Chapter 23
Social Work, Care Managers, and Physician Advisors: Liability Related to Discharge Planning and Continuity of Care

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Ethical Issues in Social Work

Social workers are licensed professionals who provide advice and guidance to vulnerable persons who are frequently at difficult points in their lives and who require counseling for complex decision-making. Hospitals are the most common setting for the employment of healthcare social workers. In the area of healthcare, social work has a focus on patient autonomy with respect to choices intended to further personal as well as societal well-being. Social work is concerned with the complexity of the human experience. Social workers are our interval members of the healthcare team and focus on preservation of personal autonomy, family relationships, community support, and support structures for patients who may have difficulty making appropriate choices for themselves.

Healthcare social workers work with patients and their families in the context of a particular illness and provide emotional support and counseling regarding choices and decisions. Social workers practicing within the hospital setting are also referred to as a "clinical social workers" or "medical social workers." Thus, within hospitals and healthcare systems, social workers are frequently closely on with members of the acute care team. Social workers typically make early contact with patients and families, seek to align goals of care with available resources, and explore post-discharge family and support structures. Typically, social workers help coordinate post-discharge planning and help identify optimal post-discharge rehabilitation or, in addition, social workers are actively involved in end-of-life care and palliative

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care and are therefore closely involved with clinical healthcare decision-making. Patient advocacy relates to the ethical principle of beneficence.

The National Association of Social Workers (NASW) established a Code of Ethics in 1996, subsequently revised in 2017 to articulate their shared ethical principles and ethical standards. The mission of the profession of social work is rooted in a set of six core values: (1) service; (2) social justice; (3) dignity and worth of the person; (4) importance of human relationships; (5) integrity; and (6) competence. The NASW Code articulate set of values, principles, and standards to guide decision-making and conduct to help address complex situations. Furthermore, the NASW Code of Ethics serves six purposes:

1. The Code identifies core values on which social work's mission is based.
2. The Code summarizes broad ethical principles that reflect the profession's core values and establishes a set of specific ethical standards that should be used to guide social work practice.
3. The Code is designed to help social workers identify relevant considerations when professional obligations conflict or ethical uncertainties arise.
4. The Code provides ethical standards to which the general public can hold the social work profession accountable.
5. The Code socializes practitioners new to the field to social work's mission, values, ethical principles, and ethical standards.
6. The Code articulates standards that the social work profession itself can use to assess whether social workers have engaged in unethical conduct. NASW has formal procedures to adjudicate ethics complaints filed against its members.* In subscribing to this Code, social workers are required to cooperate in its implementation, participate in NASW adjudication proceedings, and abide by any NASW disciplinary rulings or sanctions based on it.

   NASW Code of Ethics. 2017 [1]

Since social workers have expertise in understanding and optimizing the social situations from which patients are admitted, and will subsequently be discharged to, social workers have an important role on the integrated healthcare team. Where social workers focus on strategies to help assist with complex care coordination, post-discharge planning, and the management of post-discharge care challenges, nurses and providers can better focus on the acute process of disease management. Thus, in order to provide optimal care to patients, the team model of care should integrate the perspectives and opinions of clinical social workers.

Legal Issues in Social Work

Social workers are healthcare professionals who must practice in accordance with professional standards applicable to the professional social work; in addition, social workers are also interval members of a healthcare team. Thus, social workers are held to a standard of care and, deviation from the applicable standard of care may be actionable as professional malpractice or negligence. In general, liability exposure for social workers is highly dependent on the specific population served; for example, psychiatric patients, pediatric patients, elderly

patients, and indigent patients will all have varying needs and associated risks for liability.

Social workers are subject to the same federal and state statutes which govern healthcare providers, such as HIPAA and EMTALA; however, in some cases social workers are held to even higher standards, especially in the cases of statutes governing the obligations of social workers to investigate and report cases of suspected abuse and neglect of children, elders, and other vulnerable patients and minors' right to consent to mental health counseling and to drug and alcohol abuse treatment. Thus, similar to other members of the healthcare team, social workers are at risk for errors of commission (such as the breach of confidentiality) and also omission (failure to report); in many cases, such liability arises out of conflicting ethical and legal duties.

Ethical obligations and legal obligations are frequently at odds. On the one hand, the "rule of law" demands that, if justice is to prevail, laws must be applied to every similarly situated person equally. Accordingly, Wasserstrom writes that "given what we know of the possibilities of human error and the actualities of human frailty, and given the tendency of democratic societies to make illegal only those actions which would, even in the absence of law, be unjustified, we can confidently conclude that the consequences will on the whole and in the long run be best if no one ever takes it upon himself to 'second guess' the laws and to conclude that in his case his disobedience is justified." Nonetheless, the countervailing view is that blind obedience, especially where the circumstances so dictate, for the good of another person, under the ethical principle of justice, should be approached with discretion. Under such logic, thoughtful social workers, as professionals, should exercise careful discretion and judgment and perhaps violate such laws which may constrain the ability of a professional to best care for those who entrust them with their care. Accordingly, Rawls argued that "we are not required to acquiesce in the crushing of fundamental liberties by democratic majorities which have shown themselves blind to the principles of justice upon which justification of the Constitution depends" [2]. Reamer argues that reasonable, thoughtful, and principled practitioners might reasonably disagree about the appropriate course of action and that where difficult and controversial situations pose ethical conflicts, social workers may be obligated to make decisions that, in their best judgment, is both defensible and consistent with their professional ethical standards.

In the N.Y. case of *Community Service Society v. Welfare Inspector General of New York* [3], the N.Y. Appellate Division decision unanimously upheld the right of a social service agency and its workers to maintain privileged confidential relationship with a client on the grounds of social worker-client privilege, thereby finding grounds for privileged communications between a social worker and his or her client.

In the case of *Jaffee v. Redmond*, the US Supreme Court recognized the federal psychotherapist-patient privilege as it applied to licensed clinical social workers [4]. Here, a police officer, Mary Lu Redmond, was the first responding officer to a "fight in progress" call at an apartment complex where there had been a stabbing, and as Redmond called for an ambulance, several men ran out,

one brandishing a pipe and another brandishing a butcher knife, and Redman shot the man with the butcher knife. During pretrial discovery, the court learned that after the shooting Redmond had participated in approximately 50 counseling sessions with a clinical social worker licensed by the State of Illinois. Where the plaintiff sought discovery of these sessions, defendants asserted that the contents of the conversations between were protected against disclosure under the psychotherapist-patient privilege; an argument that was rejected by the district judge. The district judge, during his instructions to the jury, advised that the refusal to turn over the clinical notes had no "legal justification" and that the jury could therefore presume that the contents of the notes would have been unfavorable; the jury then found against Redman. On appeal, the Court of Appeals for the Seventh Circuit reversed and remanded for a new trial reasoning that reason and experience, " the touchstones for acceptance of a privilege under Rule 501 of the Federal Rules of Evidence, compelled recognition of a psychotherapist patient privilege." The Supreme Court held that "confidential communications between a licensed psychotherapist and her patients in the course of diagnosis or treatment are protected from compelled disclosure under Rule 501 of the Federal Rules of Evidence" in part because the court also recognized that "social workers provide a significant amount of mental health treatment" [5].

In Maine, case of *Harrison v. Granite Bay Care, Inc*., a social worker was terminated on the grounds of allegedly "creating disharmony in the workplace" when she reported what she considered to be violations of state employment law to her supervisor and, thereafter, to Maine's Department of Health and Human Services. Although the district court granted a motion for summary judgment against the social worker, on appeal, the First Circuit vacated the judgment finding a misapplication of whistleblower statute. Here the issue is whether the filing of a mandatory report with DHHS constitutes protected activity under the Maine Whistleblower Protection Act. The final outcome of this case remains pending at present.

The Maryland case of *In re Adoption/Guardianship No. CCJ14746* addressed the issue of whether licensed clinical social workers may provide expert witness testimony concerning the diagnosis and treatment of emotional and mental disorders [6]. Here, upon hearing the facts of the case, the Court of Special Appeals affirmed the judgment of the Circuit Court for Washington County finding that the clinical social worker in that case was specifically authorized to diagnose mental disorders and, therefore, was qualified to testify as an expert. In this case, petitioner Munson invoked the language of the state social work act which itself made a critical distinction between a licensed social worker and a licensed clinical social worker, where a licensed clinical social worker was specifically authorized by the Maryland Legislature to render diagnoses based on a recognized manual of mental and emotional disorders [7].

Ethical and Legal Issues in Case and Care Management

Care management is fundamental to population health; case management is fundamental to the management of the health of a defined population. Care management is a team-based, patient-centered approach which aims to assist patients and their support systems in the management of medical conditions more effectively so as to coordinate complex care, decrease the cost of care, and improve outcomes. Hospital-based care managers are patient advocates who help drive appropriate plans of care especially when multiple disciplines are involved in the care of complex patients.

Although distinctions between "case managers" and "care managers and care coordinators" have been drawn, the positions are sufficiently similar [8] as to be discussed as an aggregate in general terms. The Case Management Society of America (CMSA) defines case management as "provided by healthcare professionals working with people to identify issues and barriers that may prevent them from getting better and uncovering mutually agreed upon solutions to achieve their healthcare goals" [9].

The Agency for Healthcare Research and Quality (AHRQ) describes care coordination as "deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care" [10].

The Commission for Case Manager Certification (CCMC) describes advocacy in case management as a process that promotes beneficence, justice, autonomy, self-determination, and independence for patients and their families or caregivers. The Commission articulates in its statement that the profession adheres to the ideals of service and advocacy for patients regardless of race, ethnicity, religion, age, gender, sexual orientation, national origin, marital status, or disability. Furthermore, the service and advocacy ideal of case managers is the education of patients about their rights, benefits, and healthcare and human services, facilitating informed decision-making, and considerations for the client's values, beliefs, interests, and culture. In its Social Justice Statement and its Code of Professional Conduct for Case Managers, the Commission commits to responsibilities to (1) place the public interest above our own at all times; (2) respect the rights and inherent dignity of others; (3) always maintain objectivity in our relationships with clients; and (4) act with integrity, dignity, and fidelity with clients and others.

Case managers work with members of the interdisciplinary healthcare team to promote the best interests of the patient and his or her family; therefore, from an ethical standpoint, case managers must weigh and balance the potential risks and benefits of possible actions, interventions, treatments, and decisions when considering care options. In addition, since case managers are also employees who are tasked with directing access and utilization in the context of insurers, patient finances, and inpatient throughput management, there are potential ethical conflicts which arise because of competing imperatives.

Case managers function at the intersection of numerous federal and state statutes and regulations which include, for example, HIPAA, CMS mandates, insurance law, and workers compensation. Important areas of potential liability for care managers include denial of service, premature or improper discharge, or premature or improper

transfer. Furthermore, it is important to realize that the case managers (like social workers) have important and legislatively mandated functions as part of the healthcare patient management team.

The Federal Register is the legal repository for laws that are finalized by Congressional action. Title 42 (Public Health) Chapter IV (Hospitals) addresses most of the federal statutes that govern healthcare, specifically hospitals. 42 CFR § 440.169 statutorily defines case management services:

(a) Case management services means services furnished to assist individuals, eligible under the State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other service

….

(d) The assistance that case managers provide in assisting eligible individuals obtain services includes -

(1) Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services. These assessment activities include the following:

(i) Taking client history.
(ii) Identifying the needs of the individual, and completing related documentation.
(iii) Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the eligible individual.

(2) Development (and periodic revision) of a specific care plan based on the information collected through the assessment, that includes the following:

(i) Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual.

(ii) Includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals.

(iii) Identifies a course of action to respond to the assessed needs of the eligible Individual.

(3) Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

(4) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to help determine whether the following conditions are met:

(i) Services are being furnished in accordance with the individual's care plan.
(ii) Services in the care plan are adequate.
(iii) There are changes in the needs or status of the eligible individual. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

(e) Case management may include contacts with non-eligible individuals that are directly related to the identification of the eligible individual's needs and care, for the purposes

> of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
> 72 FR 68091, Dec. 4, 2007, as amended at 74 FR 31196, June 30, 2009

Similarly, CMS defines the process of "discharge planning." Discharge planning is a federally mandated process to transition through the levels of care and is a vital component of a successful transition from hospitals and PAC settings. The most appropriate location to which a patient should be discharged should be based on the patient's clinical care requirements, available support network, and patient and caregiver treatment preferences and goals of care. Therefore, the role of case management in the continuity of care following an acute care hospitalization is obvious. CMS defined "discharge planning" in a final rule [11], published September 26, 2019, which also empowered patients to make informed decisions about their care as they are discharged from acute care into post-acute care (PAC). The final rule revised hospital discharge planning requirements affect long-term care hospitals (LTCHs), inpatient rehabilitation facilities, inpatient psychiatric facilities, children's hospitals, cancer hospitals, IRFs, critical access hospitals (CAHs), and home health agencies (HHAs). The intent of the rule was to promote the seamless exchange of patient information between healthcare settings and to ensure that each patient's healthcare information accompanies them after discharge from a hospital or PAC provider [12]. Compliance with the rule is a Condition of Participation (CoP) for the Medicare and Medicaid programs.

CFR Title 42, Subsection 482.43 addresses Condition of Participation as they relate to discharge planning:

> The hospital must have an effective discharge planning process that focuses on the patient's goals and treatment preferences and includes the patient and his or her caregivers/support person(s) as active partners in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals for care and his or her treatment preferences, ensure an effective transition of the patient from hospital to post-discharge care, and reduce the factors leading to preventable hospital readmissions.
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> (a) Standard: Discharge planning process. The hospital's discharge planning process must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning and must provide a discharge planning evaluation for those patients so identified as well as for other patients upon the request of the patient, patient's representative, or patient's physician. [CMS did not finalize the proposed design requirements.]
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> (1) Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge.
> (2) A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services, including, but not limited to, hospice care services, post-hospital extended care services, home health services, and non-health care services and community based care providers, and must also include a determination of the availability of the appropriate services as well as of the patient's access to those services.
> (3) The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative).

(4) Upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient.
(5) Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of a registered nurse, social worker, or other appropriately qualified personnel.
(6) The hospital's discharge planning process must require regular re- evaluation of the patient's condition to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(7) The hospital must assess its discharge planning process on a regular basis. The assessment must include ongoing, periodic review of a representative sample of discharge plans, including those patients who were readmitted within 30 days of a previous admission, to ensure that the plans are responsive to patient post-discharge needs.
(8) The hospital must assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The hospital must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.

(b) Standard: Discharge of the patient and provision and transmission of the patient's necessary medical information. The hospital must discharge the patient, and also transfer or refer the patient where applicable, along with all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, at the time of discharge, to the appropriate post-acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners responsible for the patient's follow-up or ancillary care.
(c) Standard: Requirements related to post-acute care services. For those patients discharged home and referred for HHA services, or for those patients transferred to a SNF for post-hospital extended care services, or transferred to an IRF or LTCH for specialized hospital services, the following requirements apply, in addition to those set out at paragraphs (a) and (b) of this section:

(1) The hospital must include in the discharge plan a list of HHAs, SNFs, IRFs, or LTCHs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, IRF, or LTCH, in the geographic area requested by the patient. HHAs must request to be listed by the hospital as available.

(i) This list must only be presented to patients for whom home health care post-hospital extended care services, SNF, IRF, or LTCH services are indicated and appropriate as determined by the discharge planning evaluation.
(ii) For patients enrolled in managed care organizations, the hospital must make the patient aware of the need to verify with their managed care organization which practitioners, providers or certified suppliers are in the managed care organization's network. If the hospital has information on which practitioners, providers or certified supplies are in the network of the patient's managed care organization, it must share this with the patient or the patient's representative.
(iii) The hospital must document in the patient's medical record that the list was presented to the patient or to the patient's representative.

`(2) The hospital, as part of the discharge planning process, must inform the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of post-discharge services and must, when possible, respect the patient's or the patient's representative's goals of care and treat-

ment preferences, as well as other preferences they express. The hospital must not specify or otherwise limit the qualified providers or suppliers that are available to the patient.

(3) The discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare.

CFR Title 42, Subsection 482.43

Furthermore, Sect. 484.58 was added to the CoP added to read:

(a) Standard: Discharge planning. An HHA must develop and implement an effective discharge planning process. For patients who are transferred to another HHA or who are discharged to a SNF, IRF or LTCH, the HHA must assist patients and their caregivers in selecting a post-acute care provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The HHA must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.

(b) Standard: Discharge or transfer summary content.

1. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post- discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care.
2. The HHA must comply with requests for additional clinical information as may be necessary for treatment of the patient made by the receiving facility or health care practitioner.

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) [13] further mandates hospitals, including short-term acute care hospitals, CAHs, and PAC providers (LTCHs, IRFs, HHAs, and SNFs), to develop and implement quality measures and resource use measures to assist patients and their families in their decision-making during the discharge planning process. IMPACT requires the standardization of PAC assessment data so as to facilitate comparison across PAC settings, to be used by hospitals as a means to facilitate coordinated care and improved Medicare beneficiary outcomes. These data sets include the Long-Term Care Hospital CARE Data Set (LCDS) for LTCHs, the Minimum Data Set (MDS) for SNFs, the Outcome and Assessment Information Set (OASIS) for HHAs, and the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF PAI) for IRFs. Meaningful measures prioritized by CMS include:

- Promote effective communication and coordination of care
- Promote effective prevention and treatment of chronic disease
- Work with communities to promote best practices of healthy living
- Make care affordable
- Make care safer by reducing harm, cost in the delivery of care
- Strengthen person and family engagement as partners in their care [14]

CMS also published a proposed rule on June 16, 2016, in the Federal Register, titled "Medicare and Medicaid Programs; Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care" which proposed to update CoPs to mandate improved communication between providers and patients and patient access to their medical records.

Liability for case managers stems primarily from failures to communicate or document in accordance with the relevant laws, regulations, or rules. Although verbal communication is a foundation for decision-making in case management, contemporaneous documentation of the details and the outcomes of the discussions is necessary in the event that that is a post-action review. Such reviews often arise from patient or caregiver complaints and may escalate internally to quality assurance or to risk management or externally to state boards or CMS. Alternatively, if there is a demonstrable deviation from standards of care which results in a patient harm, litigation is possible. Thus, case managers must be familiar with and understand the national standards of care published by the Case Management Society of America, adhere the standards, and carefully document why services were provided or denied. In addition, since case managers are hospital employees, case managers should also be careful so as to respect the boundaries of such job description, which, at times, may result in ethical dilemmas. Nonetheless, the conduct and decisions of case managers, similar to other employees such as social workers, physician advisors, and nurses, can implicate the hospital in regulatory inquiries and/or litigation.

Ethical and Legal Issues Facing Physician Advisors

In contract to social workers and case managers, physician advisors are a new member to the multidisciplinary care management team. Although there is likely no one single definition for a physician advisor, one legal definition of a physician advisor might be, for example, "a physician licensed to practice medicine who provides medical advice or information to a private review agent or a utilization review entity in connection with its utilization review activities" [15]. The physician advisor is a clinical leader that facilitates the coordination of clinical care and cost-of-care initiatives. In general, the physician advisor functions as a liaison between the clinical medical staff and care management so as to provide advice and support regarding the medical necessity of inpatient services which may include (1) a secondary level of physician review regarding medical necessity and status determinations; (2) concurrent and retrospective payer denial appeals and management; (3) recovery audit contractor (RAC) denials and appeals; (4) clinical documentation improvement (CDI) to best reflect comorbidities and case mix index; (5) utilization management issues including length of stay, optimal resource utilization, and level of care transfers; and (6) discharge planning and readmissions management. Acute care hospitals and healthcare systems have rapidly embraced the physician advisor model because of demonstrated return on investment (ROIs) realized from such programs. Thus, an effective physician advisor program will improve hospital reimbursement and maintain the spirit of medical staff self-governance [16] required by the Joint Commission through a paradigm of clinical peer communication and coaching.

In general, the level of clinical documentation by clinicians has been suboptimal; understandably, charting has been seen as subordinate to actual hands-on patient care. Nonetheless, it is the medical record that supports not only the level but also

quality of the care that was provided. Thus, the quality of medical record documentation is fundamental to supporting claims and reimbursement but also providing the foundation for a successful defense in the event of malpractice litigation. Nonetheless, for every hour a clinician spends with a patient, the clinician then spends 2 hours on EHR documentation; thus, providers already typically spend 27% of their total working time on direct face-to-face patient interactions and about 49.2% of their time on EHR documentation [17].

In order to understand the importance of clinical documentation, and therefore a key tenet of the physician advisor paradigm, it is important to understand the coding and claims submission process (see Chap. 11). The clinical documentation entered by providers into the medical record is subsequently extracted by clinical coders. The data extracted by clinical coders is then translated into claims, case mix, quality reporting data, and disease management. Importantly, a chart which does not accurately reflect all of a patient's chronic and acute comorbidities can underrepresent the severity of illness and overestimate the expected outcomes of care resulting in an adverse quality-of-care assessment. In essence, a patient who looks healthier on the record, because of poor documentation, is expected to have less complications, lower mortality risk, and less need for post-discharge support; the insufficiency of documentation in turn results in underpayment to the health system, poorer quality or outcome metrics, and potential liability exposure. Clinical documentation is also at the foundation for value-based care initiatives.

Liability for physician advisor activities has not been clearly established, although there are potential concerns. The physician advisor team typically manages the CDI process through a process termed the "physician query" which is an EMR chart-based communication questioning the provider's wording of a clinical issue. The query will typically suggest an alternate wording to better describe a clinical issue or problem; however, the query may also raise a previously undocumented problem. The intent of the query is to more accurately portray a patient's clinical situation. Moreover, clinicians' compliance with queries is monitored and enforced, typically by amendments to medical staff bylaws. The query raises at least three potential liability exposures: (1) a potential false claims issue where queries may be exploited to artificially exaggerate the severity of illness, and therefore reimbursement; (2) rephrasing a provider's clinical impressions in such a way as to change the provider's liability in the event of malpractice litigation; and (3) medical staff disciplinary proceedings which are based in query compliance and standardized documentation, rather than quality of care.

Conclusions

Traditionally, the oversight for inpatient care has been managed by the medical staff, through peer review and quality improvement processes, and by clinical support staff including social workers and case managers through the utilization review process. The increased complexity of the private payer review and the regulatory

review environment now necessitates a coordinated multidisciplinary process by which utilization and financial metrics can be best aligned with the mission of acute care organizations. It is important that providers understand that the multidisciplinary structure is supportive, and not adverse, to their clinical work. In addition, it is important that clinicians respect and collaborate with their multidisciplinary partners, since, to a large extent, such partnership unloads a multitude of administrative tasks from busy clinicians while working in parallel to support important quality, satisfaction, and financial metrics. Nonetheless, social workers, case managers, and physician advisors usually all operate as hospital employees but mostly within national standards, policies, and job descriptions. Although there is, at present, no established line of case precedent in this area, regulations and potentially applicable national standards provide important guidance to minimize the risk of liability exposures.

References

1. NASW Code of Ethics. 2017. Available online at: https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English.
2. Reamer F. Ethical and legal standards in social work: consistency and conflict. Fam Soc. 2005;86(2):163–9. https://doi.org/10.1606/1044-3894.2237.
3. Community Service Society v. Welfare Inspector General of New York (New York Supreme Court, Appellate Division, 411 N.Y.S.2d 188 (N.Y. 1978))411 N.Y.S.2d 188 (N.Y. 1978)).
4. Jaffee v. Redmond (United States Supreme Court, 518 U.S. 1 (1996))518 U.S. 1 (1996)).
5. *Citing* U. S. Dept. of Health and Human Services, Center for Mental Health Services, Mental Health, United States, 1994 pp. 85–87, 107–114.
6. In re Adoption/Guardianship No. CCJ14746 (Maryland Court of Appeals, 759 A.2d 755 (2000))759 A.2d 755 (2000)).
7. Maryland Code (1981, 1994 Repl. Vol., 1999 Supp.) § 19-302(d)(2) of the Health Occupations Article.
8. Care Excellence. Case managers play a critical role in healthcare. Available online at: https://careexcellence.org/blog/case-manager-roles/.
9. Case Management Society of America. Available online at: http://solutions.cmsa.org/acton/fs/blocks/showLandingPage/a/10442/p/p-0003/t/page/fm/0.
10. The Agency for Healthcare Research and Quality. Available online at: https://www.ahrq.gov/ncepcr/care/coordination.html.
11. 84 FR 51836. Pp. 51836-51884. 42 CFR 482. 2019.
12. CMS. CMS' Discharge planning rule supports interoperability and patient preferences. 26 Sept 2019. Available online at: https://www.cms.gov/newsroom/fact-sheets/cms-discharge-planning-rule-supports-interoperability-and-patient-preferences.
13. Improving Medicare Post-Acute Care Transformation Act of 2014. Pub. L. 113–185.
14. CMS. IMPACT Act of 2014 Data Standardization & Cross Setting Measures. Available online at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-of-2014-Data-Standardization-and-Cross-Setting-Measures.
15. Law Insider. Definition of Physician advisor. Available online at: https://www.lawinsider.com/dictionary/physician-advisor#:~:text=Definition%20of%20Physician%20advisor.%20Physician%20advisor%20means%20a,entity%20in%20connection%20with%20its%20utilization%20review%20activities.

16. Hurst K. Professional self-regulation in the context of Clinical Governance. Int J Health Care Qual Assur. 2003;16:199–212.
17. Sinsky C, Colligan L, Li L, et al. Allocation of physician time in ambulatory practice: a time and motion study in 4 specialties. Ann Intern Med. 2016;165(11):753–60.