Due to concerns about new procedures being performed in physicians’ offices, the Mississippi State Board of Medical Licensure (MSBML) has adopted a new Regulation regarding office-based surgery. MSBML originally adopted the Regulation to be effective September 1, 2001; however, the Regulation was revised at the urging of representatives of Medical Assurance Company and others, and will be effective June 1, 2002.

Definitions and Registration with MSBML

Even though you may believe that the simple procedures performed in your office do not fall within this new Regulation, you should be aware that the definition of “surgery” in the Regulation includes “any operative procedure performed upon the body of a living human being for the purposes of preserving health, diagnosing or curing disease, repairing injury, correcting deformity or defects, prolonging life, relieving suffering or any elective procedure for anesthetic, reconstructive or cosmetic purposes”. The Regulation covers surgery which is performed outside the hospital, an ambulatory surgical center, abortion clinic, or other medical facility licensed by the Mississippi State Department of Health. Thus, even some of the simplest procedures will be subject to this new Regulation.

The Regulation is patterned after office-based surgery regulations in a few other states, and divides office surgery into three levels. Physicians performing Level II or Level III office-based surgery must register with MSBML using a registration form provided in the Regulation. New Documents and Records

1. Record of Each Surgical Procedure - The physician must maintain complete records of each surgical procedure, including anesthesia records, when applicable.

2. Special Written Informed Consent - Records for Level II and Level III surgery must contain written informed consent reflecting the patient’s knowledge of identified risks, consent to the procedure, type of anesthesia, and the anesthesia provider. The consent form must also state that the physician’s office is regulated pursuant to the Rules and Regulations of the MSBML.

3. Log of Surgical Procedures Performed - Physicians performing Level II or Level III surgical procedures must maintain a log of those procedures performed, which must include a confidential patient identifier, type of procedure, type of anesthesia used, duration of the procedure, type of post-operative care, and record of any Surgical Events (see below).

Not Just for Surgeons Anymore!

New Office Based Surgery Regulations May Affect You

by Robert M. Jones, Esq.

Continued on page 4
RISK MANAGEMENT DATA ANALYSIS (1996-2000)
Obstetrics and Gynecology
by Beth Womack, RHIA

Last issue, we published the overall risk management data analysis for claims reviewed from January 1996 through December 2000 (The Risk Manager, First Quarter 2002). Beginning with this issue, we will briefly review data from the top five specialties by volume.

Obstetrics and Gynecology had the most cases reviewed (N=73, 21% of the total). These included both claims (36%) and lawsuits (64%). Examination revealed that 64% had clinical issues, 90% had risk management issues, and 84% had “other” issues. Please note: The matters discussed in this article relate to issues raised in the claims and lawsuits or identified by our staff. Identification of these issues does not necessarily mean that the physician was negligent or that there was any validity to the claim or lawsuit.

As expected, the primary location of the incident initiating the claim was the hospital (85%). As borne out in the overall analysis, the main pay source of the patient was private insurance (52%) followed by Medicaid (44%), Medicare (3%), and Self-pay (1%).

In those cases where clinical issues were identified, eighty one percent (81%) involved Practice related issues, while 36% involved Diagnosis related issues. Practice related issues included such things as iatrogenic injuries (surgery related perforations leading), inappropriate treatment, and failure to treat. Diagnosis related issues included failure to diagnose/inappropriate diagnosis related to postoperative complications, the birth process, and breast cancer. Delay in Diagnosis, and failure/delay in referral or consult were also included in this category.

In those cases where risk management issues were identified, fifty percent (50%) raised questions regarding Medical Record Documentation shortfalls, thirty-six percent (36%) regarding Informed Consent issues, thirty two (32%) regarding Communication issues, thirty percent (30%) regarding Practice Issues, and 24% regarding System Failures in the office.

In the Medical Records Documentation area, the main issue was a lack of documentation of the patient’s plan of care in the hospital, including issues regarding progress or labor notes, documentation of delivery, particularly difficult deliveries, and lack of documentation of the patient’s plan of care in the office notes. Informed consent issues ranged from no documentation to failure to document one or more of the essential elements of the process. The number one Communication issue was miscommunication with other healthcare providers, followed by unclear/inadequate instructions to the patient and miscommunication with the patient.

Practice issues included the Dr. “Nice Guy” syndrome (acquiescing to the patient’s wishes against the physician’s better judgement) and physician unavailability/slow response. The predominant System Failure issue in the Office was patient followup. The Other Issues category included an array of things which the physician may not have control over, such as Hospital issues (lost fetal monitoring strips, staff performance or lack of communication), jousting by another physician, or patient family issues.

We hope that this information can benefit the physician by pointing out areas of risk identified in claims and providing guidance in adopting reliable risk management systems.
Follow-Up Systems Quiz: How Do You Rate?

☐ “No-show” patient records are always reviewed by licensed personnel at the end of the day to assess importance of follow-up communication.

☐ We always follow-up with a phone call on postoperative or postpartal patients, or patients with complications or required monitoring, if they “no show” for an appointment.

☐ Follow-up phone calls, letters, messages are always documented in the patient record, including unsuccessful attempts.

☐ Our appointment system tracks “reschedules” and allows us to intervene when a patient reschedules a “must see” appointment.

☐ All patients are contacted and given results of testing, whether normal or abnormal results.

☐ Patients are NOT told, “If you do not hear from us, you can assume your tests were okay” or “Call us to get your results”.

☐ Laboratory results and results of other diagnostic tests are not filed in the patient record without being reviewed and initialed by a licensed professional, preferably the physician.

☐ Unexpected findings on radiologic imaging always initiates a call from the radiologist to the requesting physician.

☐ “Bad news” for the patients is always communicated by the physician.

☐ For patients “lost to follow-up”, the patient record clearly documents attempts to contact the patient.

Follow-up Systems Quiz: How Do You Rate?
Scoring - one (1) point for each “Yes” answer.

9-10 Points: Congratulations! You see the importance of follow-up for patient care and risk management. Let’s make it a perfect score!

6-8 Points: You probably need to review your way of doing things. You are teetering on the edge.

3-5 Points: Your follow-up systems are in serious trouble and need intensive care.

0-2 Points: Call the MACM Risk Management Department NOW!
**HIPAA PRIVACY REGULATIONS: UPDATE**

As you are well aware, the HIPAA Privacy Regulations are still being examined, with modifications being made in response to comments received by HHS. Because of the continued uncertainty as to the “final” set of regulations, we are finding it difficult to provide you with any definitive guidance on requirements, checklists, and forms. We had hoped to have such information available by early July; however, as of the date of publication of this newsletter, final guidance from HHS was not available. We will, nevertheless, continue to monitor the latest “modifications” to the “final” Rule and provide you this information as soon as we are able.

**Surgery continued from page 1**


5. **Report of Surgical Events to MSBML** - Each physician must report to MSBML any Surgical Event that occurs within the office-based surgical setting. A “Surgical Event” is a potentially harmful or life-threatening episode related to either the anesthetic or the surgery. The Surgical Event must be reported within fifteen days after its occurrence using the form provided in the regulation. The filing of the report does not, in and of itself, constitute an acknowledgment or admission of malpractice, error or omission. If a Surgical Event should occur in your office, we recommend that you complete the Surgical Event Report Form so as not to acknowledge nor admit any error on your part.

6. **Written Response Plan** - All surgeons performing office-based surgery must have a written response plan for emergencies within their facility.

7. **Notice Posted in Office** - In offices where Level II or Level III office-based surgery is performed, a notice stating that the office is regulated by the Rules and Regulations of MSBML must be prominently posted.

**Other Requirements**

The new Regulation also provides that (a) the use of local, general or topical anesthesia and/or intravenous sedation is the prerogative of the surgeon; (b) equipment used in the office surgery must meet current performance standards; (c) the level of sterilization must meet current OSHA requirements; (d) with respect to liposuction procedures, the physician is responsible for determining the appropriate amount of supernatant fat to be removed from a particular patient, but the Regulation recommends the amount of fat to be removed in the office setting; and (e) ASA Guidelines for Office-Based Surgery are recommended for use in Level III procedures.

For each level of office surgery the Regulation sets forth additional requirements regarding training, equipment and supplies, assistance of other personnel, level of anesthetic, and whether a transfer agreement with a hospital is required.

We urge you to review the Regulation in order to be sure that you and your clinic meet the requirements for each level of office surgery performed by you. In the event of an incident relating to your failure to comply with this new Regulation, the patient may be able to rely on your violation of the Regulation to establish a medical malpractice claim against you. In essence, this Regulation is now the minimum standard for office-based surgery in Mississippi.

The Regulation may be viewed on the MSBML website at “www.msblem.state.ms.us.” At the time of the publication of this article, the revised Regulation could be found under “New Filings” on the MSBML Home Page. The version of the Regulation under “Rules & Regs” was the original version, and should not be relied upon at this time. Be sure that you view the version of the Regulation which will be effective June 1, 2002.
Q. Several employees in our clinic call in prescriptions and prescription refills for themselves, friends, and family members without the physician’s knowledge. When confronted about this, they reply that it is ok to do this because they “work in the doctor’s office”. We are implementing a policy that forbids this practice. What are the implications from a legal/risk management standpoint?

A. Simply working in a physician’s office does not authorize someone to call in a prescription. Mississippi statutes state that only physicians and certain other healthcare providers may prescribe medications. The applicable statute is Miss. Code Ann. Section 41-29-144. All schedule II substances must be written by a physician; in other words, they cannot be called in and nurse practitioners cannot write them.

According to the Mississippi Bureau of Narcotics, calling in ANY medication without proper authorization is fraud. If a medication that is not a controlled substance is called in, the charge is termed “uttering a felony” as it is essentially a spoken forgery. Depending on the situation, these cases are charged as either felonies or misdemeanors. The sentence in these cases vary, however, precedents have been set for both jail time and significant fines. A written/forged prescription is a felony and is punishable by a 5 year prison sentence.

If the medication is a controlled substance, the charge is “obtaining by fraud”. This is a felony charge. Persons who have been convicted of certain felonies are unable to vote or run for public office. They are also not eligible to become a school teacher, nurse, or physician.

The physician is liable for any prescription that bears his/her name even if he/she did not authorize the prescription. Repercussions for the physician may include restriction or loss of his/her medical license.

In addition to the above, be aware MACM’s liability insurance policy does not cover a claim where the employee unlawfully fills a prescription because the policy excludes claims arising from (a) criminal acts, and (b) knowingly allowing someone to practice medicine who is not lawfully qualified to practice medicine.

Q. I received correspondence from an attorney requesting copies of medical records for a patient. Enclosed with the request for records is a copy of the medical privilege statute, Section 13-1-21, which in part states that the patient does not have to sign an authorization for release of records if the patient has filed a lawsuit. What do I do?

A. The application of this provision of Section 13-1-21 has been limited by Mississippi Supreme Court decisions. In order to release medical record information, you must either have a signed authorization from the patient/their legal representative or a subpoena requesting records. Notify the attorney that you will need a patient authorization or a subpoena for the records.

Q. We received a telephone call from an individual identifying himself as a subsequent treating physician. He asked to come to our office to review a patient’s original records. He said he would bring a release form signed by the patient. Our offers to send a copy of the medical records to him after we received the properly signed release were rebuffed. Were we right to refuse this request?

A. Yes, you were right to refuse this unusual request. The physician in question is also a trial attorney and may have been gathering information for a lawsuit. MACM recommends that offices establish written policies on the release of medical records and follow them. Be suspicious of any unusual request. When in doubt call MACM for advice.
Weight Loss Drugs?

If you prescribe weight loss drugs, be aware that the latest drug to be targeted by the plaintiff’s bar appears to be Meridia. In March 2002, the consumer advocacy group, Public Citizen, petitioned the FDA to recall the drug on the basis of what the group called serious side effects. One national plaintiff law firm is taking advantage of this and advertising for clients through its internet website newsletter. Although the solicitations suggest that the firm is targeting the drug manufacturer and marketers, we know that the physician is many times named, particularly in Mississippi where naming a physician allows state jurisdiction versus federal, a much more plaintiff friendly venue. Whether this latest mass tort claim effort takes hold is yet to be seen, but in the meantime, be sure to keep up with the latest literature, choose your patients appropriately, monitor them as indicated, and document good informed consent.