overutilization or unusual utilization of E&M coding
- Cloning notes (OIG) v. copy/paste notes (Medical Malpractice)
- Coding engine dependence
- Modifier use
- Overutilization, Cloning, Coding Errors leading to “Not medically necessary” services
- Documentation deficiencies and errors
Surgical Mystery

Telephone Encounter

Answered by

Reason

Reason for Appointment
1. Preload

Current Medications
None

Past Medical History
Asthma
Chronic obstructive pulmonary disease (COPD)
Coronary artery disease
Hyperlipidemia
Myocardial infarction

Surgical History
Dilatation and curettage
Cholecystectomy
Laryngeal polyps
Tonsillectomy and adenoidectomy
AVR
Where’s the HPI?

Reason for Appointment
1. Prior labs

Vital Signs
BP 150/74 mm Hg, Ht 61.50 in, Wt 95.50 lbs, BMI 17.75 Index.

Physical Examination:
General Examination:
GENERAL APPEARANCE: in no acute distress, well developed, well nourished.
   HEAD: normocephalic, atraumatic.
   EYES: normal, sclera non-icteric, conjunctiva clear.
   ORAL CAVITY: mucosa moist, good dentition, no pallor.
   THROAT: clear.
   NECK/THYROID: neck supple, full range of motion, no cervical lymphadenopathy.
   SKIN: no suspicious lesions, warm and dry, no pallor.
   HEART: normal, S1, S2 normal, no murmurs, rubs, gallops.
   LUNGS: normal, clear to auscultation bilaterally, no wheezes, rales, rhonchi.
   CHEST: no spider angiomata, no palpable nodes, AP diameter normal.
   ABDOMEN: normal bowel sounds present, soft, non-tender, nondistended, no masses palpable, no hernias present, no splenomegaly, no hepatomegaly, no guarding or rigidity, no ascites, no rebound tenderness, no fluid wave, no succussion splash, no scars.
   RECTAL: not examined.
   EXTREMITIES: no clubbing, cyanosis, or edema.
   NEUROLOGIC: alert and oriented, nonfocal, no slurred speech, no nystagmus, no asterixis, no ataxia.
   Wearing O2 nasal canula. Thin Weight down 3 lbs.

Assessments
1. Chronic diarrhea - 787.91 (Primary)
2. Colon polyps - 211.3
3. Radiation enteritis - 558.1
4. History of cervical cancer - V10.41
5. Vitamin B12 deficiency - 266.2
6. Vitamin D deficiency - 268.9
7. Steatorrhea - 579.8
Where’s the appropriate exam?

Physical Exam

General

Integumentary

Neuropsychiatric
Mental status exam performed with findings of - able to articulate well with normal speech/language, rate, volume and coherence. The patient’s mood and affect are described as - normal.

Assessments & Plans

POSTCOITAL BLEEDING (626.7) genital culture + GBS, uterus mildly tender: augmentin trial given. Pap 3/2012 ok, Recheck 3 mos

MENOMETORRHAGIA (626.2) lasting 10 days, menses 2x per month

DYSMENOREA (625.0)

PELVIC PAIN (625.9) sharp lower abdominal pain intermittently
To Tattoo or Not to Tattoo

Drugs/Acohol:

Drugs:

Have you used drugs other than those for medical reasons in the past 12 months? No

 Alcohol Screen

Did you have a drink containing alcohol in the past year? Yes

 How often did you have a drink containing alcohol in the past year? 2 to 4 times a month (2 points)

 How many drinks did you have on a typical day when you were drinking in the past year? 3 or 4 drinks (1 point)

 How often did you have 6 or more drinks on one occasion in the past year? Never (0 point)

Points: 3

Interpretation: Positive

Miscellaneous:

No Tattoos.

Children: Yes.

Marital status: Married.

Occupation: Office workers.

Physical Examination

General Examination:

GENERAL APPEARANCE: in no acute distress, well developed, well nourished.

HEAD: normocephalic, atraumatic.

EYES: sclera non-icteric, conjunctiva clear.

ORAL CAVITY: mucosa moist, good dentition, no pallor.

THROAT: clear.

NECK/THYROID: neck supple, full range of motion, no cervical lymphadenopathy.

SKIN: 3 tattoos (RUE, LUE, RLE), warm and dry, no pallor.

HEART: regular @ 76/minute. S1, S2 normal, no murmurs, rubs, gallops.

LUNGS: clear to auscultation bilaterally, no wheezes, rales, rhonchi.

CHEST: no spider angiomata, no palpable nodes, AP diameter normal.

ABDOMEN: normal bowel sounds present, soft, non-palpable.
To Tattoo or Not to Tattoo

Social History
- Tobacco Use
  - Tobacco Use/Smoking
    - Are you a non-smoker
  - Drugs/Alcohol
    - Have you used drugs other than those for medical reasons in the past 12 months? No
    - Alcohol Screen
      - Did you have a drink containing alcohol in the past year? Yes
      - How often did you have a drink containing alcohol in the past year? 2 to 4 times a month (2 points)
      - How many drinks did you have on a typical day when you were drinking in the past year? 3 or 4 drinks (1 point)
      - How often did you have 6 or more drinks on one occasion in the past year? Never (0 point)
    - Points: 3
    - Interpretation: Positive
- Miscellaneous:
  - No Tattoos
- Children: Yes
- Marital status: Married
- Occupation: Office workers

Allergies
- N.K.D.A.

GI Procedures
- COLON 01/02/2011

Review of Systems
- General/Constitutional:
To Tattoo or Not to Tattoo
4. Chronic constipation
Police will continue with habits he's a fiber and stool softeners as needed. Her constipation symptoms for the most part are well controlled at this time.

5. Weight Loss
[Redacted] has lost a few more pounds in the last 2 months. I've encouraged her to eat smaller meals throughout the day and use some nutritional supplements. Her BMI is acceptable, but I would not like her to lose any more weight. She did an endoscopic ultrasound on [Redacted]
Done at [Redacted] The gastric wall was normal as was the pancreas. We'll continue to follow her weight.

Follow Up
4 Months
Exam Type: CT abdomen and pelvis without contrast performed on __________ PM
Indication: inguinal hernia/djd
Comparison: Right hip CT dated __________ CT abdomen dated __________

Technique: Following the administration of oral contrast only, axial CT images were acquired through the abdomen and pelvis. Sagittal and coronal images reformatted from the source data. Additional coronal and sagittal reformats of the hips were performed.

Findings:
Evaluation of the solid visceral organs and vascular structures is suboptimal secondary to lack of intravenous contrast.
Small bleb seen at the left lung base. Ovar seen within the rectum of the liver. There is a less than 1 cm hypodense focus within the left lobe of the liver which is too small to accurately characterize. The gallbladder is not dilated. Pancreas, spleen and adrenal glands have an unremarkable unenhanced appearance. There is no hydrenephrosis. Aorta is normal in caliber. Small fat attenuation focus within the lower pole the left kidney measuring 4 mm possibly representing a small angiomyolipoma. This is unchanged.

No small bowel obstruction. No nodular soft tissue density seen on the right inguinal ring which is unchanged from prior CT NIPS study and is likely postsurgical. No bowel containing hernias. A normal appendix is noted.

Urinary bladder is decompressed. No free fluid No free air or fluid collections.

No fracture or subluxation seen within the right hip. There is progression of degenerative changes within the right hip, noting increased sclerosis and subchondral cystic changes...

IMPRESSION:
EHR Liability Issues

Reasons for RAC Overbilling Audits

- Failure to Meet Medicare Medical Necessity Standards: 40%
- Incorrect Coding: 35%
- Insufficient Documentation: 8%
- Other: 17%

AHA (November 2010). RAC TRAC Survey
## DATA BREACH: HIPAA CIVIL PENALTIES

<table>
<thead>
<tr>
<th>HIPAA Violation</th>
<th>Minimum Penalty</th>
<th>Maximum Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual did not know (and by exercising reasonable diligence would not have known) that he/she violated HIPAA</td>
<td>$100 per violation, with an annual maximum of $25,000 for repeat violations (Note: maximum that can be imposed by State Attorneys General regardless of the type of violation)</td>
<td>$50,000 per violation, with an annual maximum of $1.5 million</td>
</tr>
<tr>
<td>HIPAA violation due to reasonable cause and not due to willful neglect</td>
<td>$1,000 per violation, with an annual maximum of $100,000 for repeat violations</td>
<td>$50,000 per violation, with an annual maximum of $1.5 million</td>
</tr>
<tr>
<td>HIPAA violation due to willful neglect but violation is corrected within the required time period</td>
<td>$10,000 per violation, with an annual maximum of $250,000 for repeat violations</td>
<td>$50,000 per violation, with an annual maximum of $1.5 million</td>
</tr>
<tr>
<td>HIPAA violation is due to willful neglect and is not corrected</td>
<td>$50,000 per violation, with an annual maximum of $1.5 million</td>
<td>$50,000 per violation, with an annual maximum of $1.5 million</td>
</tr>
</tbody>
</table>
HIPAA Breaches by Category

- Hacking: 23%
- Public Access or Distribution: 23%
- Improper Disposal: 7%
- Unauthorized Access/Use: 7%
- Virus: 5%
- Loss: 4%
- Theft: 28%
- Unknown: 3%

Q1 2012
HIPPA Breaches by Type of Information

Q1 2012

Source: International Association of Privacy Professionals: Planning for and Responding to a Health Information Data Breach
ICD-10
ICD-10: It’s Here. Well, Maybe.

- "There are no more delays and the system will go live on Oct 1 (2014). Let's face it guys, we've already delayed it several times and it's time to move on. It's a standard in the rest of the world."
  - Marilyn Tavenner
  - Administrator, CMS

- DELAYED: To 2015?
ICD-10

- 45 CFR 162.1002  HIPAA Administrative Simplification
- SPECIFICITY
- Implementation Deadline:
  - ICD-9 = 14,567 diagnosis codes; ICD-10 = 69,832 codes
  - ICD-9 CM = 3,878 procedure codes; ICD-10 PCS = 71,920
  - ICD-9 Five digits; ICD-10 Seven digits; alpha numeric
    - Allows disease etiology, anatomic site, severity coding
- Specific and lateral (right vs. left diagnoses)
- Not an update; fundamentally different
- Ability exists to add new codes in future releases
ICD-10 Example: S52.521A

- **S52** Fracture of Forearm
- **S52.5** Fracture lower end of radius
- **S52.52** Torus fracture of lower end of radius
- **S52.521** Torus fracture of lower end of right radius
- **S52.521A** Torus fracture of lower end of right radius, initial encounter for closed fracture
ICD-10 Internet Based Resources

- General ICD-10 Information
  - [http://www.cms.hhs.gov/ICD10](http://www.cms.hhs.gov/ICD10)

- ICD-10-PCS Coding System and Training Manual
  - [http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/08_ICD10.wsp](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/08_ICD10.wsp)

- ID-10-CM Coding System

- AMA information releases and examples
ICD-10 On Line Training

- CMS training: Provider Resources Internet Page at CMS.Gov
  www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html
  - Physician training
  - Vendor information
  - FAQs
  - Medical Practice Tips
  - Checklists and Implementation Guides
The World Health Organization (WHO)

- ICD-10 Instruction Manual
  - [http://www.who.int/classifications/icd/ICD10Volume2_en_2010.pdf?ua=1](http://www.who.int/classifications/icd/ICD10Volume2_en_2010.pdf?ua=1)
- Available in 42 languages
- On-Line Training Tool
  - [http://apps.who.int/classifications/apps/icd/icd10training/ICD-10%20training/Start/index.html](http://apps.who.int/classifications/apps/icd/icd10training/ICD-10%20training/Start/index.html)
- Download area makes all licensed materials available
  - [http://www.who.int/classifications/icd/en/](http://www.who.int/classifications/icd/en/)
ICD-10 Implementation

- **Awareness**
  - Communication
  - Training Plan

- **Assessment**
  - Review implementation
  - Remediation strategy
  - Identify outliers

- **Remediation**
  - Update policy and process
  - Re-training

- **Testing**
  - End to end testing

- **Transition**
  - Evaluate outcomes
  - Implement remediation
ICD-10: 141,000 Codes

- Hurt at the opera Y92253
- Stabbed while crocheting Y93D1
- Walked into a lamppost W2202XA
  - Lamppost, subsequent encounter W2202XD
- Submersion due to falling or jumping from crushed water skis V9037XA
- Struck by a duck (W6162XA)
- Bitten by a duck (W6161XA)
- Spacecraft crash injuring occupant
  - V95.41 (not billable)
- Fear of the Easter Bunny (phobia, other animals)
  - F40.218

*
Medical Malpractice - Healthcare Fraud
Areas of Risk Exposure

- Medical Record Documentation
- Informed Consent Deficiencies
- Inadequate Patient Education
- Poor Physician-Patient Communication
- Poor Physician-Physician-Nurse Communication
- Lack of Medical Necessity for Performed Medical Services
- Improper Performance of Medical Services/Care
Areas of Risk Exposure

- Overutilization or Unusual Utilization Triggers Investigation
- Investigation Leads to Publicity
- Investigations Lead to Medical Malpractice Suits
- Hospital / Physician Arrangements At Risk
- Hospital Survival At Risk
- Physician License At Risk
Quality Failures That Could Be Improved Through Education

1) Inadequate informed consent: What is your doctor’s process? Who delivers it?

2) Missed abnormal lab results: What is the system to ensure this does not occur?

3) Incomplete H&P – pre-surgical workup: How is adverse patient managed?

4) Medication management errors: How does the practice develop medication data and check for contraindications?

5) Patient handoff: What is the process to avoid failure to communicate with other providers?
Compliance and Quality Investigations
Quality, Compliance, and Malpractice

- St. Joseph’s Medical Center, Baltimore MD, opens new state of the art Cardiac Catheterization Lab
- Retains leading NE area Interventional Cardiologist, Mark Midei, MD, as Director
- Cath Lab quickly becomes “go to” facility for difficult cases & stent placement
- Stent utilization exceeds all manufacturer’s prior records (according to e-mail messages by manufacturer later discovered during investigation)
Quality, Compliance, and Malpractice

- As stent use increases, an employee who had a stent placed files a *qui tam* complaint with the OIG complaining he had a coronary artery stent inserted that was not medically necessary
- The OIG analyzes stent utilization and conducts an investigation of stent billing and medical records
- 658 stent placements are questioned as “not medically necessary”
- Fines and penalties are assessed against the hospital
Quality, Compliance, and Malpractice

- Hospital conducts its own investigation → relieves Dr. Midei and sends letters to all 600+ patients advising them to consult with their Cardiologist
- Hospital settles the OIG charges for $22M for alleged violations of Anti-Kickback and Stark Laws
- Dr. Midei is subjected to a highly publicized U.S. Senate Finance Committee investigation
- Dr. Midei's license to practice medicine is revoked by State Board of Medicine
Quality, Compliance, and Malpractice

- A media frenzy is ignited with repetitive negative news stories about Dr. Midei, the hospital and the parent company, Catholic Health Initiatives
- Over 600 medical malpractice lawsuits are filed against Dr. Midei and his cardiology group
- St. Joseph’s Hospital closes the Cath Lab due to lack of utilization
- Hospital sold by CHI to University of Maryland System
Quality, Compliance, and Malpractice

- **2014 Update:**
  - Weinberg v. SJMC, Midei Stent trial with $60M damages claimed: $500,000 settlement
  - Sullilvan v. SJMC, Midei Stent trial: Hung Jury
  - Most cases settled by CHI, SJMC to avoid trial
  - Multiple $Millions spent to resolve claims
Questions?

Engineering Flowchart

DOES IT MOVE?

No
- Should it?
  - No
    - No Problem
  - Yes
    - WD-40

Yes
- Should it?
  - Yes
    - No Problem
  - No
    - Tape
D. Scott Jones, CHC

- Senior VP Claims, Risk Management & Corporate Compliance – HPIX
- Leads a team managing 700 malpractice claims annually
- Compliance, Risk and Claims for 3600 providers
- Former medical practice & hospital administrator
- Board Certified Healthcare Compliance Officer (CHC)
- Author, 12 nationally published books and over 50 articles on quality, practice management, and regulatory compliance
- Frequent speaker to state, regional and national organizations
- Over 1000 risk assessment service visits to healthcare organizations nationwide

- sjones@hpix-ins.com
- (904) 294.5633
Thank You!