Preoperative history and physical examinations and evaluations

Anne M. Menke, RN, PhD
OMIC Patient Safety Manager

**PURPOSE OF RISK MANAGEMENT RECOMMENDATIONS**

OMIC regularly analyzes its claims experience to determine loss prevention measures that our insured ophthalmologists can take to reduce the likelihood of professional liability lawsuits. OMIC policyholders are not required to implement these risk management recommendations. Use your professional judgment in determining the applicability of a given recommendation to your particular patients and practice situation. These loss prevention documents may refer to clinical care guidelines such as the American Academy of Ophthalmology’s *Preferred Practice Patterns*, peer-reviewed articles, or to federal or state laws and regulations. However, our risk management recommendations do not constitute the standard of care nor do they provide legal advice. Consult an attorney for legal advice. Information contained here is not intended to be a modification of the terms and conditions of the OMIC professional and limited office premises liability insurance policy. Please refer to the OMIC policy for these terms and conditions.

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Many patients contemplating eye surgery also have medical conditions that could increase the risk of the operative or diagnostic procedure and anesthesia/sedation. To prepare for and reduce the risks, CMS (Centers for Medicare and Medicaid Services) mandates 3 separate evaluations of patients before surgery: a preoperative history and physical examination (H&P) within 30 days of surgery, a pre-surgical assessment that updates the H&P on the day of surgery, and an anesthesia and procedure risk assessment (APRA) immediately prior to surgery.

While ophthalmologists are medical doctors, as specialists they generally limit their care and treatment to ophthalmic conditions. Accordingly, most ophthalmologists do not perform the preoperative H&P themselves. Instead, they regularly refer the patient to the primary care physician (PCP) for this evaluation. For similar reasons, ophthalmologists may not feel they can adequately update the H&P on the day of surgery or perform the APRA immediately before surgery. Regardless of their comfort or competency level, ambulatory surgery centers (ASCs) may ask them to perform these evaluations. This is more likely to be the case if the ASC does not have anesthesiologists on site, since a physician must perform the APRA according to CMS Conditions of Participation.¹ We provide recommendations about the ophthalmologist’s role by answering questions that physicians ask us on our Hotline.

Q: I have been conducting the H&P reassessments for years. What are the malpractice risks?

A: The primary purpose of the preoperative H&P is to determine if the chosen procedure and anesthesia are safe and appropriate for the patient, and to help anticipate potential complications related to ophthalmic or medical comorbidities. If a patient experiences an unanticipated outcome, he or she might allege that the reassessment was negligent or failed to detect preexisting medical conditions. If you conduct these evaluations, make sure your H&P skills are up-to-date.

Q: My hospital has asked me to update the patient's preoperative H&P by conducting a physical assessment prior to surgery. I haven't done a preoperative H&P since my residency years ago, and don't feel competent to do one now. What should I do?

A: Your signature on the reassessment form indicates that you have conducted a history and physical examination, however brief. Ophthalmologists whose current competency does not include these skills should decline such requests, and work with the hospital administration to find alternative solutions, such as those described below.

Q: Does a physician have to perform the H&P update on the day of surgery?

A: No. CMS allows other “qualified practitioners” (QPs) to perform the outpatient H&P and the update to it at the ASC. CMS defines QPs as “those licensed practitioners who are authorized in accordance with their State scope of practice laws or regulations to perform an H&P and who are also formally authorized by the ASC to conduct an H&P. Other qualified licensed practitioners could include nurse practitioners [NPs] and physician assistants [PAs].” 1

Q: The ASC where I operate has hired NPs and PAs to reassess the patient. The ASC wants me to cosign the evaluation. Is it risky for me to do that?

A: No. These practitioners are highly trained professionals whose scope of practice and workload regularly includes performing H&P examinations. OMIC has analyzed the liability risk for ophthalmologists when non-physicians such as Certified Registered Nurse Anesthetists (CRNAs) provide care. 2 When physicians supervise CRNAs who are not their employees, they are not necessarily liable for the actions of the CRNA. Courts generally focus on the amount of control the physician exercises over the provider—whether the anesthesia provider is a CRNA or an anesthesiologist. While plaintiff attorneys might argue that the ophthalmologist’s signature on anesthesia orders, evaluations, or records is proof of control, they will need further evidence that the physician directed the actions of the CRNA to win their case. Similarly, simply cosigning the update to the patient’s condition does not make the ophthalmologist liable for the actions or omissions of the NP or PA.

Q: Does my signature imply that I am certifying the reassessment?

A: No. Your signature on a reassessment form acknowledges that another licensed provider has evaluated the patient’s medical condition. It does not imply that you are attesting to the accuracy or thoroughness of the examination in question. Once the NP or PA has completed the history and physical examination, read it, and write “Patient reassessed and cleared for surgery by ______ NP/PA” (include the provider’s name and title).

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Q: Anesthesia providers perform a preanesthesia evaluation. Can the hospital use this to update the patient’s condition?

A: Many hospitals and surgery centers meet the CMS H&P requirements in this way. Anesthesiologists and CRNAs have considerable expertise in conducting H&Ps, and must evaluate the patient prior to administering sedation or anesthesia.

Q: There are no anesthesiologists at the ASC where I operate. The ASC insists that I assess the patient immediately before surgery to evaluate the risk of anesthesia and the procedure. Do I have to perform this?

A: CMS stipulates that only a physician may perform this anesthesia and procedure risk assessment (APRA). CMS defines physicians as a doctor of medicine or osteopathy, doctor of dental surgery or dental medicine, doctor of podiatric medicine, doctor of optometry, or a chiropractor. If you are the only physician involved in your patient’s care, the ASC may ask you to do this.

Q: What is the purpose of the APRA?

A: According to the CMS manual, the APRA is intended to “evaluate, based on the patient’s current condition, whether the risks associated with the anesthesia that will be administered and with the surgical procedure that will be performed fall within an acceptable range for a patient having that procedure in an ASC.” The Manual does not explain how to do this evaluation. However, it gives the ASA Physical Status Classification System as an example. The American Society of Anesthesiologists developed this system to help determine a patient’s risk. Here are the categories:

- ASA PS I Normal healthy patient
- ASA PS II Patient with mild systemic disease
- ASA PS III Patient with severe systemic disease
- ASA PS IV Patient with severe systemic disease that is a constant threat to life
- ASA PS V Moribund patient who is not expected to survive without the operation
- ASA PS VI Declared brain-dead patient whose organs are being removed for donor purposes.

CMS considers this system a standard tool for predicting morbidity and mortality in surgical patients. It explains that an ASC “that employed this classification system in its assessment of its patients might then consider, taking into account the nature of the procedures it performs and the anesthesia used, whether it will accept for admission patients who would have a classification of ASA PS IV or higher. For many patients classified as ASA PS level III, an ASC may also not be an appropriate setting, depending upon the procedure and anesthesia.”

Q: Do I have to determine the patient’s ASA PS level?

A: No. The CRNA determines this during the pre-anesthesia assessment.

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Q: How can I reduce the risks of conducting the APRA?

A: Work with the ASC to develop a written policy on how best to conduct the APRA. Consider making it part of the time-out process performed immediately before the surgery. Ask the CRNA to tell you the assigned ASA PS level and his or her assessment of the patient’s ability to undergo surgery at the ASC. Use this anesthesia assessment, along with your knowledge of the risks of the planned procedure, to confirm that surgery may proceed.

The ophthalmologist, PCP, and anesthesia providers all have a vital role to play in ensuring that surgical care is safe. Working together, they can reduce the patient safety and liability risks.

OMIC policyholders who have additional questions or concerns about this issue may obtain confidential assistance through our Risk Management Hotline. Call us at 800-562-6642, option 4, or email us at riskmanagement@omic.com.