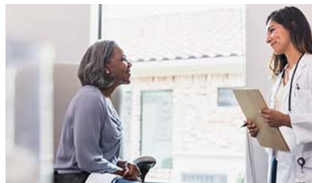

Patient blocks exam elements? Work with them before turning them away

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Practice management

If a patient declines part of their examination — a weigh-in or disrobing, for example — you may be able to work around it, or take the opportunity to educate the patient on the necessity of the declined element. If you can't get past it, however, make sure to proceed carefully to avoid charges of discrimination or abandonment.

Patient-provider communications have been a popular topic in health care circles for decades, treated in hundreds of studies. This has been partly motivated from the patient side via the patients' rights movement and by traditions that grew from it, such as patient advocacy and the patient-as-consumer model (*PBN 3/11/19*).

While these efforts generally aim at better cooperation between providers and patients, some patients' rights activists encourage their members to strongly assert their preferences in the doctor's office, sometimes in the face of customary practice. One such group, More-Love.org, an "online resource that empowers parents to raise kids who are free from body hate, disordered eating and eating disorders," recently attracted attention for distributing cards saying "Please don't weigh me unless it's (really) medically necessary" for patients to bring to the doctor's office. This initiative comports with the thinking of advocates who sometimes question the necessity of the traditional medical weigh-in (*PBN 6/19/19*).

Confronting patient refusal

Providers are occasionally confronted by patient refusal to accept some specified element of diagnosis or treatment. Sometimes the conflict is administrative. Christopher J. Kutner, a partner in the health services practice group at Rivkin Radler LLP in Uniondale, N.Y., describes a recent call from a client at an ambulatory surgery center (ASC) where a patient refused to sign the informed consent form for the procedure unless it could be rewritten to his specifications. (The patient was also a lawyer.)

In this case the patient was turned away. "I advised them to document what occurred and what the patient said and to make sure they had witnesses to the incident," Kutner says, to demonstrate that the ASC "complied with their professional obligations and had a record of the incident."

But in many cases the patient refusal has to do with an element of the provider's work, such as a weigh-in or disrobing for an examination. The AMA Code of Medical Ethics addresses the disrobing issue, calling for "efforts to provide a comfortable and considerate atmosphere for the patient and the physician," such as "providing appropriate gowns, private facilities for undressing, sensitive use of draping and clearly explaining various components of the physical examination." And medical chaperones for patients concerned to be alone with a provider while in a vulnerable state are part of accepted medical practice (*PBN 3/7/16*).

But some patients can't be persuaded by these means, leaving the provider who needs to perform the examination in a quandary. While CMS' recent shift to allow for a time-based E/M standard removes the need to count exam elements to establish the level of service, it does not remove the clinical need to perform an appropriate examination (*PBN 5/17/21*).

Faisal Khan, senior legal counsel and hospitals and health systems practice lead at Nixon Gwilt Law in Cleveland, advises providers to conduct a "micro consent discussion" with the patient on the point at issue. That may be "a conversation about the clinical importance of the refused tasks and how by failing to do it, the patient may be jeopardizing his/her care because the provider may not have the requisite clinical data to render a proper diagnosis," Khan explains.

Heed HIPAA hitch

While some arguments are irrefutable — for example, religious reasons — patients may resist for reasons that can be addressed by a workaround. Jeffery P. Drummond, health care partner at Jackson Walker in Dallas, points out that some patients don't want certain information that may be ascertained by examination to go on their health insurance record.

Providers are usually obliged by contract and allowed by HIPAA to communicate an insured patient's medical information to insurers. But, Walker says, such patients may avail an exception in the HITECH Act that he calls the "hide rule," by which "a patient may request that a health care provider not provide information relating to a particular service or treatment to an insurer for payment or health care operations purposes, so long as the patient has paid for the service or treatment in full, out of pocket, prior to making the request," he says.

If this is the case with the recalcitrant patient and they agree to pay for the encounter, Walker says the provider should still alert them to the downsides of such a course; for example, "the patient might need follow-up care from the same or a different provider that the insurer refuses to pay for because there is no evidence of the first treatment; or the patient might need prescription drugs that the insurer refuses to pay for because, as far as the insurer knows, there's no disease/illness/condition warranting the prescription drug."

Last resort: Firing

If the patient continues to refuse, the provider should first determine whether they need that information to complete the work. Weigh-ins aren't always crucial to follow-up exams; Kevin D. Devaney, a health care attorney with Eastman & Smith in Toledo, Ohio, suggests you might be able to estimate the patient's weight visually in that case.

But in some cases it's indispensable — for example, "if they don't want to touched with a stethoscope, and you're a cardiologist," Devaney posits. In that case, you have to consider abandoning the service — and, potentially, discharging the patient.

What you certainly can't do, Devaney says, is charge Medicare or other insurers for incomplete services. "'I would have but he wouldn't let me' is unsatisfactory," he says. Nor can you get around it with an advance beneficiary notice (ABN), which, Devaney says, stipulates a completed rather than an incomplete service. "My position is: If you can't do the critical elements, don't bill it," Devaney says. "Just eat the claim. You'd spend more money chasing the bill anyway."

If the inability to perform some portions of service conflicts with your ability to treat the patient, you may need to consider discharging or "firing" the patient (*PBN 7/17/17*). Be aware of your state standards; in Ohio, for example, you need to give the patient a formal 30-day notice, Devaney says.

"Typically you're not required to provide the patient with a reason," Devaney says. "But if you do, you can just say, 'Failure to follow medical advice.'" Notify the patient by certified mail, and keep a copy in your records, as well as the clinical basis for your action, so if a patient abandonment charge is raised you have a solid defense (*PBN 4/23/18*).

Kutner advises that you inform the patient "that there are other providers available to treat that patient, and give the patient the names and addresses of the other providers so you're not accused of patient abandonment. "I think it is also wise to ensure the patient follows up with the new provider, because until provider A is sure that provider B has taken the patient in and under provider B's care, arguably provider A still bears some responsibility," he says. Be sure to document all your actions in such cases.

But make sure, in all your actions, that you are clearly addressing this patient's refusal rather than preemptively assuming refusal by a class of patients. "As long as your reason is objective and particular to the patient, you shouldn't have to worry about a discrimination case," Devaney says. "Just stay away from 'Won't treat this kind of person' statements. If you need the patient to disrobe because it's necessary and a Muslim person won't do it, your response is it's not because they're Muslim but because you can't provide clinical care because of their refusal."

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