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Ophthalmic Risk Management Digest

OMIC DIGEST

# Evaluating Competency, Handling Incompetency

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**OMIC Risk Manager**

All physicians, at some point, will find themselves in situations where they need to evaluate their own or another health care provider's competency. Especially when evaluating others' competency, physicians are often unsure of the best way to do so, how to communicate their evaluation to the subject, and their responsibility to report their findings. Viewing the issue from the patient safety perspective provides guidance. The following two OMIC case studies furnish a basis for considering the process.

A senior ophthalmologist was gravely concerned. This wasn't the first time his partner had run into problems with poor outcomes and dissatisfied patients. Four patients had even sued for medical malpractice about seven years ago. In each case, the other partners, OMIC, and defense experts had supported the ophthalmologist's care, and all four cases had been dismissed without an indemnity payment. Then one year ago, a patient experienced a ruptured posterior capsule. Uncharacteristically, the ophthalmologist didn't manage the complication well in the OR or during the postoperative period. Indeed, his attempts to recover the nucleus caused further damage. He never did a postoperative retinal exam despite worsening vision problems and never referred the patient to a retinal specialist. Discussing his care with the defense attorney assigned to assist him, the ophthalmologist was the first to offer the above criticisms, and agreed to settle the lawsuit against him for $160,000.

Now, nearly a year after that surgery, the group learned of four new cataract cases with poor outcomes, and all felt the surgeon's technique was clearly substandard. They had also noted changes in his behavior. The senior partner raised these quality and health concerns with his colleague at regular, short intervals—to no avail. The partners concluded that something was seriously wrong with their close friend and colleague and issued a mandatory order that he cease patient care. Their worst fears were confirmed when he was examined by a neurologist and deemed mentally incompetent secondary to frontal lobe dementia. Lawsuits based on the ophthalmologist's substandard care ensued, ultimately settling for a total of $850,000.

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## MESSAGE FROM THE CHAIRMAN

**One of the many benefits of the** close relationship between OMIC and the Academy is the ability to coordinate our efforts to address legal, regulatory, and quality of care issues of common concern. Recently, OMIC and the Academy joined forces to stop legislation that would have adversely affected ophthalmic practice in two states.

In March, OMIC responded to a request from Academy EVP/CEO, David Parke, MD, to help the Washington Academy of Eye Physicians and Surgeons (WAEPS) respond to a proposed state Medical Quality Assurance Commission (MQAC) regulation that would characterize retrobulbar and periorbital ocular blocks as anesthesia "where significant cardiovascular or respiratory complications may result." Such a characterization would require every ophthalmology office that administers anesthetic blocks to undergo an accreditation or certification process similar to that of the Accreditation Association for Ambulatory Healthcare. Clearly, the process would not only be burdensome, but also extraordinarily expensive and unnecessary as ophthalmologists have been administering these anesthetic blocks in their office practices for decades with no significant risk to patients.

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## Red Flags Rule, HITECH/HIPAA Obligations, and RAC Audits

The Federal Trade Commission again postponed enforcement of the "Red Flags" rule for health care providers through December 31, 2010, largely in response to a lawsuit by the American Medical Association. The Red Flags rule, passed in 2003 under the Fair and Accurate Credit Transactions Act, requires that "creditors" create a written protocol to protect sensitive financial information and notify clients of security breaches.

The HITECH Act, an amendment to the HIPAA Privacy law, passed in late 2009 as part of the American Recovery and Reinvestment Act. It requires that physicians maintain a protocol to protect patient's sensitive health information. Violations are subject to penalty immediately, with an extended implementation period for physicians who use Electronic Medical Records systems.

As part of the Tax Relief and Health Care Act of 2006, the Centers for Medicare and Medicaid Services authorized the Medicare Recovery Audit Contractor (RAC) program to identify improper Medicare payments. A temporary "stop work" order during litigation regarding the awarding of RAC contracts was resolved in 2009 and the law was expanded to all 50 states this year. Contracted auditors across the country are paid a contingency fee to identify improper billing practices and receive a portion of the over (or under) payments they collect from health care providers.

OMIC's professional liability policy provides coverage for patient notification costs associated with regulations such as the Red Flags rule and HITECH Act, subject to a sublimit of $10,000 per policy period. RAC audits and other "billing errors" proceedings are covered at a sublimit of $35,000 per policy period. Coverage provides reimbursement for legal and audit expenses, including shadow audits, as well as fines and penalties (where allowed by law).

## Message from the Chairman

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As is often the case, this rule was "hidden" in a larger regulation pertaining to office-based surgery. When it appeared likely the regulation would pass, WAEPS contacted the Academy for assistance, and Dr. Parke asked OMIC for claims data related to the use of local blocks in office-based surgery. His response to MQAC stated:

"…complications of retrobulbar injection in the outpatient office setting are extraordinarily rare. A survey by the largest medical malpractice carrier in ophthalmology (Ophthalmic Mutual Insurance Company) found only one case in a 21-year review of its claims data bank of a cardiovascular event from a retrobulbar injection performed outside of the operating room. This is in a period of time when literally millions of such injections were performed. This indicates that the risk is very small."

Having compelling evidence-based data is of extraordinary benefit when dealing with regulatory agencies. With the support of the Academy, the Washington Medical Association, and other concerned organizations, WAEPS was successful in having the rule taken off the hearing calendar and reevaluated with more input from ophthalmology.

OMIC also worked closely with Academy Secretary for State Affairs, Dan Briceland, MD, to help the West Virginia Academy of Ophthalmology (WVAO) fight an optometry bill that would have allowed optometrists to perform glaucoma surgery. OMIC has extensive experience in this area. Over 300 optometrists are directly insured by OMIC, and approximately 35% of its 4,100 insured ophthalmologists employ or contract with an optometrist. In a letter drafted for WVAO to present to West Virginia legislators, OMIC pointed out the risk to patients:

"OMIC engages in an ongoing process of assessing the risk of optometrists performing 'surgery.' Based on an objective risk assessment, OMIC is not willing to extend liability coverage to any optometrist who performs laser surgery or any therapeutic ophthalmic laser procedure."

The letter noted that only one state (Oklahoma) allows optometrists to perform surgical or therapeutic laser procedures.

"OMIC's decision to not extend this coverage to optometrists is based on the lack of data available on this liability risk, as well as the company's assessment that there is also an absence of data to properly underwrite, determine a premium rate, and have the expertise to administer claims arising from surgical or therapeutic laser procedures performed by optometrists."

After a hard-fought battle, the WVAO was able to defeat the bill and stop the expansion of optometry into glaucoma surgery.

**Richard L. Abbott, MD**
**OMIC Chairman of the Board**