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Part B News
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In this issue

Practice management

Preventive measures, appropriate responses reduce litigation risks

You've educated your staff on how to recognize the warning signs that a patient is litigious (*PBN 9/15/25*). You've emphasized that they should communicate their concerns to a supervisor or practice owner. Your next step is to give your team more guidance on what to do when they believe a patient is likely to sue the practice, has threatened to sue, or is currently suing the practice.

You can't eliminate the risk that a patient will sue the practice, but there are ways you can reduce the risk of lawsuits, protect your staff and increase patient satisfaction at the same time, experts say.

Take a preventive approach

"Understanding the avoidable risks and pitfalls in advance helps to safeguard health care practitioners against personal liability and potential disasters if an unanticipated adverse event occurs," explains Richard F. Cahill, J.D., vice president and associate general counsel for The Doctors Company, a division of TDC Group.

Good communication skills are crucial to managing risk, experts agree.

"Before we get to possibly litigious patients, let's talk about nipping patient dissatisfaction in the bud, when feasible," says Angela T. Burnette, counsel, Alston & Bird. For example, long wait times during an appointment can frustrate patients, especially when it is a common occurrence. If your providers are running late, apologize to the patient for the delay and

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give an estimated time that they'll be seen, Burnette says. "That 15-second conversation goes a long way in smoothing things out and helping the patient feel seen," she adds.

"Be responsive to patient demands so they are not escalated by non-responsiveness," advises Ericka L. Adler, a partner and leader of the health care practice at Roetzel & Andress in Chicago. "Training staff on listening and building trust with patients can really make a difference," and staff should also receive training on how to remain calm and professional, she says.

Providers should follow the unwritten rules of polite conversation during visits, such as maintaining eye contact with the patient, rather than peering at their computer; asking the patient questions; listening to them without interrupting; and avoiding medical jargon and using terms that the patient can understand, Burnette says.

Take particular care about how patients receive their test results, which is another area where a communication breakdown can flare up into legal problems for the practice, Burnette warns. "Due to electronic medical records and patient portals, patients are receiving written radiology reports and lab results before you have reviewed or explained it to them. The wording of a radiology report may seem fine to you but is keeping a patient up at night," Burnette explains.

Train staff to be professional and sympathetic when they have to relay bad news, she says, and gives the example of a patient who was upset by the way a practice member told her she had skin cancer. "The patient later shared with the physician that the staff member sounded like she was bored and reading a grocery list — but it was the first time the patient learned they had a skin cancer," Burnette says.

Finally, communications with your patients should be clear, consistent and professional, says Craig Conley, shareholder and chair of Baker Donelson's health care litigation group.

Pay attention to how staff communicate with each other. "Have things escalated to a decision-maker early on, when possible, hopefully someone with training in handling difficult people," Adler says. In addition, the practice should give staff clear guidelines on how to respond to a problem patient, she says. When staff communicate their concerns about patients, they should watch their language. "Derogatory or offensive personal comments should be expressly avoided," Cahill says.

Set standards for your patients

Whether it is unjustified threats to sue, hostility toward staff or constant non-compliance, you can protect your practice from patients who are likely to cause headaches with a code of conduct contract. "Setting boundaries and expectations for patients is acceptable," Adler says.

These agreements, which patients read and sign, can deter patients who are spoiling for a fight. "A

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clear and concise set of rules may also tend to discourage contentious patients from seeking care from the outset," Cahill says. He recommends a uniform policy "consistent with the community standard and require individuals to sign a formal conditions of treatment so that even prospective patients understand the expectations of the practice at the earliest stage of the evolving relationship" (*see resource, below*).

"Protecting staff is also key so they are not abused," Adler says. With that in mind, include standards for how patients must treat members of the practice. This can also make the practice unattractive to abusive patients.

You can deploy compliance or conditions of treatment agreements on an as-needed basis if clinically appropriate. For example, when a patient repeatedly cancels or misses appointments or does not comply with their treatment plan, "you could consider asking the patient to sign a compliance agreement or conditions of treatment agreement, stating they agree to comply with the recommended treatment plan," Burnette says. She advises practices to call in an attorney to make sure the agreement itself complies with laws and local requirements.

Document disputes and other problems

Remind staff to take notes when a patient complains or is hostile. These notes can be brief, unless the patient has given signs that they're likely to sue. "Thorough and complete documentation is key when dealing with a potentially litigious patient," Conley says. When dealing with these patients, staff should document each interaction and let the patient know that they're doing so, Adler says.

Patient conduct agreements, combined with careful documentation, will protect the practice if it fires the patient and the patient cries foul. But emphasize that the documentation must be thorough, objective and professional, Conley says.

Follow 3 more best practices

1. "Be curious," not defensive or dismissive, Burnette counsels. A member of the medical team or a patient advocate should reach out to patients who express concerns about a member of your staff, she says. This can keep patients from getting frustrated and escalating the problem. It can help the practice, too. "You might learn valuable information as to an opportunity for improvement or a need for additional staff training, such as a new lab tech who left significant bruises after several needlestick attempts," Burnette elaborates. The same guidance applies if a patient suddenly announces they're going to sue during a visit, she says.
2. "For a patient who has threatened to sue, has asked you to discount your care because of the outcome, or whose lawyer has requested medical records from you, notify your risk manager and your malpractice carrier," Burnette says. "Do not wait to contact a carrier until you receive the actual lawsuit," she says.
3. "Watch what you say in terms of admitting a medical error or mistake or trying to negotiate with the patient — you do not know all the facts, and certain admissions could be used against you in court and possibly jeopardize your malpractice insurance coverage," Burnette says.

Avoid these 6 'worst practices'

Solidify the lesson by training staff on things they should not do when they're confronted by a patient who is litigious, a bully or simply unhappy. Starting with a reflexive response:

1. Arguing with the patient. Adler, Burnette and Conley warn against arguing with a patient. Even when a staff member knows the patient is being unreasonable, if they become defensive or get into a shouting match, it will make things worse.
2. Ignoring patient complaints, Adler says. This will frustrate the patient and increase the chances that they'll file a complaint. "Not documenting discussions and following up with patients is a major issue," she warns.
3. Giving patients a pass. Don't allow patients who are difficult or abusive to remain with the practice after several attempts to resolve the issue, Adler says.
4. Withholding records. Practices should not try to withhold medical records from a patient or a patient's attorney when the practice knows the patient intends to file a lawsuit, Burnette says. "There is no HIPAA exception for angry or litigious patients. Such patients could file a HIPAA access complaint online with the [HHS] Office for Civil Rights and then providers could have a federal HIPAA investigation on top of the still unhappy/litigious patient," she warns.

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5. Altering records. Don't try to revise the patient's chart in response to a threatened lawsuit, Burnette says. "Instead, consider the chart 'frozen in time' and contact your risk manager and your insurer to provide preliminary notice of the incident, to discuss your situation, and to help gather and preserve relevant documentation," she says.
6. Creating great expectations. Providers should not guarantee a positive outcome for a procedure or treatment, Conley says.

Final step: Termination

"Terminate patients when signs are clear that the patient is or will become an issue," Adler says. This can be a difficult decision to make but practices have the right to refuse to treat disruptive patients (*PBN 8/28/23*). However, the practice must follow the proper procedure for doing so, she warns.

"Review the chart to confirm the objective, non-discriminatory facts supporting your decision to terminate, such as ongoing non-compliance or open hostility toward your staff," Burnette says. Make sure you follow state law and "check your managed care and payer contracts to confirm any other specific requirements," she advises.

You can check your state's medical licensing board for guidance and sample termination letters, Burnette says. If possible, you should bring in a health care attorney to help you through the process, especially if this is the first time your practice has terminated a patient, or the patient has an acute or serious chronic condition. In these circumstances "the provider should assist in transitioning the patient to a new provider so the patient's treatment is not interrupted or delayed," Burnette says.

Finally, warn treating practitioners who are on call or who moonlight at a local emergency room that they might need to treat a patient the practice has fired. They must follow Emergency Medical Treatment and Labor Act (EMTALA), the federal patient anti-dumping law, if they're called on to treat a patient the practice has terminated in the emergency room, Burnette says. — *Julia Kyles, CPC* (*julia.kyles@decisionhealth.com*) ■

RESOURCE

- The Doctors Company — "Proactively Manage Patient Expectations with a Conditions of Treatment Agreement:" *www.thedoctors.com/the-doctors-advocate/first-quarter-2024/proactively-manage-patient-expectations-with-a-conditions-of-treatment-agreement/*

Practice management

Failed restrictive covenant case signals a warning to practices

Recently a New Jersey practice lost a suit to enforce a restrictive covenant against a physician they had released. Experts say the case reveals pitfalls that practices should take care to avoid when they write and enforce their noncompetes and other covenants, and ways to get around them if they still come up.

According to presiding Chancery Court Judge Darren T. DiBiasi's decision, Timothy Vogel, M.D., was a well-regarded pediatric neurosurgeon when he was recruited from Cincinnati Children's Hospital Medical Center to New Jersey Brain and Spine (NJBS) in 2016. NJBS was eager to establish a pediatric neurosurgery practice, mainly to head off New York's Columbia University, which had an apparent interest in supplying those services to Hackensack University Medical Center (HUMC), with which the practice is associated for other specialties.

Vogel signed up, moved his family to New Jersey, and for seven years performed at a high level, winning renown in his profession and cementing NJBS' pediatric neurosurgery practice at HUMC. But NJBS was losing money on him, owing to the vagaries of the subspecialty including a high number of Medicaid patients, as well as Vogel's high salary. In 2022, NJBS informed Dr. Vogel that it was "moving in a different direction" and he was terminated without cause or advance notice.

Vogel continued to work at Hackensack under other employment agreements, notwithstanding the hospital was within the region circumscribed by his employment agreement with NJBS. He didn't have much choice; capabilities for Vogel's subspecialty, explains Steven I. Adler, a partner with Mandelbaum Barrett P.C. and one of the lawyers who represented Vogel at trial, are offered by "virtually none of the other hospitals in New Jersey." Also, having been dismissed, Vogel had no reason to consider the covenant binding.

NJBS disagreed, sought an injunction, and sued for breach of contract, among other charges, seeking to recover $4.3 million from Vogel. NJBS also, in the course of litigation, charged that Vogel had actually

(continued on p. 6)

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Benchmark of the week

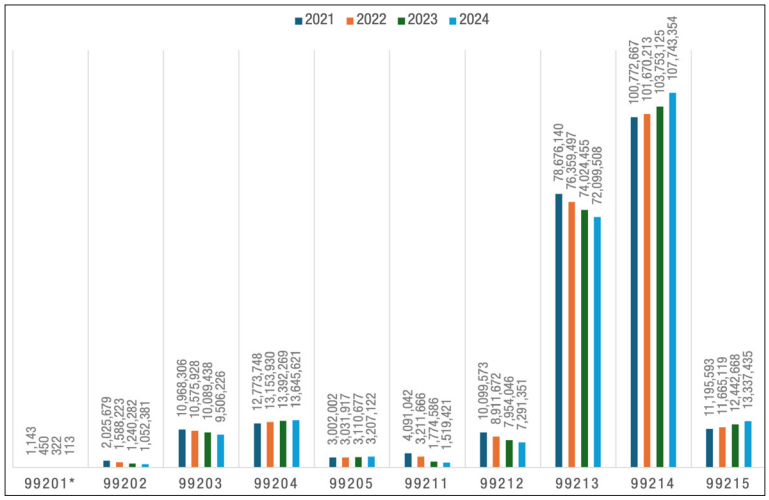
E/M office visit payments fall to four-year low, despite high-level code climb

Higher-level E/M office visit codes for established patients continued to climb in 2024, with significant growth for Level 4 and 5 codes. Yet total payments for the office visit suite (**99202-99215**) were at their lowest levels in four years.

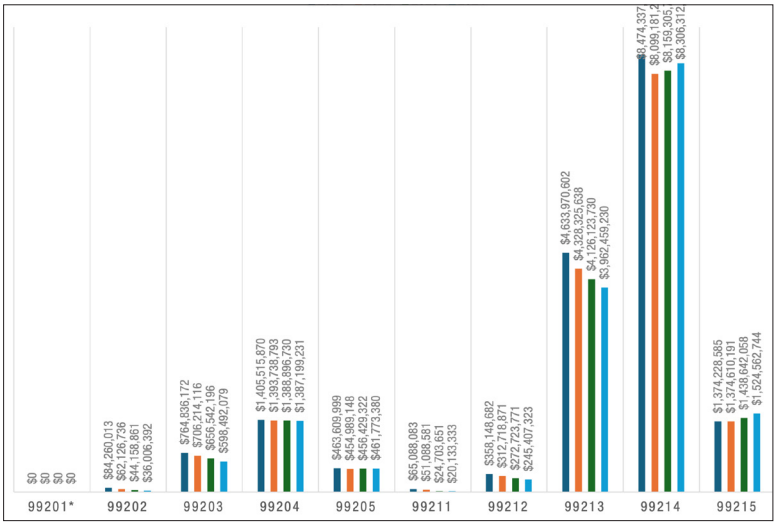
Between 2023 and 2024, providers increased reporting of 99214 by 4 million services, a 4% jump, and that's up 7% total since 2021, according to the latest available Medicare claims data. However, denials on 99214 also jumped a point, reaching 4% in 2024, the highest mark over the four-year period. Claims for 99214 reached 13.3 million in 2024, up from 11.1 million in 2021. While the total reimbursement figures for 99214 and 99215 continued to grow in 2024, the reduction in claims across most of the rest of the code set, along with other payment factors, delivered a total of $16.5 billion in payments in 2024 (*PBN 1/6/25*). That's down from $17.6 billion in 2021.

Lower-level established codes 99211, 99212 and 99213 all saw sizable reductions in claims over the four-year period. Claims for 99211 fell from more than 4 million in 2021 to just 1.5 million in 2024, a 63% decrease. Similarly, 99212 and 99213 had significant losses. The new patient code sets followed a similar pattern: 99204 and 99205 hit high water marks in 2024, while 99202 and 99203 dropped. Remember that the AMA deleted 99201 effective Jan. 1, 2021. That year, providers tried to report it 1,143 times. By 2024, that number had fallen to 113. — *Richard Scott* (*richard.scott@decisionhealth.com*)

Utilization of E/M office visit codes, 2021-2024



Payments for E/M office visit codes, 2021-2024



Source: Part B News *analysis of 2021-2024 Medicare claims data*

(continued from p. 4)

been dismissed for cause and supplied witnesses who testified to that. Ultimately, the judge dismissed the testimony as "inconsistent with the evidence," pointing to the lack of any disciplinary paper trail.

Is the burden undue?

No case in which the judge suggests one's witnesses are not on the level can be said to have much chance of success. The practice's switcheroo on firing Vogel without cause might have been made in hopes of strengthening a weak case against him.

"The practice had the right under his contract to let him go without cause," Adler says. "But if the court found they really did let him go without cause, then they would be more likely to find in the employee's favor, because he didn't actually screw up as an employee and thus bring this restrictive covenant upon himself."

It's also unusual for a practice to seek to enforce a restrictive covenant when the employee in question is released without cause, rather than leaving on his own.

Still, it could have gone the other way. Salvatore G. Gangemi, a partner with the Harris Beach Murtha firm in Stamford, Conn., thinks NJBS would have had a better chance if Vogel had violated other aspects of the covenant — for example, "if he'd taken with him some confidential information, like patient lists, and started calling those people."

The court might also have found for NJBS if the judge accepted that the practice's harm from Vogel's continued presence outweighed Vogel's harm from the restrictions of the covenant. But his lawyers successfully argued that freezing Vogel out of his field in his home territory with the covenant's time and regional restrictions placed, in legal terms, an undue burden on him.

All restrictive covenants put some burden on the contracted employee, Adler explains. But if, for example, "an employer is trying to bar a former employee from working in a particular industry, but that industry is the only industry in which the employee ever worked, courts usually will not enforce the restrictive covenant, since it would impose an undue hardship [and] make the former employee unemployable. Courts do not want to preclude an employee from earning a living and supporting his or her family."

Consider options other than noncompetes

Noncompete clauses are finding new challenges in state legislatures, and may lose salience as ways of keeping departing doctors out of your backyard.

Last year saw the courts strike down the Federal Trade Commission's proposed national noncompete regulation (*PBN 9/9/24*). But the states are moving ahead: The Economic Innovation Group's state noncompete law tracker shows that while only four states have banned noncompetes outright, most states have some restrictions on them, including limits on contracts that can contain them based on salary level.

Given the environment, says Tamika Hardy, a partner with Rivkin Radler in Uniondale, N.Y., "employers need to move away from restricting how and where people work; they need to focus instead on their business interests — patient lists, referral lists and vendor lists. They should focus more on non-solicitation of the things that make your business unique and profitable."

Hardy also suggests you look at other ways, certainly other than litigation, to get what your practice needs in the employment and post-employment.

"I try to get my clients to ask themselves, what is the *legitimate* business interest that you are trying to protect [with this covenant]?" Hardy says. "Everything you put in this agreement should be geared toward protecting that."

"If you can't clearly articulate the interest you are trying to protect [with your noncompete], then your noncompete is overbroad," Gangemi says.

Also remember that, if it comes to cases, just as courts consider some employee burdens undue and some not, they might consider some business interests legitimate and some not, and merely preferring less competition may not cut it.

"Again, noncompetes are not there to prevent competition," Gangemi says. "Noncompetes exist to

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prevent *unfair* competition. In the United States, fair competition is fair game."

3 more tips

Talk to patients, not the court. "While a patient has the right to be treated by the doctor of their choice, [under normal agreements] they can't be solicited [by their former doctor]," Hardy says. That gives you the floor to convince them to stay. "If the goal is not to lose patients, give yourself the space and time to develop relationships with the patients who were being treated by this departing physician."

Add takeback terms. In negotiating the agreement, put in reimbursement terms for yourself, Hardy says: "For example, you might include a provision that says that if the doctor leaves you have to be paid back for what you invested in their marketing and education."

Come to terms. Even if you're the one making the call to terminate an employment agreement, try to bring the employee to the table and negotiate terms, using the current language as a starting rather than a stopping point. "Perhaps instead of saying all of these hospitals that are in this vicinity [are off limits]," Hardy says, "maybe you can say, '90% of our patients are at these four hospitals so we're going to let you work at the other ones.'" If it goes well, there'll be less chance of a challenge afterward. — *Roy Edroso* (roy.edroso@decisionhealth.com) ■

RESOURCE

- Economic Innovation Group state noncompete law tracker: https://eig.org/state-noncompete-map/

Practice management

Survey says docs feel MD shortage; go for young recruits, high engagement

A Medscape survey of 1,001 physicians suggests that the shortage of health care providers in the U.S. is being felt keenly at ground level, with doctors lamenting a lack of sufficient "qualified applicants" to relieve it. Experts suggest luring recruits with relevant offers and engagement.

The Medscape survey, results of which were published on Aug. 22, conforms in some ways with other recent surveys and research showing the paucity of providers increasing (*PBN 4/10/23*). Some 69% of respondents, for example, said their offices were actively looking for new doctors, and at least half said that the unfilled positions had either some or a substantial effect on their own work hours.

The good news is that 37% reported the availability of "qualified applicants" in their area had increased, as opposed to 30% who said it had decreased. However, 63% said they'd still "seen evidence of a shortage" of such applicants.

More ominously, 58% of respondents said they were not confident that this physician shortage situation was going to improve over the next 10 years.

What's the problem?

Worries over a decline in MDs in practice is nothing new. As far back as 2010, for example, *Part B News* reported that "the physician shortage has put increasing pressure on hospitals and practices to ratchet up their recruitment offerings." (*PBN 2/10/10*).

The forces traditionally blamed for this are various, including retirement waves among doctors; the cap Congress put on medical educational funding for new physicians in 1997; and the COVID pandemic. Multiple means have been employed to relieve the problem, including programs to help license and place physicians from overseas in American communities (*PBN 7/10/23*).

Tara Osseck, regional vice president of recruiting at Jackson Physician Search, sees other factors including "rising patient demand with higher complexity, and widespread burnout leading some doctors to cut back or leave practice early. On top of that, rural areas feel the brunt of maldistribution, even in specialties that seem balanced nationally."

Most of the respondents said they relied on networking to identify recruits, with 56% tapping into their own physicians and other staff, and 32% finding recruits at "conferences and association meetings." About 32% tried higher compensation and 27% used a recruiting firm. As the Medscape survey shows, their efforts have not had a significant effect, and practices seeking new hires might consider other recruitment approaches.

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Bring in the youth

Shaun Rangappa, M.D., chief clinical executive of the health care business transformation practice at international crisis and transformation advisors FTI Consulting, says that "attracting early career or experienced physicians in this era of widespread burnout and industry consolidation requires more than just job postings, happenstance networking and recruiter reach-outs."

Rangappa thinks it's wise to look for "early-career clinicians," including "new grads from internal medicine, family medicine, OB/GYN and other primary care feeder programs," who are "intellectually curious, seeking emotional connection with colleagues and tutoring from mentors," and "want to be respected by the practice and also challenged," and offer them an environment that meets those needs.

To attract this young talent, Rangappa suggests incentives including "structured onboarding and mentorship where possible, especially in the first 12-18 months," "protected time for case review, learning and feedback," and "professional development investment."

Rangappa also believes these prospects may be attracted by an overt display of interest in emerging, forward-looking medical trends, such as data analysis, evidence-based medicine and artificial intelligence (AI), and "encouragement to ask questions and collaborate across complex patients or scenarios."

Make medicine great again

Stu Schaff, founder and CEO of health care consultancy The Best Practice in Chicago, sees the issue as at least partly cultural. "It's a tough time to be a health care provider," he says. "I would imagine there are people who previously would have chosen to become physicians who are making other choices now. Some of the sheen has come off the idea of becoming a doctor."

Prospects who've persisted in medicine despite that will be more likely to choose a practice "where physicians love to work." In Schaff's view, this requires active and engaged management, the kind that "sets clear expectations for physicians, puts them in the best position to meet those expectations by supporting them every way they can, and rewards them if they choose to exceed expectations in a meaningful way."

"Even professional athletes who are arguably amazing at what they do get coached — and their coaches get paid a tremendous amount of money," Schaff adds. "We haven't adopted that same practice with physicians. But it's time we change our thinking. We need to lead our physicians like we lead any other members of our teams."

"Retention is just as important" as recruitment, Osseck says, and you can maintain that by giving your most valued physicians "better schedules, reduced administrative burden, and compensation models that reward quality and access, not just productivity. The fastest progress will come not from any single fix, but from addressing training, deployment and retention together." — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCE

- Medscape, "Feeling the Impact of the Physician Shortage: Medscape Report 2025," Aug. 22, 2025: *https://www.medscape.com/slideshow/2025-doc-shortage-report-6018535* (subscription required)

Practice management

Public interest: Another noncompete hurdle

Along with other relevant legal issues, courts may also rule on whether blocking a physician's employment is harmful to the public interest.

In the Vogel case, that argument was prepared because the pediatric neurosurgeon "would not be able to perform his complicated cases elsewhere, since other hospitals were not equipped to do those surgeries," says Steven I. Adler, Vogel's attorney. But it was not needed, as the defense's other arguments carried the day.

If all else failed, though, Vogel's niche subspecialty, and the vulnerable and underserved population he treated, could have succeeded. Henry Norwood, of counsel with Kaufman Dolowich in San Francisco, notes that "enforcing this noncompete would potentially result in less access to care for children," and that "weighed on the court's decision."

Norwood suggests you keep that in mind especially when drafting a noncompete involving a specialist physician such as Vogel, and preempt objections with "lesser restrictions on the geographic and temporal terms of the noncompete." — *Roy Edroso* (*roy.edroso@decisionhealth.com*)

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