

Pain Medicine

Claims Data Snapshot

2023



This publication analysis of aggregated data from clinically coded cases opened between 2012-2021 in which Pain Medicine is identified as the primary responsible service.

Keep in mind...

A clinically coded malpractice case can have more than one responsible service, but the “primary responsible service” is the specialty that is deemed to be most responsible for the resulting patient outcome.

Our data system, and analysis, rolls all claims/suits related to an individual patient event into one case for coding purposes. Therefore, a case may be made up of one or more individual claims/suits and multiple defendant types such as hospital, physician, and other healthcare professionals.

Cases that involve attorney representations at depositions, State Board actions, and general liability cases are not included.

This analysis is designed to provide insured doctors, healthcare professionals, hospitals, health systems, and associated risk management staff with detailed case data to assist them in purposefully focusing their risk management and patient safety efforts.

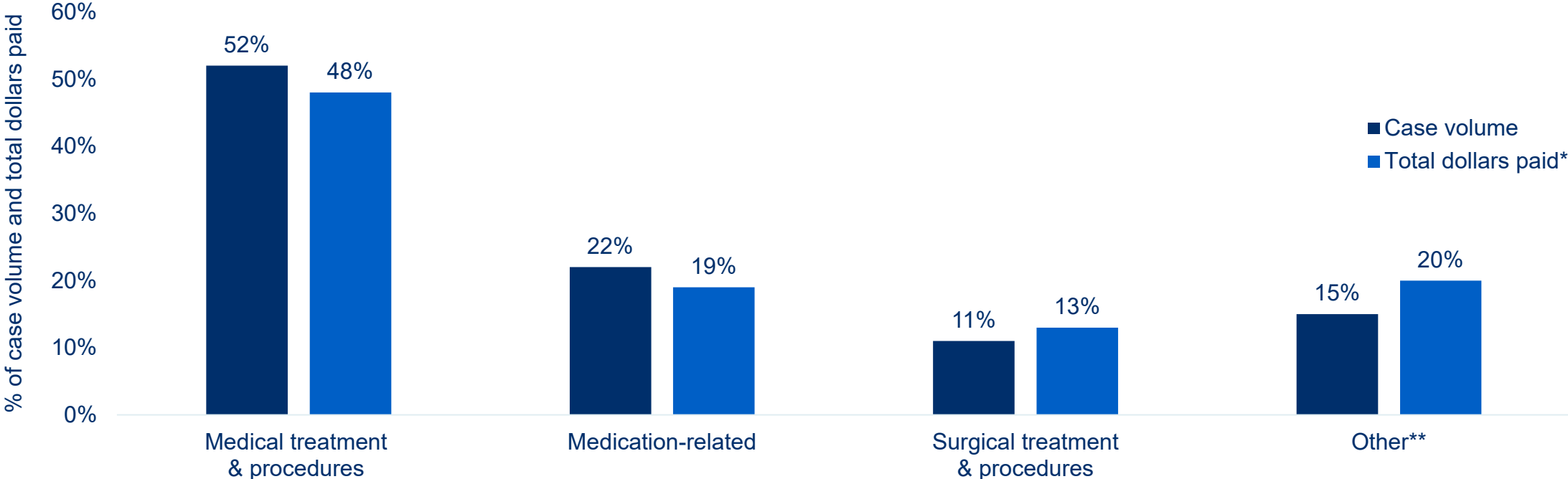
Key Points - Clinically Coded Data

INTRODUCTION | **KEY POINTS** | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | CASE EXAMPLES | RISK MITIGATION

- **Medical treatment allegations, which account for half of Pain Medicine's case volume**, primarily reflect procedural performance cases. These cases, half of which involve spinal injections, can be impacted by the delayed recognition of complications, while patient treatment/management cases most often reflect issues with selection of the most appropriate course of treatment for the patient, and appreciating and reconciling symptoms and test results.
- **The monitoring and managing of patients' medication regimens account 72% of all medication-related allegations.** Selection of the most appropriate medication for the patient's condition is one of the most frequently noted risk issues. Patient behavioral issues related to patient non-adherence to prescriptions are sometimes a result of inadequate patient/family education of the importance of prescription adherence. Inadequate patient monitoring, and suboptimal communication about medication regimens across the patient's care team are also commonly noted risk issues.
- **Surgical allegations, comprising 11% of case volume, most commonly involve procedural performance issues related to placement of neuro-stimulators.** Surgical patient management cases, including pre-, intra-, and post-operative management, are often related to the provider's response to developing complications. While complications of procedures may have been the result of procedural error, the failure to timely recognize and/or monitor/manage the issue prevents the opportunity for early mitigation of the risk of serious adverse outcome.
- **Contributing factors, which are multi-layered issues or failures in the process of care that appear to have contributed to the patient's outcome**, and/or to the initiation of the case, provide valuable insight into risk mitigation opportunities. Technical skill and clinical judgment factors, specifically inadequate patient assessment processes resulting in procedures or medications not ideal for the patient, poor procedural technique, and timely recognition/management of known complications are key drivers of both clinical and financial Pain Medicine case severity.

Major Allegations & Financial Severity

Each case reflects one major allegation category. Categories are designed to enable the grouping and analysis of similar cases and to drive focused risk mitigation efforts. The coding taxonomy includes detailed allegation sub-categories; insight into these is noted later in this report.

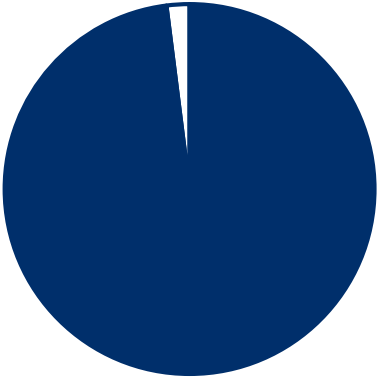


MedPro Group + MLMIC cases opened 2012-2021, Pain Medicine as responsible service (N=335); *Total dollars paid = expense + indemnity; **Other includes allegations for which no significant case volume exists

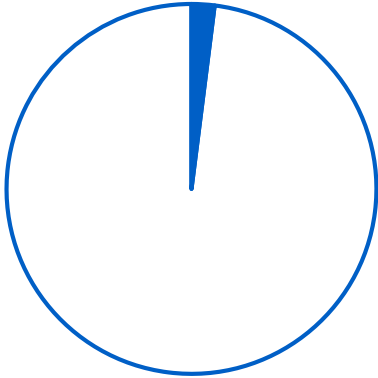
Clinical Severity*

Clinical Severity Categories	Sub-categories	% of case volume	<p>Typically, the higher the clinical severity, the higher the indemnity payments are, and the more frequently payment occurs.</p>
LOW	Emotional Injury Only	9%	
	Temporary Insignificant Injury		
MEDIUM	Temporary Minor Injury	47%	
	Temporary Major Injury		
	Permanent Minor Injury		
HIGH	Significant Permanent Injury	44%	
	Major Permanent Injury		
	Grave Injury		
	Death		

Claimant Type & Location



Ambulatory
98%



Inpatient
2%

Top Locations	% of case volume
Office/clinic	65%
Ambulatory surgery	24%
Special procedures	4%
Inpatient surgery	2%

Contributing Factors

“Contributing factors reflect both provider and patient issues. They denote breakdowns in technical skill, clinical judgment, communication, behavior, systems, environment, equipment/tools, and teamwork. The majority are relevant across clinical specialties, settings, and disciplines; thus, they identify opportunities for broad remediation.”

Despite best intentions, processes designed for safe patient outcomes can, and do, fail.

Contributing factors are multi-layered issues or failures in the process of care that appear to have contributed to the patient's outcome, and/or to the initiation of the case, or had a significant impact on case resolution.

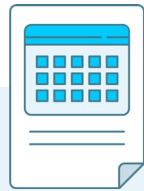
Multiple factors are identified in each case because generally, there is not just one issue that leads to these cases, but rather a combination of issues.



Administrative



Behavior-related



Clinical environment



Clinical judgment



Clinical systems



Communication



Documentation



Supervision



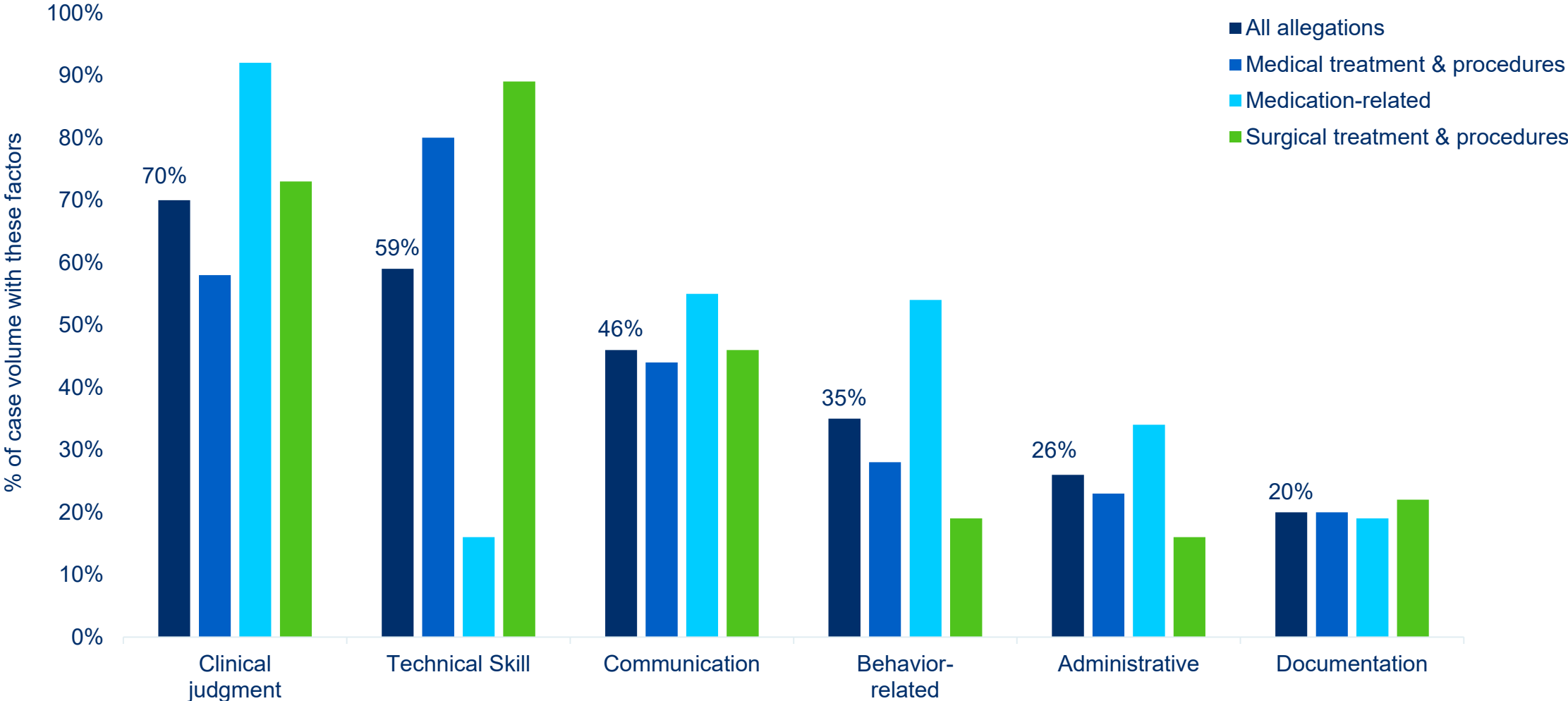
Technical skill

Contributing Factor Category Definitions

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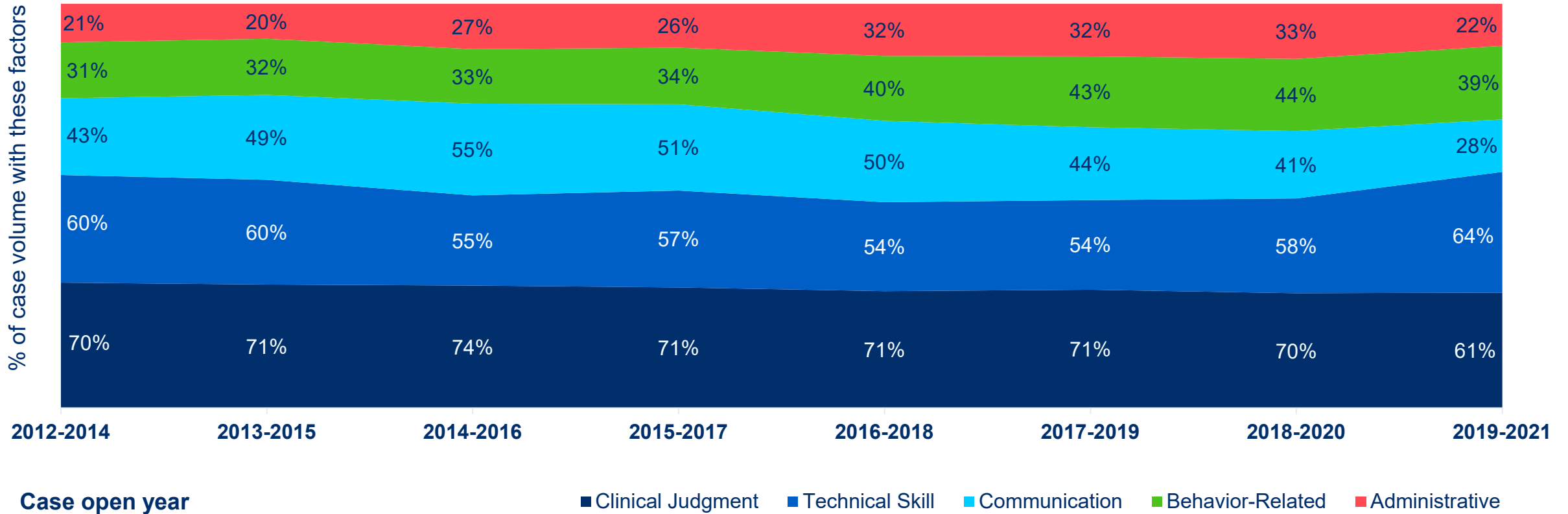
Administrative	Factors related to medical records (other than documentation), reporting, staff, ethics, policy/protocols, regulatory
Behavior-related	Factors related to patient nonadherence to treatment or behavior that offsets care; also provider behavior including breach of confidentiality or sexual misconduct
Clinical environment	Factors related to workflow, physical conditions and “off-hours” conditions (weekends/holidays/nights)
Clinical judgment	Factors related to patient assessment, selection and management of therapy, patient monitoring, failure/delay in obtaining a consult, failure to ensure patient safety (falls, burns, etc), choice of practice setting, failure to question/follow an order, practice beyond scope
Clinical systems	Factors related to coordination of care, failure/delay in ordering test, reporting findings, follow-up systems, patient identification, specimen handling, nosocomial infections
Communication	Factors related to communication among providers, between patient/family and providers, via electronic communication (texting, email, etc), and telehealth/tele-radiology
Documentation	Factors related to mechanics, insufficiency, content
Supervision	Factors related to supervision of nursing, house staff, advanced practice clinicians
Technical skill	Factors related to improper use of equipment, medication errors, retained foreign bodies, technical performance of procedures

Most Common Contributing Factor Categories by Allegation



MedPro Group + MLMIC cases opened 2012-2021, Pain Medicine as responsible service (N=335); More than one factor per case, therefore totals >100%

Distribution of Top Five Factor Categories Over Time



While the distribution of these top (most common) factors across rolling three-year timeframes is relatively consistent, take note of even slight increases over time as indicators of emerging risk issues.

Focus on Most Common Drivers of Clinical and Financial Severity

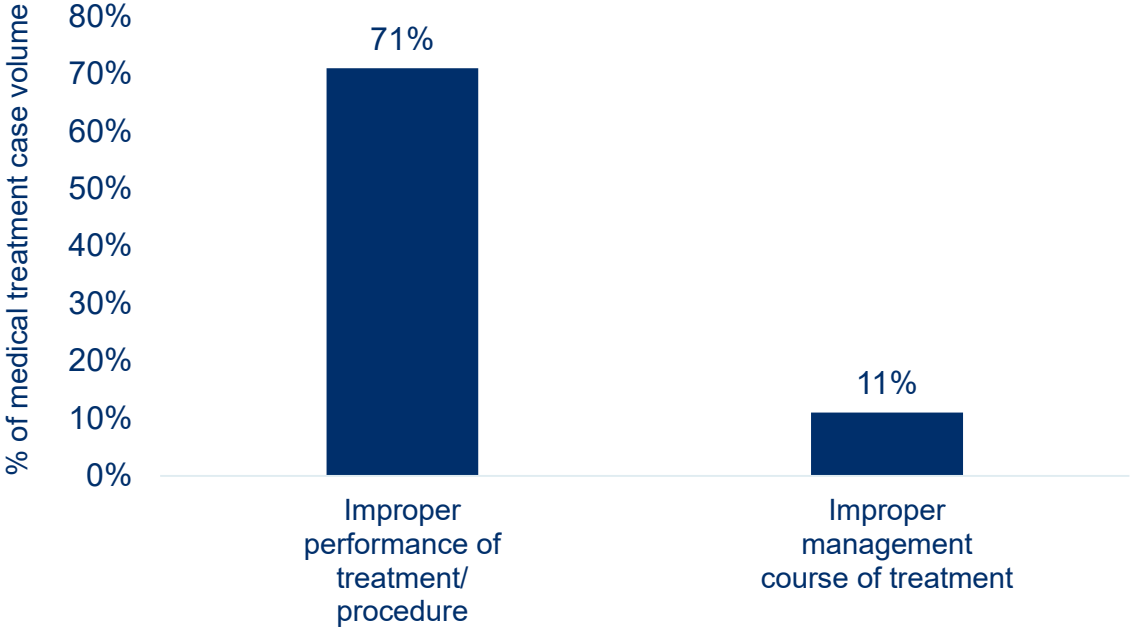
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Factors associated with high clinical severity outcomes	(TS) recognition/management of a known procedural complication (34%)	% of high severity case volume
	(CJ) selection/management of most appropriate surgical procedure (24%)	
	(CJ) selection/management of most appropriate medication (22%)	
	(CJ) failure to appreciate/reconcile relevant signs/symptoms/test results (20%)	
	(TS) poor procedural technique (16%)	
Factors associated with the costliest indemnity payments	(CJ) inadequate patient assessment – history & physical (26%)	% more expensive than the average indemnity payment*
	(TS) poor procedural technique – medication administration (22%)	
	(CJ) selection/management of most appropriate medication (22%)	
	(TS) recognition/management of a known procedural complication (20%)	

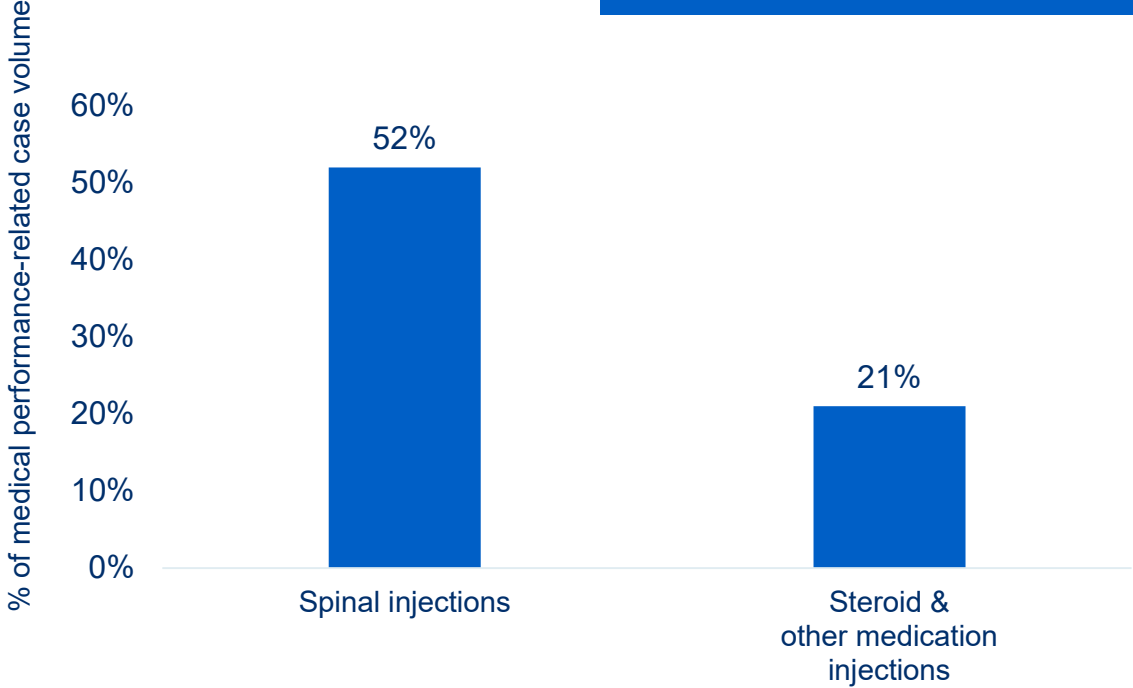
Technical skill and clinical judgment factors, specifically inadequate patient assessment processes resulting in procedures or medications not ideal for the patient, poor procedural technique, and timely recognition/management of known complications are key drivers of both clinical and financial Pain Medicine case severity.

Focus on Medical Treatment Allegations

Top allegation details

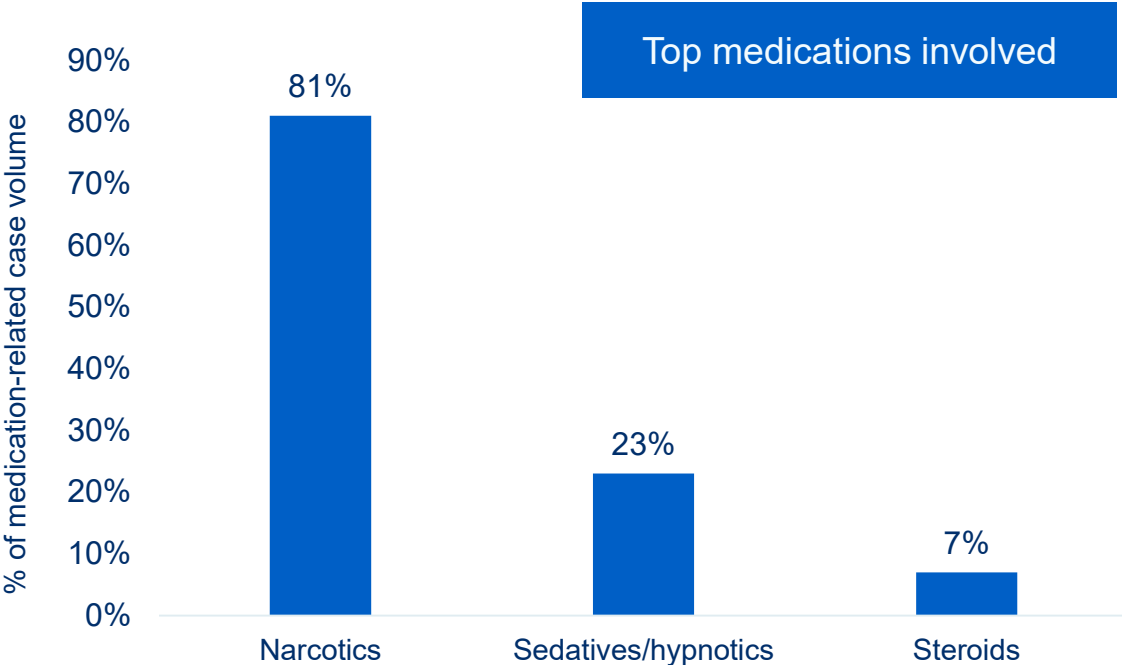
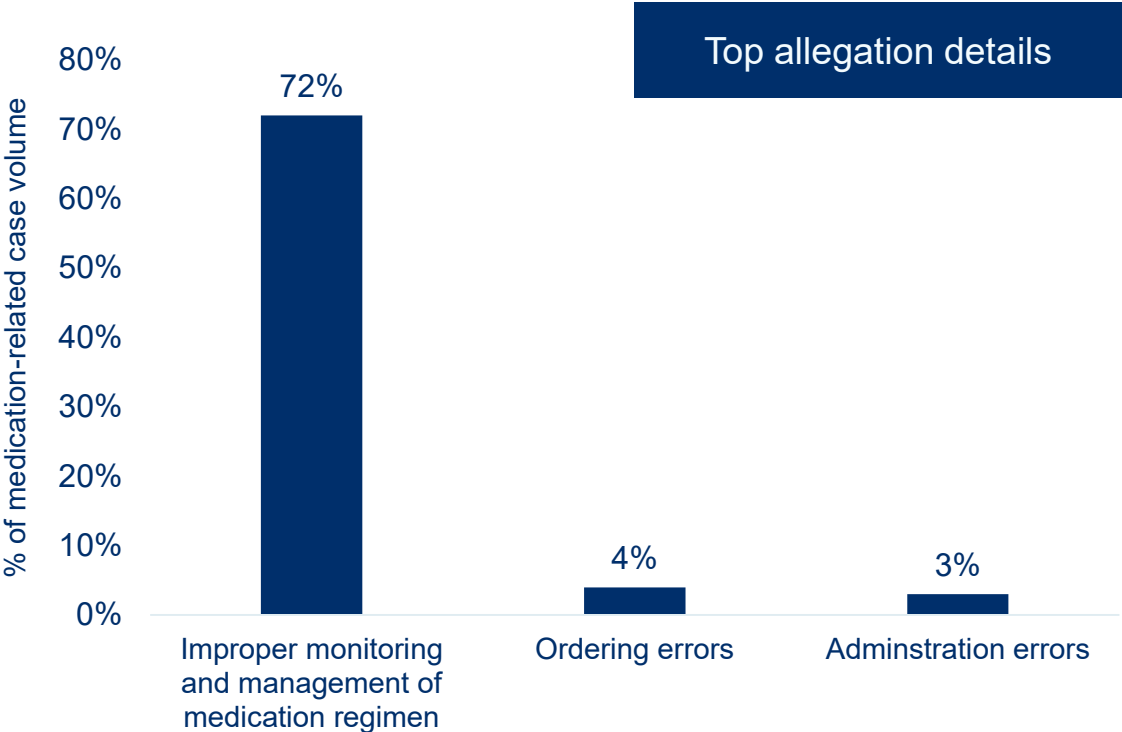


Top procedures involved



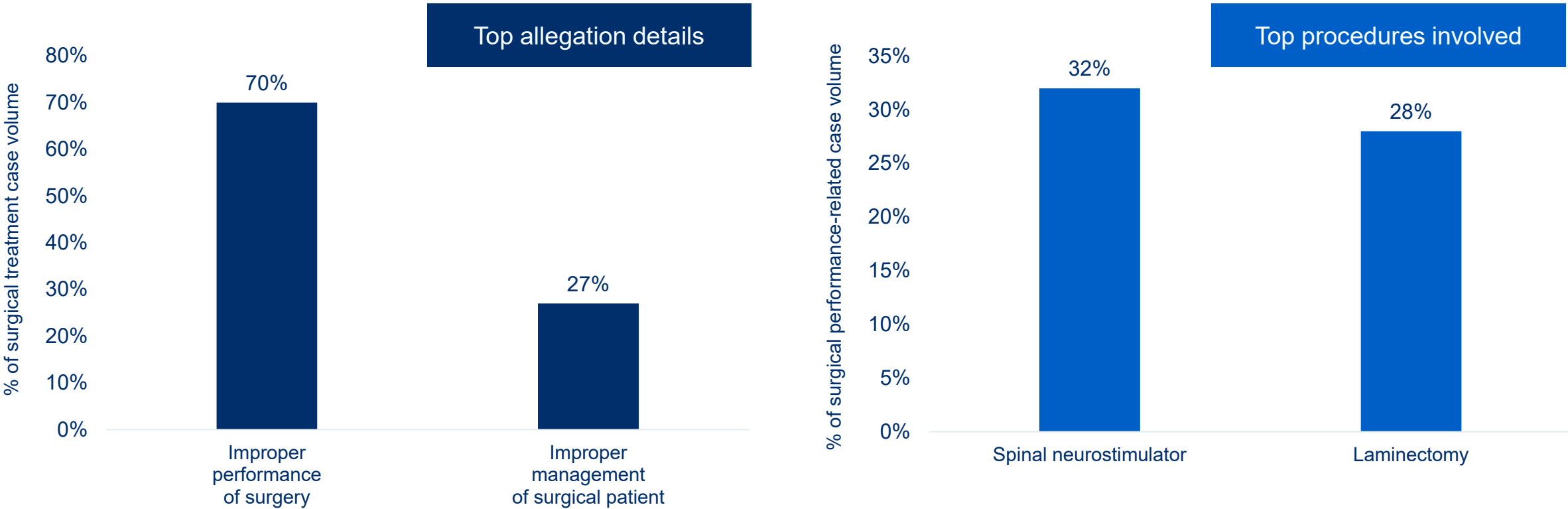
Procedural performance cases can be impacted by delayed recognition of complications, while management cases most often reflect issues with selection of the most appropriate course of treatment for the patient, and appreciating and reconciling symptoms and test results.

Focus on Medication-Related Allegations



Selection of the most appropriate medication for the patient’s condition is one of the most frequently noted risk issue in medication cases. Patient behavioral issues related to patient non-adherence to prescriptions are sometimes impacted by inadequate patient/family education of the importance of prescription adherence. Inadequate patient monitoring, and suboptimal communication about medication regimens across the patient’s care team are also commonly noted risk issues.

Focus on Surgical Treatment Allegations



Cases involving the management of surgical patients, including pre-, intra-, and post-operatively, are often related to the provider’s response to developing complications. While complications of procedures may have been the result of procedural error, the failure to timely recognize and/or monitor/manage the issue prevents the opportunity for early mitigation of the risk of serious adverse outcome.



The following stories are reflective of the allegations and contributing risk factors which drive cases brought against Pain Medicine providers.

We're relaying these true stories as lessons to build understanding of the challenges that you face in day-to-day practice. Learning from these events, we trust that you will take the necessary steps to either reinforce or implement best practices, as outlined in the section focused on risk mitigation strategies.

Case Examples

INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | **CASE EXAMPLES** | RISK MITIGATION

SETTLED

\$1.3M

CONTRIBUTING FACTORS

Clinical judgment

Selection of most appropriate procedure (intentionally injected at wrong level)

Communication

Inadequate informed consent for procedure (patient consented for C5-6, Pain Mgmt injected C7-T1)

Documentation

Inaccurate documentation

Technical skill

Inappropriate technique in administering drug

IMPROPER PERFORMANCE OF CERVICAL EPIDURAL STEROID INJECTION RESULTING IN CHRONIC REGIONAL PAIN SYNDROME

A female in her early 40s, with a history of chronic neck pain, hypertension, and anxiety was referred to a Pain Medicine physician (Pain Med) for evaluation of increased neck pain following a motor vehicle accident. After diagnostic testing, Pain Med identified C5-6 as the appropriate space for a cervical epidural steroid injection (CESI). **Plan was to enter the C7-T1 space and thread the catheter up to C5-6 interspace for injection of steroid/anesthesia.** The patient underwent two such procedures, two months apart, but **achieved minimal relief.**

Patient returned for a third injection two months after the last procedure. C7-T1 was successfully entered, and contrast confirmed proper location. When attempting to thread the catheter up to the C5-6 interspace, Pain Med encountered resistance. **Rather than aborting the procedure, he elected to inject steroid/anesthesia directly into C7-T1 space. Patient screamed in pain following this injection, and was unable to obtain adequate pain control post-procedure.** She was sent to the Emergency Department for further evaluation and was admitted for pain control. A CT scan identified significant air bubbles in the epidural space.

The patient was subsequently **diagnosed with chronic regional pain syndrome and permanent C8 nerve root damage.**

Pain Med wrote his operative note on return to his office, but erroneously documented lumbar pain and lumbar epidural steroid injection.

Case Examples

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SETTLED

\$750,000

CONTRIBUTING FACTORS

Clinical environment

Night shift

Clinical judgment

Inadequate patient assessment
– premature discharge from ED
and failure to rescue

Selection/management of most
appropriate medication and
procedure (removal of pump
without further investigation of
malfunction cause)

FAILURE TO MANAGE PATIENT'S PAIN MEDICATIONS RESULTING IN ACUTE INTOXICATION FROM FENTANYL AND METHADONE RESULTING IN DEATH

Due to a severed tendon in his left hand, a male in his 50s was suffering from chronic regional pain syndrome. He was treating with a Pain Medicine physician (Pain Med A) and used an intrathecal pain pump which delivered fentanyl and bupivacaine. **The pump malfunctioned, resulting in withdrawal symptoms.** To manage these symptoms, the patient was **prescribed a 72-hour fentanyl patch (25mcg)** by **Pain Med B**, but did not achieve relief.

Pain Med A removed the pump, and prescribed methadone 10 mg/three times daily as needed. The patient's wife called later that same day, stating the medication was insufficient for the patient's pain level. **Pain Med A increased methadone levels threefold to 30 mg/three times daily.** The patient's wife called again that night and Pain Med A **called in a prescription for a 75mcg fentanyl patch.**

The patient was referred to a Neurosurgeon for evaluation for pump replacement (appointment scheduled for the day after the pump was removed). The Neurosurgeon told patient to stop taking methadone (as it was not helping) and to use a fentanyl patch (Neurosurgeon prescribed five 72-hour patches) and lorazepam. **The patient filled those prescriptions and also, that same day, filled prescriptions from Pain Med A, who prescribed a clonidine patch after four calls from the patient.** The pump was scheduled to be replaced the following week.

The patient began vomiting that night and went to Emergency Department where he was treated with Zofran. The patient was discharged at 4am. **It was noted that the patient and the wife were both "hesitant for discharge home." He returned twice within the next 24 hours.** The patient was tearful, had chills, nausea, abdominal pain, and tremors. During the second visit, Pain Med A was called by the Emergency Medicine physician. Pain Med A **recommended the patient continue fentanyl, add methadone to prevent further withdrawal and continue clonidine, zofran and lorazepam.** The patient asked to be admitted, but **Pain Med A did not have admitting privileges.**

Family found the patient unresponsive the next day. CPR was unsuccessful. **Cause of death per autopsy was acute intoxication by fentanyl and methadone.**

Risk Mitigation Strategies

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- **Conduct an appropriate and thorough assessment of the patient.**
 - Understand patient complaints and concerns.
 - Update and review medical and family history at every visit to ensure the best decision-making.
 - Be alert to high-risk diagnoses, such as cancer, cardiac disease, stroke and infections.
 - Maintain problem lists.
- **Communicate with each other.**
 - Focus on care coordination if other specialties are involved, including next steps and determining who is responsible for the patient.
 - Give thorough and clear patient instructions.
- **Engage patients as active participants in their care.**
 - Consider the patient's health literacy and other comprehension barriers.
 - Recognize that patient satisfaction with treatment outcomes can be influenced by a thorough informed consent and education process.
- **Document.**
 - Timely document thorough, objective information about the results of patient assessments, education of the patient/family about treatment plans - including medication regimens, and any instances of patient nonadherence.
 - Thorough, consistent documentation in the chart enhances communication between providers and provides a supportive framework for defense of any subsequent malpractice case.
- **Review office processes for test tracking, consults/referrals, appointment setting, and managing patient nonadherence.**
- **Know (and adhere to) your supervision responsibility for advanced practice providers.**

MedPro Group & MLMIC Data

MedPro and MLMIC are partnered with Candello, a national medical malpractice data collaborative and division of CRICO, the medical malpractice insurer for the Harvard-affiliated medical institutions.

Derived from the essence of the word candela, a unit of luminous intensity that emits a clear direction, Candello's best-in-class taxonomy, data, and tools provide unique insights into the clinical and financial risks that lead to harm and loss.

Using Candello's sophisticated coding taxonomy to code claims data, MedPro and MLMIC are better able to highlight the critical intersection between quality and patient safety and provide insights into minimizing losses and improving outcomes.

Leveraging our extensive claims data, we help our insureds stay aware of risk trends by specialty and across a variety of practice settings. Data analyses examine allegations and contributing factors, including human factors and healthcare system flaws that result in patient harm. Insight gained from claims data analyses also allows us to develop targeted programs and tools to help our insureds minimize risk.



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