THE MONTHLY PUBLICATION FOR CAP MEMBERS

CAPsules®

COOPERATIVE OF AMERICAN PHYSICIANS

Support for CAP Members During the California Wildfires

The Cooperative of American Physicians (CAP) understands that many physician members are experiencing significant challenges stemming from the California wildfires that should not be faced in isolation. We are committed to sharing support and resources for those in need during this difficult time.

As our communities process the far-reaching impacts of these wildfires, our deepest sympathies are with all who are affected. The catastrophic damage caused by the fires is unprecedented and beyond imagination.

Your well-being is our priority. If your home or practice has been directly affected by the wildfires, please contact CAP at 800-610-6642 or MS@CAPphysicians.com to discuss options for financial relief.

Additionally, your CAP membership offers you free access to a variety of programs to help navigate the professional and personal challenges you may be facing as a result of these wildfires, including:

- CAP's Human Resources team is available to address questions related to staffing and employee concerns. Call **888-311-2322** or email **HR@CAPphysicians.com**.
- CAP's *My Practice* program can help with practice management issues related to disrupted business operations. Call **213-473-8630** or email **ATena@CAPphysicians.com**.
- CAP's Risk Management Hotline can offer guidance on any risk management challenges that arise as a result of the fires, including temporary practice closure, health information requests, patient communications, and more. Call **800-252-0555** to speak to a dedicated risk management and patient safety expert.
- The CAP Marketplace directory includes a variety of experts who offer support in areas like accounting and financial planning, legal services, staffing, and more if you need assistance with any practice operations impacted by the fires. Visit the CAP Marketplace.

You also have access to MetLife's Employee Assistance Program (EAP), which provides counseling to members and their families. Call **888-319-7819** to speak with a counselor or schedule a phone or video conference appointment.

We are deeply saddened by the devastation these fires have caused in our communities and understand that recovery and rebuilding will require time and substantial resources. CAP stands by our members during this incredibly challenging time to provide critical assistance and help alleviate the hardships many of you are experiencing.

DECEMBER 2024 - JANUARY 2025

Case of the Month

The Critical Link Between Informed Consent, Thorough Documentation, and Effective Defense of Medical Care

by Bradford S. Dunkin, MHA

A 57-year-old male patient presented to Dr. S, an otolaryngologist, complaining of throat pain. Physical examination revealed swollen, reddening, nontender tonsils. Dr. S performed a nasopharyngolaryngoscopy to further examine the area. Inspection of the nasopharnyx revealed no discrete lesions with asymmetric enlargement of the right tonsil. Examination of the hypopharnyx also revealed no discrete lesions. The larynx inspection revealed bilaterally symmetric true vocal fold motion with no discrete lesions and good glottis closure.

A computed tomography (CT) scan was ordered and showed concern for bilateral cervical lymphadenopathy, larger on the right side than the left. Fine needle aspirates were taken from the right cervical lymph node. Pathological findings were negative for both epithelial and granulomatous cells. The pathologist reported that cytologic features indicated that low-grade lymphoid neoplasm could not be excluded if the adenopathy was not significantly resolved within one month. It was recommended the patient have an excision biopsy with submission of fresh tissue for flow cytometry.

One month later the patient returned to Dr. S to discuss and schedule the biopsy and tonsil removal. The patient underwent the procedure without complications and was discharged home the same day with a scheduled one-month follow-up visit with Dr. S.

The next day, Dr. S called the patient. Since the patient was not able to speak on the phone, Dr. S asked the patient's wife to contact the office about her husband's status. The wife reported that her husband was experiencing significant pain. Dr. S recommended the patient take ibuprofen.

A couple of weeks after the surgery the patient resumed normal work duties. After two days back at work, the patient came home and told his wife he was tired, not feeling well, and experiencing a choking sensation. Several days later the patient woke up at 4:30 a.m. and told his wife he was coughing up blood. The patient and his wife remembered that the surgery center informed them that if the amount of blood did not exceed one tablespoon, they did not have anything to be concerned about. Later that morning the patient woke up again telling his wife he was coughing up blood in excess of one tablespoon.

The patient's wife took her husband to the emergency department at their local hospital. On arrival, the patient was choking, gagging, unable to speak, and coughing up excessive blood.

Soon thereafter, the patient went into cardiac arrest. It was difficult to intubate the patient due to a large blood clot. At one point, the staff initiated CPR and established an airway. After he stabilized, the patient was taken to surgery to address an atrial bleed from the central left tonsillar fossa, the same area where Dr. S removed the left tonsil.

The patient remained in a coma for several weeks and was eventually discharged to a skilled nursing facility.

The patient was ventilator dependent and suffering from anoxic encephalopathy due to the cardiac arrest

continued on page 3

Continued from page 2

and delayed intubation depriving him of oxygen for an extended period of time.

The patient sued Dr. S, alleging negligence and failure to provide medical care within the standard of care for physicians practicing in the field of Otolaryngology. In particular, the plaintiff's attorney focused on two areas: 1) lack of an adequate informed consent and 2) failure of Dr. S to respond appropriately to several calls to his office reporting that the patient was experiencing bleeding post operatively. As part of the complaint, the patient's wife alleged that she called Dr. S's office several times, reporting that the patient was coughing up blood, felt like he was choking, and was unable to swallow food or liquids. The wife claimed the office staff told her that it was all right if the patient did not eat or drink temporarily. This instruction concerned the wife because the patient had a blood pressure condition which would cause him to pass out from standing up if he did not eat.

During discovery, defense experts reviewed the medical records and concluded the overall care the patient received was appropriate, of good quality, and within the standard of care. However, plaintiff experts opined the informed consent was insufficient and the care was negligent, specifically with respect to the plaintiff's claims that the patient's wife called the office several times about the patient bleeding prior to presenting to the emergency department, where he experienced cardiac arrest.

The defense medical experts confirmed that the patient was informed of various outcomes after the surgery, including the possibility of minor bleeding, which can occur and is a known risk of the procedure. The defense expert concluded, "There does not seem to be anything different that could have been done for this patient, any sooner. Nor does there appear to have been any sort of surgical error, because if there had been a problem it would have occurred sooner. The tonsillar fossa is very vascular and, if dehydration is present, can easily commence bleeding, especially if the patient is coughing. It appears that what happened to the patient was a known risk of the tonsillectomy and that it was not caused by any negligence on the part of the doctor." Plaintiff experts faulted the informed consent for underestimating the percentage of possibility of post-operative bleeding. In any event, the patient was told that if bleeding were to exceed one tablespoon of blood, then the doctor's office was to be called or the patient should report to the hospital emergency room, which they eventually did.

During the trial, emphasis shifted away from informed consent and the plaintiff's attorney focused on the numerous times when the patient's wife called the doctor claiming the patient was experiencing bleeding. However, all phone calls were well documented in the patient's medical record. There was no report of the patient bleeding. The patient's wife mentioned the patient's discomfort and pain, which was not out of the ordinary. The patient was advised to take ibuprofen for pain and reminded to hydrate appropriately, which, it appears, he did not.

One defense expert opined, "Bleeding in the week or more after surgery is a known risk. The possibility of slow healing is increased by dehydration, which was likely in this patient." The other phone calls documented in the record were reports from the patient's wife that the patient was doing fine overall.

There is no denying that the outcome of the matter was tragic for the patient who is no longer able to work and requires lifelong daily care and assistance. Dr. S's defense attorney was able to successfully defend his care due to the thorough informed consent discussion had with the patient. The diligent documentation of the informed consent discussion and the calls later made by his wife to the office thoroughly captured the patient's condition and instructions for care based on the information provided.

To avoid the allegations that are associated with improper or incomplete informed consent, the Cooperative of American Physicians (CAP) recommends the following:[1, 2]

- Explanation of the nature and purpose of the proposed treatment, including:

continued on page 4

Continued from page 3

  - The risks, complications, and expected benefits of the recommended treatment, including the likelihood of success or failure.
  - Any alternatives to the recommended treatment and their risks and benefits.
  - The risks and benefits of declining the proposed treatment.
- For planned procedures, do not wait to obtain consent on the day of the procedure. The informed consent process should begin as early as two weeks prior to the planned procedure, preferably in the provider's office setting. This allows enough time for the patient and physician to have a detailed discussion and to answer all the patient's questions in a stress-free setting as opposed to a pre-operative holding area.
- Thoroughly document the informed consent discussion and be sure to include all the previously mentioned elements. Also be sure to include any pertinent questions that the patient had, and what answer was provided.
- Do not just rely on the language in a standardized or general consent form. Your documentation of the informed consent conversation and the potential risks should be specific to the procedure being performed.
- Ensure that the copy of the signed consent form is placed in the patient's medical record and a copy is added to the hospital record as well, if the procedure takes place in a hospital setting.
- Stay within the scope of the procedure noted on the signed consent form. Outside of an emergent life-threatening occurrence that would require the physician to take immediate life-saving measures, do not be tempted to "fix other problems" you might encounter intraoperatively.

Documenting phone calls in a medical office practice is an essential part of ensuring accurate and thorough patient records. Here are some guidelines for documenting phone calls effectively:

- **Date and Time:** Start by noting the date and time of the phone call.
- **Caller Information:** Record the name, phone number, and any relevant patient information of the person calling.
- **Reason for the Call:** Document the purpose of the phone call, whether it is a general inquiry, appointment scheduling, medication refill request, test result inquiry, or any other reason.
- **Conversation Summary:** Summarize the key points of the conversation, including any symptoms or concerns mentioned by the caller, advice given, instructions provided, or referrals made.
- **Actions Taken:** Detail any actions taken as a result of the phone call, such as scheduling an appointment, forwarding a message to the healthcare provider, or arranging a prescription refill.
- **Follow-Up:** Note any follow-up actions required, such as calling the patient back with additional information or scheduling a callback from the healthcare provider.
- **Signatures:** If required, obtain the signature of the staff member who took the call and documented the information.
- **Electronic Health Record (EHR):** Ensure that the phone call is documented in the patient's electronic health record if your practice uses an EHR system.

Remember, patient confidentiality and privacy should always be maintained when documenting phone calls. Only record necessary information and ensure that it is stored securely according to HIPAA guidelines.

Bradford S. Dunkin, MHA, is CAP's Assistant Vice President, Risk Management and Patient Safety. Questions or comments related to this article should be directed to BDunkin@CAPphysicians.com.

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RISK MANAGEMENT
AND
PATIENT SAFETY NEWS

The Role of Informed Consent in Medical AI: Balancing Innovative Advancements With Patient Rights

by Yvette M. Ervin, JD

The use of Artificial Intelligence (AI) in medicine is quickly becoming the norm in today's healthcare environment. From using predictive analytics to streamlining protocols and medical record documentation, AI has the potential to expedite advancements in patient care. Yet the use of AI raises legal and ethical questions, one of which is the role of informed consent, a cornerstone of patient rights.

Informed Consent in Healthcare

Informed consent in healthcare is a key patient right and centers around disclosure, understanding, and explicit permission to perform a procedure. A provider must properly disclose information so patients can make decisions about their medical options and procedures.[1] Patients should have a thorough understanding about a particular test, treatment, or procedure, and the associated risks and benefits, alternative options, and the potential consequences of doing nothing.[2]

AI and Informed Consent—Legal and Ethical Considerations

Many healthcare institutions and medical providers have embraced and implemented AI in at least some form. Some common uses of medical AI involve patient scheduling and communication, documentation, summarization of patient data, image interpretation, and medical diagnosis. While these uses and applications of AI assist in achieving efficiency and an accuracy that can exceed human doctors, they now become a factor in the decision-making process and informed consent.[3]

The first issue to consider is transparency. Without regulations or organizational policies in place, it is not clear when or how to disclose the use of AI, which is now seemingly discretionary and may be influenced by the extent to which AI was used. Was AI a component of the clinical decision-making? Was it used to summarize the patient's medical history? Was it used to explore differential diagnoses? From a risk management perspective, the recommendation would be to err on the side of transparency and disclose to patients the use of AI, how it is being used in care, documenting this discussion, and providing patients whenever possible, the option to "opt out."

While regulations have yet to catch up, erring on the side of disclosure is more likely to mitigate risk and allegations that there was no informed consent. To inform patients about the use of AI in their care, however, providers must have sufficient knowledge to explain to patients how the AI program works.[2] In discussing the use of AI with patients, the provider should be able to:

- Provide a general explanation of how the AI program works and explain their experience with the AI program.
- Describe the rationale and validity of the AI program (accuracy, limitations, risks, etc.).

continued on page 6

Continued from page 5

- Describe the role of the AI program and how it is used in conjunction with the provider (diagnosis, reading images, procedures/treatments).
- Describe safeguards that are in place (cross-referencing), as well as privacy assurances and/or any impact to patient confidentiality.

During these discussions, providers should also be prepared to answer patient questions and address concerns regarding the use of AI—and potentially, requests or concerns if AI is not being used.

The second important issue is documentation. As usual, discussions with patients should be well-documented, and options should be provided to patients whenever possible regarding their preferences and comfort with the use of AI.

Documentation becomes even more critical in the precarious circumstance in which the provider and AI program arrive at different recommendations or conclusions. The provider should clearly document their rationale and justification for their diagnosis and/or recommendation and why it deviates from the AI program. To reinforce this, Electronic Medical Record templates should be amended to provide an area for instances in which AI was disregarded.

As the use of medical AI increases and evolves, so will the legal landscape. One significant potential implication will be the impact medical AI will have on the standard of care.[4]

Will the future standard of care require the use of AI and the provider's review of its recommendation? Where will the liability fall in cases of a misdiagnosis? Will we see AI "testifying" in Court?

These questions can trigger both excitement and fear. It is important to acknowledge that while medical AI is intended to improve patient care and safety, it is not infallible and should not be immune to the foundational patient rights of informed consent, privacy, and autonomy.

Yvette Ervin, JD, is a Senior Risk Management and Patient Safety Specialist. Questions or comments related to this article should be directed to YErvin@CAPphysicians.com.

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Victory Via Veto - AB 2773

by Gabriela Villanueva

In 2024, the California legislature introduced 1,505 bills in the Assembly and 619 in the Senate. Governor Newson signed 1,017 bills into law and vetoed 189, including Assembly Bill 2773 (AB 2773), which proposed changes to the Elder Abuse and Dependent Adult Civil Protection Act.

Sponsored by plaintiff attorneys, AB 2773 lowered the burden of proof to a "preponderance of the evidence" from the status of "clear and convincing" for claims against residential care or skilled nursing facilities, specifically in cases where evidence was improperly destroyed.

Early in the legislative session, CAP opposed AB 2773, which was introduced by Assemblymember and Chairman of the Assembly Judiciary Committee, Ash Kalra. Governor Newsom emphasized that AB 2773 would impact and limit judicial discretion, emphasizing that a judge's ability "to craft appropriate remedies" should not be completely removed, the same message CAP leveraged in its opposition. He went on to say in his veto letter, "A more nuanced approach would be to specify that a judge may reduce the standard of proof under these circumstances."

The bill was not defeated at the committee hearings, nor at the floor vote level. Instead, it made its way to the governor's desk when CAP, along with other like-minded entities, made their final case to the governor to encourage his veto. While the veto was achieved, the governor provided a "suggestion" as how to craft bill language with a more "nuanced approach" to gain his support on the issue. Therefore, it is wholly expected that the consumer attorneys will return to the legislature to re-run this bill.

Constant attacks on hard-won liability protections require ongoing vigilance and a strong response from organizations like CAP. Legislation such as AB 2773 is likely to become more frequent following the passage of Assembly Bill 35 (AB 35), which weakened the protections provided by the Medical Injury Compensation Reform Act of 1975 (MICRA). Consumer attorneys will continue to seek out and exploit any remaining vulnerabilities until MICRA's protections are completely dismantled. While this trend cannot be fully stopped, it can certainly be challenged and defeated.

Read the governor's veto letter:
www.CAPphysicians.com/VETOLETTER

Gabriela Villanueva is CAP's Government and External Affairs Analyst. Questions or comments related to this article should be directed to GVillanueva@CAPphysicians.com.

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PUBLIC POLICY

Ask My Practice

By Andie Tena

2025 Physician Fee Schedule Updates: Projected Payment Reductions and Key Revisions

On November 1, 2024, the Centers for Medicare & Medicaid Services (CMS) released the final rule for the 2025 calendar year (CY), which includes significant updates to the Medicare Physician Fee Schedule (PFS) and the Quality Payment Program (QPP).

The new payment rates and telehealth guidelines took effect on January 1, 2025. The projected 2.83% reduction in payment rates is expected to have a financial impact on physician practices, particularly as operational costs continue to rise.

Independent and small group practices may face heightened challenges, balancing reduced reimbursement with escalating expenses. While the proposed payment reductions raise concerns, physicians who remain proactive and prepare for potential challenges will be in the best position to adapt.

While the key change in the final rule is a 2.83% reduction in Medicare reimbursement rates for physicians, "in accordance with update factors specified in law, finalized average payment rates under the PFS will be reduced by 2.83% in CY 2025 compared to the average payment rates for most of CY 2024. The change to the PFS conversion factor reflects the 0% update required by statute for CY 2025, the expiration of the 2.93% temporary increase in payment amounts for CY 2024 required by statute, and a small budget neutrality adjustment necessary to account for changes in valuation for particular services. This amounts to a finalized CY 2025 PFS conversion factor of $32.35, a decrease of $0.94 (or 2.83%) from the current CY 2024 conversion factor of $33.29."[1]

The U.S. Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), will focus on advancing high-quality primary and accountable care and furthering "whole person care," increasing access to behavioral health, oral health, and caregiver training services, removing barriers to covered preventive services, preserving some telehealth flexibilities and implementation of the inflation reduction act.

Many of the current telehealth flexibilities that were in place during the public health emergency terminated as of December 31, 2024. However, the following will continue:

- Certain practitioners will be able to continue to provide direct supervision of auxiliary personnel via virtual real time audio/video technology through 2025.

continued on page 9

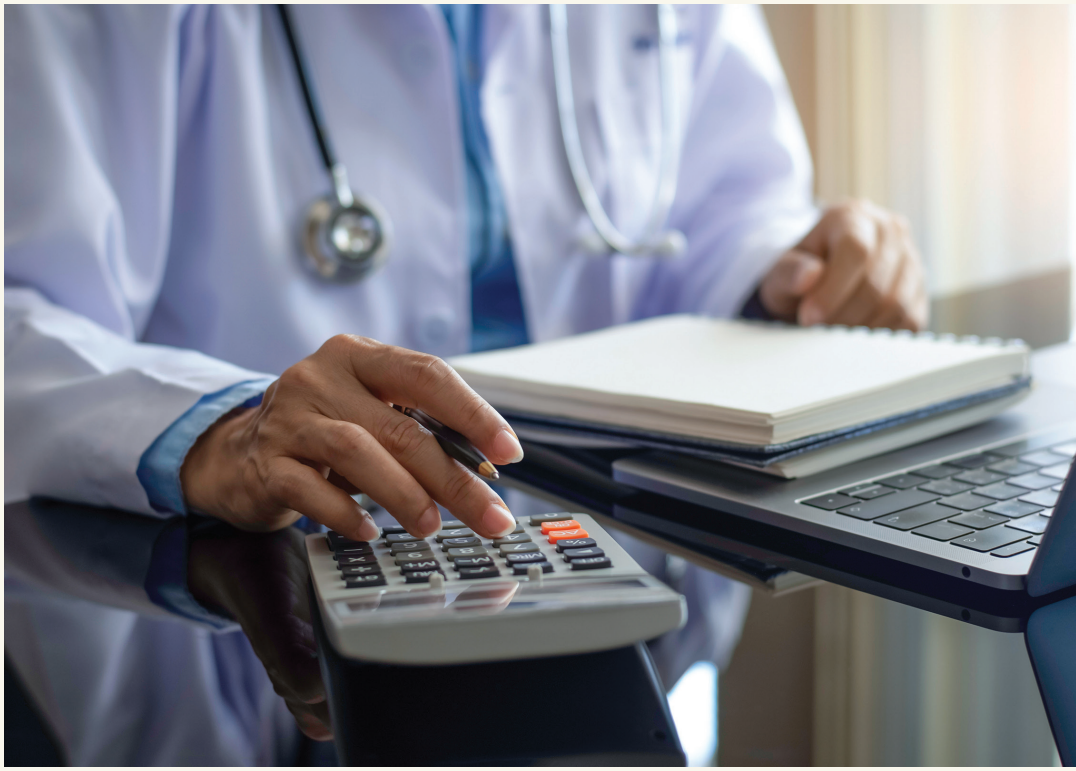
Continued from page 8

- Through March 31, 2025, CMS will continue to permit distant site practitioners to use their currently enrolled practice locations instead of their home addresses when providing telehealth services from their home.
- If a physician is able to utilize two-way interactive technology for telehealth visits but the patient is either not capable of or does not consent to video, the physician may utilize audio only.

To effectively navigate the upcoming changes, physicians may consider the following steps:

- **Stay Informed:** Monitor ongoing CMS updates and legislative actions that may affect Medicare payment policies.
- **Review Practice Finances:** Conduct a thorough review of your practice's revenue cycle, billing practices, and payer mix to ensure maximum reimbursement.
- **Prepare for Potential Cuts:** Develop a financial contingency plan to mitigate the impact of any potential payment reductions in 2025.
- **Monitor QPP Changes:** Stay updated on changes to the Quality Payment Program. New performance and reporting requirements may introduce additional financial implications, depending on the measures you select. https://qpp.cms.gov/

For further details, you can review the CMS Fact Sheet on the 2025 Physician Fee Schedule Final Rule: CMS 2025 PFS Final Rule Fact Sheet



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Get a Head Start in the New Year With No-Cost Assistance to Support Your Life Plans

SYMPHONY RISK

If you and your family are considering new goals, engaging in new life events, responding to new challenges, or simply navigating existing personal or professional situations this year, now may be the time to take advantage of free assistance available to you as a CAP member.

You and your family can access this program, offered through MetLife's Employee Assistance Program, to help with:

- **Family:** Divorce, caring for an elderly family member, returning to work after having a baby
- **Work:** Relocation, building relationships with coworkers and staff
- **Legal:** Issues relating to civil, personal, and family law, financial matters, real estate, and estate planning
- **Money:** Budgeting, financial guidance, retirement, buying or selling a home, taxes
- **Identity Theft Recovery:** ID theft prevention tips and help if you are victimized
- **Health:** Anxiety/depression, proper amounts of sleep, unhealthy habits
- And much, much more

Take Advantage of This Free Program

Call **1-888-319-7819** to speak with a counselor or schedule a phone or video conference appointment.

When you call, select **"Employee Assistance Program"** when prompted and immediately get connected to a counselor. Provide your name and identify yourself as a member of the Cooperative of American Physicians. Family members will need to identify themselves as a dependent of a member of the Cooperative of American Physicians.

Or

Log on to **metlifeeap.lifeworks.com**, and provide the **username metlifeeap** and **password eap**, to access free resources online.

This program is provided through MetLife and is made available to members through CAP's affiliation with Symphony Health, a division of Symphony Risk Solutions.

Contact Symphony Health at **800-819-0061** or via email at **healthcareservices@symphonyrisk.com** to learn more or request a free consultation.

Your benefit includes up to five phone or video consultations with licensed counselors for you and your eligible household members, per issue, per calendar year. Any personal information provided is completely confidential.

MetLife and LifeWorks abide by federal and state regulations regarding duty to warn of harm to self or others. In these instances, the consultant may have a duty to intervene and report a situation to the appropriate authority. This service is provided by MetLife and LifeWorks and other limitations may apply.

Protect Yourself and Your Practice From Dangerous Cyber Threats

CAP members are reminded of the value-added insurance coverages CAP provides as part of their membership, including CyberRisk insurance. This cyberliability policy covers up to $50,000 and 5,000 patient notifications per covered claim should you experience a data breach in your practice.

As data breaches are now more frequent and sophisticated than ever, it is important to purchase additional coverage to protect yourself and your practice.

CAP members are eligible to purchase up to $1 million in CyberRisk coverage to protect you should a cyberattack render you vulnerable to stolen protected health information (PHI), HIPAA violations and penalties, identity theft, practice closure, and other risks.

Get a Free Quote Now at **www.CAPphysicians.com/CRQuote**

CyberRisk insurance is available for purchase at excellent rates through Symphony Health, a division of Symphony Risk Solutions. Contact Symphony Health at **800-819-0061** or via email at **healthcareservices@symphonyrisk.com** to learn more or request a free consultation.

Important Reminder About Your Automatic CyberRisk Insurance Benefit

CAP members should note that their CyberRisk insurance includes a $2,500 deductible per covered claim.

In addition, your CyberRisk insurance benefit is subject to a shared annual aggregate limit of $10,000,000, which means that all amounts paid under CyberRisk on your behalf and on behalf of all other CAP members will reduce and may completely exhaust such shared annual aggregate limits. If the shared annual aggregate limit is exhausted, your individual CyberRisk limits will also be deemed exhausted, and there will be no further CyberRisk insurance benefit available to you or others for the remainder of the year.

Free Training for CAP Member Practices

To avoid potential claims, CAP encourages all member practices to implement strict cybersecurity measures. As part of the benefits of your CyberRisk insurance, you and your staff can access free HIPAA training courses on how to prevent data breaches, and much more at https://CAP.nascybernet.com.

(First-time users will need to sign up for a free account with your CAP member number as your "Sign Up Code." Once you have registered, you will be able to create usernames and passwords for your employees also.)

Easy Claims Handling

To report any claim or potential incident, please contact Tokio Marine HCC below, advise that you are a CAP member, and give your CAP member/entity number:

Tokio Marine HCC - Cyber & Professional Lines Group

- **Claims Department:**
  16501 Ventura Blvd., Suite 200
  Encino, CA 91436
- **Claims Telephone Number:**
  888-627-8995
- Claims Email Address:
  cpl.claims@tmhcc.com

There are no upfront costs to report a claim or potential claim. Tokio Marine HCC's goal is to get you back up and running while reaching a successful resolution. When it comes to providing expert breach response, Tokio Marine HCC's in-house claims team considers the needs of each member.

COOPERATIVE OF
AMERICAN PHYSICIANS

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DECEMBER 2024 – JANUARY 2025

IN THIS ISSUE

1 Support for CAP Members During the California Wildfires

2 Case of the Month
The Critical Link Between Informed Consent, Thorough Documentation, and Effective Defense of Medical Care

5 Risk Management and Patient Safety News
The Role of Informed Consent in Medical AI: Balancing Innovative Advancements With Patient Rights

7 Public Policy
Victory Via Veto - AB 2773

8 My Practice
2025 Physician Fee Schedule Updates: Projected Payment Reductions and Key Revisions

9 Get a Head Start in the New Year With No-Cost Assistance to Support Your Life Plans

10 Protect Yourself and Your Practice From Dangerous Cyber Threats

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We welcome your comments! Please submit to communications@CAPphysicians.com.