EHR best practices: complying with new TMB documentation rules

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TMB RULE UPDATES

The Texas Medical Board (TMB) has recently amended their rules related to physician documentation and what constitutes an “adequate medical record.” Physicians must now meet two new standards related to documentation.

Standard 8
“Include a summary or documentation memorializing communications transmitted or received by the physician about which a medical decision is made regarding the patient.”

To comply with Standard 8, all communication with patients outside the office

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setting, such as phone calls, emails, and texts should be documented in the medical record. Documenting all interactions with patients — regardless of the communication method — will help physicians and subsequent caregivers provide patient care. Documenting this information will also confirm the receipt of instructions given to the patient in response to specific complaints, should a medical liability claim arise.

**Standard 10**

“All non-biographical populated fields, contained in a patient’s electronic medical record, must contain accurate data and information pertaining to the patient based on actual findings, assessments, evaluations, diagnostics, or assessments as documented by the physician.”

Regarding Standard 10, pre-populated fields in electronic health records (EHRs) must contain accurate information. Notes that are cloned or carried over from previous visits should be updated to ensure accurate information is in the EHR.

While copying text from one visit to the next may save time, medical records reflecting incorrect history, outdated patient concerns, or outdated exam information could lead to TMB action for failure to maintain an “adequate medical record.” Board members have indicated they will be carefully scrutinizing medical records for accuracy during an investigation. Additionally, inaccurate records can be detrimental in the event of a medical malpractice claim.

**EHR BEST PRACTICES**

As EHR use increases rapidly, TMLT’s Risk Management Department is focused on helping physicians navigate electronic documentation while reducing risks for medical liability or TMB complaints. Please consider the following best practices to help reduce risk related to EHR systems.

**TEMPLATES, DEFAULTS, AND COPIED RECORDS**

As addressed in the discussion about TMB Standard 10, many EHRs use drop-down menus or re-populate data from a previous visit. While these features save time, physicians are not always aware that templates can import inaccurate information. Some programs may also be set up so that specific complaints default to “resolved” if the physician or the patient does not renew that complaint on the next visit. Make sure medical history, medications, and allergies are consistently and appropriately updated.

Notes should be individualized for each patient encounter, and relevant sections reviewed to avoid importing incorrect, redundant, and irrelevant information. Also, do not leave areas in templates blank. Delete those areas or mark them as “not applicable.”

**PASSWORDS**

Avoid sharing passwords to make the entry of information easier. Each staff member and physician should have his or her own individual login. EHRs associate the person who enters that password as the author of the entry in the patient’s medical record.

Staff members should not have access to the physicians’ level of security because that could allow them to add or alter information as if they were the physician. Staff members should have their own passwords and level of security clearance based on their job functions.

**COMPLETING AND LOCKING NOTES**

Ideally, patient encounter records are electronically signed and “locked” as quickly as possible after the patient’s visit. Physicians and staff are encouraged to use electronic order entry and tracking or other systems to track the receipt of test results, instead of leaving notes “open” until results are received.

If test results are received promptly (one to two days), a small delay in sign-off may be acceptable, but generally more thorough test tracking methods are recommended. Information entered into the EHR is likely to be more accurate if completed immediately after the visit, and is more secure if electronically signed and locked.

**TRACKING AND SIGNING TEST RESULTS**

When patients are referred to specialists or to an outside source for lab or diagnostic tests, a tracking system is critical to ensure the patient is seen and the results are received. Many EHR systems have electronic order tracking for referrals and diagnostic tests that have been ordered. Once results are received,
make sure the report review clearly states the date the results were reviewed.

**“TO DO” LISTS**

If you use electronic tasks, messages, or “to-do” lists, it is important to review these items promptly. Setting aside a designated time every day will help ensure that you address any outstanding items. Regularly reviewing diagnostic results and messages, and documenting your review, can help to defend against allegations of delay in diagnosis or failure to follow up.

**ADDENDUM PROCESS**

Clearly identify late entries made in the EHR. Include the reason for the lateness of the entry and the date and name of the person making the late entry. Late entries that are not clearly identified could be viewed as an alteration to the medical record, which could compromise the physician’s credibility and the defense of a claim.

Current TMB rules state “Any amendment, supplementation, change, or correction in a medical record not made contemporaneously with the act or observation shall be noted by indicating the time and date of the amendment, supplementation, change, or correction, and clearly indicating that there has been an amendment, supplementation, change, or correction.”¹

**SAMPLES**

Document when sample medications are given to patients. According to TMB rule 169.7, physicians are required to make appropriate entries in a patient’s electronic health record when a pharmaceutical sample is supplied to a patient.²

**USE OF SCRIBES**

Document that a scribe was used to make entries into the EHR. A scribe can be an advanced practice provider (APP), nurse, or other staff member the physician allows to document services in the medical record. While the physician or APP must perform the medical service, the scribe may document what is dictated and performed in the medical record.

Documentation of scribed services must clearly indicate who performed the service, who recorded the service, and the qualifications of each person (i.e., professional degree, medical title). Documentation should be signed and dated by both the physician/APP and scribe.³

**EHR POLICIES AND PROCEDURES**

Federal privacy and security rules require that practices develop protocols to protect the integrity and security of their EHR (referred to collectively as electronic protected health information or PHI). Policies should be signed by the physician and include implementation dates. Staff members should sign and date their acknowledgement of review and understanding of the policies and procedures.


**Sources**


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CME: Advanced Practice Providers: Rules, Regulations, and Physician Supervision

OBJECTIVES | At the conclusion of this educational activity, the physician should be able to:
1. identify requirements for delegation to and supervision of advanced practice providers under Texas law;
2. describe the function of and requirements for a prescriptive authority agreement;
3. discuss the Medicare and Medicaid requirements for billing services of advanced practice providers; and
4. explain steps that may be taken by a physician to minimize risks associated with supervising advanced practice providers.

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DISCLOSURE
David Walsh and Jennifer Saucedo have no commercial affiliations/interests to disclose related to this activity.

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It should take approximately 1 hour to read this article and complete the questions and evaluation form.

RELEASE/REVIEW DATE
This activity is released on July 15, 2015, and will expire on July 15, 2018.
Please note that this CME activity does not meet TMLT’s discount criteria. Physicians completing this CME activity will not receive a premium discount.
INTRODUCTION

Editor’s note: In this article, the term “advanced practice provider” will be used to refer collectively to advanced practice registered nurses and physician assistants.

An advanced practice provider (APP) is a clinical medical professional who provides patient care under the supervision of a physician. APPs include advanced practice registered nurses (APRNs) and physician assistants (PAs). In some contexts, certified registered nurse anesthetists (CRNAs) may also be referred to as advanced practice providers, but this article is limited to issues relating to the supervision of APRNs and PAs. These APPs examine patients, diagnose them, and provide some treatment, all of which must be delegated by a supervising licensed physician.

An increased demand for health care providers has resulted in expansion of the roles of APPs, requiring closer examination of the legal duties required of the supervising physicians. As demand continues to rise for the kinds of care APPs are uniquely suited to provide — along with the rise in popularity of careers in health care — physicians and health care entities need to understand the required degree of physician supervision and the potential liability associated with the use of APPs.

BACKGROUND

The combination of increased access to care under the Affordable Care Act and decreased number of graduating physicians (especially those in certain fields like primary care or family medicine) has led to a rapid rise in the number of APPs. In 2014, Merritt Hawkins, a national consulting firm, found that the demand for APPs has grown by 320 percent over the last three years, propelling them into the top five most desired specialties. Three years ago, these positions did not even rank in the top 20. The integration of APPs into the health care system has helped to ease increasing levels of patient demand, particularly in the realm of routine care, like check-ups and physical examinations.

While the increase in APPs has benefitted health care providers (by reducing demand) and the populations they serve (by increasing access), these benefits have not been without growing pains. Health care providers and lawmakers have struggled to find a balance that employs APPs to their fullest potential while ensuring they practice within the scope of their training. For physicians, a major concern is liability exposure for the actions of their APPs. In Texas, as in all 50 states, physicians can delegate certain aspects of care to APPs, but these providers still must work under the supervision of a physician. Thus, physicians must remember that delegation of a task is not delegation of liability.

The most common lawsuit allegations related to APP care are:

1. inadequate examination;
2. lack of adequate physician supervision;
3. delayed referral to a consultant (including referral to the supervising physician); and
4. failure to diagnose.

Across all specialties, diagnostic errors are the most prevalent medical liability claim involving APPs. Moreover, root cause analysis has shown that inadequate supervision is frequently the cause of a failure or delay in diagnosis. This article will discuss what adequate supervision really means and review what Texas law requires when it comes to physician supervision of APPs.
TEXAS LEGAL FRAMEWORK

General Provisions

The Texas rules pertaining to the supervision of APPs are mainly found in Chapter 157 of the Medical Practice Act (MPA), which comprises Chapters 151 through 168 of the Texas Occupations Code, and Texas Medical Board (TMB or the Board) Rules 185 and 193.6. The TMB Rules are codified in the Texas Administrative Code, Title 22 (and also available on the Board’s website).

The MPA establishes the general parameters for physician delegation in Texas and the requirement of supervision. The MPA obviously permits some subjective judgment authorizing physicians to delegate any medical act that a reasonable and prudent physician would find within the scope of sound medical judgment to delegate. The physician must believe that the person performing the delegated task can “properly and safely” perform it; can perform it in its “customary manner;” and that the performance of the task would not violate any other statute. Additionally, the physician must believe the person performing the task “does not represent to the public that the person is authorized to practice medicine.” Despite delegating the act, the physician remains responsible for the delegated act. Plus, the TMB can still determine whether any particular act “constitutes the practice of medicine” and whether any particular act “may be properly or safely delegated by physicians.”

The rule is quite clear that a physician’s supervision of the APP is inherent in the authority to delegate. Importantly, a failure to supervise an APP can expose a physician to liability for unprofessional or dishonorable conduct under Texas Occupations Code, Section 164.053(a)(8) – another statutory provision that requires physicians to adequately supervise those acting under the physician’s authority. The TMB, by statute, cannot adopt rules containing global prohibitions or restrictions on the delegation of medical acts “except as absolutely necessary.”

Law Specifically Related to Physician Assistants

In addition to the general rules applicable to both PAs and APRNs, several provisions specifically govern the supervision of Physician Assistants. Chapter 185 of the TMB Rules is dedicated to PAs, and the rules for physician supervision are found in Sections 185.14-15. Chapter 204 of the Texas Occupations Code also relates to PAs and contains similar language with respect to their supervision by physicians.

It is important to note that a physician who wishes to delegate to (and thereby, supervise) a PA must take certain steps prior to employing a PA in this manner. Specifically, the physician must: a) be currently licensed in Texas by the TMB, and his or her license must be active and unrestricted; b) notify the Board of the intent to supervise a PA; and c) submit a statement to the Board that the physician will supervise the PA according to rules adopted by the Board and retain professional and legal responsibility for the care rendered by the PA.

The law permits delegation of specific medical services to PAs in any place authorized by a supervising physician to include, but are not limited to, ordering and/or performing diagnostic and therapeutic procedures; developing and implementing a treatment plan; and assisting at surgery.

However, the physician should keep in mind that the Occupations Code specifically requires the physician to determine if the PA’s skill set makes him or her qualified and trained to perform the delegated medical activity. The title of “Physician Assistant” indicates that the person has met a set of qualifications and training but it does not — in and of itself — reveal whether the individual is capable of performing the specific task.

The specific TMB rules governing physician supervision of PAs may be found in Section 185.14 of the Texas Administrative Code. These rules require that “[s]upervision shall be continuous,” but do not necessarily demand “the constant physical presence of the supervising physician” at the same place where the PA practices. The physician must always be available by “telecommunication.” The Board rules are collaborative in nature, and both the physician and PA must ensure:

- the PA’s scope of practice is identified;
- the delegation of medical tasks is appropriate for the level of competence;
• there is appropriate access to and communication with the supervising physician;
• there is a process to evaluate the PA’s performance; and
• the PA is licensed to practice and has a current annual registration permit.10

Further, the PA must immediately notify the supervising physician of any change in license status, including “permit expiration, license cancellation, or entry of a disciplinary order.” The Board rules allow a PA to have more than one supervising physician. The rules also encourage the use of “prescriptive authority agreements, standing delegation orders, standing medical orders, protocols, or practice guidelines” by requiring PAs to follow such mechanisms where available.10

**Delegation of Administration of Dangerous Drugs and Prescriptive Authority**

The MPA permits a physician to delegate the act of administering or providing dangerous drugs in the physician’s office, as ordered by the physician and under the physician’s supervision. The medication’s use must meet the immediate needs of the patient, and the physician may make this delegation to “any qualified and properly trained person acting under the physician’s supervision.”11

Again, it is important to note that the title of the individual APP, whether PA or APRN, is not the focus of proper delegation. Rather the individual’s skill level is the determining factor in making this delegation. The pertinent statute allows the delegation of the administration of dangerous drugs to be through a variety of mechanisms, including physician orders, standing medical orders, standing delegation orders, or others as defined by the Board.11

“Prescriptive authority agreement” is the physician’s delegation of the act of prescribing or ordering a drug or device to an APP.12 The Texas Legislature and the TMB have published several requirements for the delegation of prescriptive authority to APPs.13 It is important to note that neither the MPA nor the TMB Rules authorize the exercise of independent medical judgment by APPs. Additionally, the supervising physician remains responsible to both the Board and his or her patients for acts performed by the APP.

Indeed, a physician may only delegate prescriptive authority to an APP who, acting under the physician’s supervision, may prescribe or order a drug or device as **authorized by a prescriptive authority agreement.**14 Unless serving a medically underserved population or in a facility-based practice (i.e. in a hospital setting), a physician may only enter into a prescriptive authority agreement with up to seven APPs or the full-time equivalent of seven APPs.15

**Prescriptive Authority Agreements – Requirements**

There are numerous requirements for the prescriptive authority agreement, and the specifics of the requirements provide excellent guidance to the general supervision requirements of the physician.

A prescriptive authority agreement must be in writing and signed and dated by the parties to the agreement, i.e. both the physician and APP.16 It must also state the name, address, and all professional license numbers of the parties to the agreement.17 In addition, the agreement shall state the nature of the practice, practice locations, or practice settings.18 It must also identify the types or categories of drugs or devices that may or may not be prescribed.19

Along with these specific items, the agreement needs to provide a general plan for addressing consultation and referrals, in addition to a plan for addressing patient emergencies.20 The agreement must also state the general process for communication and the sharing of information between the physician and the APP.21 The agreement may also designate one or more alternate physicians who may provide appropriate supervision on a temporary basis and participate in prescriptive authority quality assurance and improvement plan meetings.22

As with all rules related to delegation of APPs, the prescriptive authority agreement should promote the exercising of professional judgment commensurate with the education and experience of the APP and the relationship between the APP and the physician.23 Moreover, the Texas Legislature has said that the laws regarding the use of prescriptive authority agreements should be liberally
A prescriptive authority agreement does not need to describe in exacting detail the steps that the APP must take with respect to each specific condition, disease, or symptom. All involved with a prescriptive authority agreement “must retain a copy of the agreement” until two years after the agreement is terminated.

A party to a prescriptive authority agreement may not attempt to waive or nullify the requirements for a prescriptive authority agreement or the processes of the various boards involved (Texas Board of Nursing and Texas Physician Assistants Board) to gather information and conduct investigations (and report the results) regarding the APP’s use of prescriptive authority. In the event that a party to the prescriptive authority agreement becomes the subject of an investigation by his or her respective board, that party must notify the other parties to the prescriptive authority agreement.

One important aspect of the delegation of prescriptive authority is to have a quality assurance and improvement plan that specifies the methods for documenting the implementation of the plan. The quality assurance program of a prescriptive authority agreement must include chart review, with the number of charts to be reviewed determined by the physician and APP. The quality assurance program must also include periodic face-to-face meetings between the physician and APP at a location to be determined by them.

The periodic face-to-face meetings for quality assurance must include the sharing of information related to patient treatment and care; needed changes in patient care plans; and issues relating to referral, as well as discussion of patient-care improvement. These meetings must be documented and occur at least monthly until the third anniversary of the date the agreement is executed and then at least quarterly, with monthly meetings held between the quarterly meetings by means of a remote electronic communications system, such as videoconferencing.

A physician’s supervision of prescription drug orders must conform to what a reasonable and prudent physician would find consistent with sound medical judgment; but, as with the general delegation rule, may vary with the education and experience of the particular APP. The rules regarding delegation and supervision of prescriptive authority require the physician to provide “continuous supervision.” The degree of supervision does not require the constant physical presence of the physician in the same location as the APP, but seems to intend that the physician be readily accessible through telecommunication (i.e. the APP can call the physician at a remote location).

2013 Legislative Changes to Prescriptive Authority

The 2013 legislative changes primarily affected the delegation of prescriptive authority. The new law no longer specifies a number or percentage of charts the physician must review when delegating prescriptive authority to an APP. Plus, the new law replaced the old site-based regulatory structure with a more collaborative model based on periodic quality assurance reviews and the use of prescriptive authority agreements.

As explained, the parties to the prescriptive authority agreement now determine the number of charts the physician will review. The factors to be considered for the chosen number include the length of time the APP has been in practice, the length of time he or she has practiced with the physician, whether the physician and APP practice in the same physical setting, and the complexity of patient-care needs.

As always, the physician should take into account the skill and experience of the particular individual. Of course, the number or percentage of charts reviewed is an important factor in determining the quality of the physician’s supervision.

Another change under the 2013 law is that the ratio for the number of APPs to whom a physician may delegate prescriptive authority depends on the practice setting. In facility-based practices and those that serve medically underserved populations, there are no limitations. In all other practice settings, one physician may delegate to no more than
seven full-time equivalent APPs.\textsuperscript{15} There is no process to circumvent these limitations.

**MEDICARE AND MEDICAID**

Another significant consideration in the use of APPs is reimbursement from Medicare and Medicaid. For example, if the APP’s service is billed under the physician’s billing number (as opposed to the APP’s), there will be an increase in reimbursement by 15\% for services to Medicare patients and 8\% for services to Medicaid patients.\textsuperscript{35} The Centers for Medicare & Medicaid Services (CMS) defines practitioners for physicians (i.e. APPs) to be “health professionals who may deliver covered services if the services are *incident to* a physician’s service or if there is specific authorization in the law.”\textsuperscript{36}

“Incident to” is defined as those services that are an integral part of the patient’s treatment course and furnished in the physician’s office (whether located in a separate office suite or within an institution) or in a patient’s home.\textsuperscript{37} For some states (Texas included), the requirements to permit the increased reimbursement pursuant to “incident to” services differ between Medicaid and Medicare. For this reason, it is recommended that practices that use “incident-to” billing for both Medicaid and Medicare closely monitor the billing process for APPs and ensure that adequate protocols are in place to document and bill for services in compliance with the requirements.

**New Medicaid Requirement for 2015**

The Texas Health & Human Services Commission issued a ruling about physician billing for services provided by APPs that became effective on January 1, 2015. The rule,\textsuperscript{38} found in the Texas Administrative Code, requires that an APP’s service be performed under the physician’s supervision consistent with the Texas Administrative Code and TMB, as previously described in this article.

This rule also requires that a physician who bills for the services of an APP under the physician’s Medicaid billing number must make a decision about the patient’s care or treatment on the same date of service as the billable medical visit and then document that decision in the patient’s record.\textsuperscript{38} If a physician billing for such services does not make a decision regarding the patient’s care or treatment on the same date of service, the physician must note on the claim that the services were provided by the supervised APP.\textsuperscript{38} Regardless, the physician must document his or her decision-making for either billing scenario.

**Medicare Requirements**

Before billing Medicare, the following requirements must be met under the “incident to” provision: (1) the APP must be an employee of the physician; (2) the initial visit (for that condition) must be performed by the physician; (3) there must be *direct supervision* by the physician as an integral part of the physician’s personal in-office service, and (4) the physician must have an active part in the ongoing care of the patient, meaning subsequent services by the physician must be of a frequency that reflects his/her continuing active participation in, and management of, the course of treatment.\textsuperscript{39}

With respect to the direct supervision element, the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure, if needed.\textsuperscript{39}

Texas physicians should note that this federal requirement is a bit more stringent than Texas laws, which only require a physician to be available by “telecommunication” when supervising an APP. However, similar to Texas state laws, the physician does not have to be physically present in the treatment room while the APP provides the service.\textsuperscript{37} If the physician is a solo practitioner, he or she must directly supervise the care. If the physician is in a group, any physician member of the group may be present in the office to supervise.\textsuperscript{37}

**PRACTICE TIPS**

The laws in Texas are moving toward a more collaborative, delegated practice between physicians and APPs. These new laws reinforce the importance of physician-led medical care teams; recognize the skills all practitioners bring to patient care; and allow the delegating/supervising physician greater flexibility to improve access to care and maintain quality of care.\textsuperscript{40} However, this increased flexibility for physicians still requires supervision of the APP.
As the health care system continues to adapt to a greater incorporation of APPs into patient care, physicians should get a clear picture of what the legal expectations are when it comes to supervision of APPs. Physicians supervising APPs should, of course, make it a point to become familiar with and closely adhere to the relevant rules. In addition, there are some steps physicians can take to lower the risk associated with supervising APPs.

**Notify the relevant state board.**
To be crystal clear: the physician should notify the appropriate board of the intent to supervise an APP, i.e. the Texas Medical Board for a physician assistant and the Texas Board of Nursing for an advanced practice registered nurse.

**Have a supervisory agreement or collaborative care plan.**
This agreement or plan should detail the working arrangements between the APP and the practice. The issues to be covered should include, but are not limited to, the following: lines of communication; methods of communicating with physicians; scope of practice; limitations of practice; locations of practice; and working environment. The agreement should be executed, signed, and dated by the primary supervising physician and the APP.

**Establish written protocols.**
These protocols should define the role of the APP in detail and should cover the main types of cases that the APP will see (for example, “always document neurovascular status on a pediatric supracondylar fracture before and after casting”). These protocols can further provide general clinical practices, such as limiting the number of times a patient can see the APP without seeing the physician or specifying the types of injuries or symptoms that must be examined by a physician within 24 hours.

A physician must document any delegation of such authority to the APP through a protocol and must maintain permanent record of all protocols the physician has signed. This is especially important for PAs because the rules require PAs to employ mechanisms that provide medical authority when such mechanisms are indicated, including, but not limited to, prescriptive authority agreements, standing delegation orders, standing medical orders, protocols, or practice guidelines.

**Be familiar with the APP’s work and promptly raise any concerns.**
While a physician expected to supervise APPs may or may not be directly involved in the hiring decisions, it is important to be aware of new people and to promptly raise any concerns about the conduct of and/or quality of care being provided by an APP.

In addition, while the APP will ideally be of high caliber in care and reliability, the physician should regularly check the APP’s work habits. This can include inquiries of patients who have had visits with the APP to get feedback. Such intermittent checks can reassure the physician of the APP’s performance; ensure that the physician is aware of issues regarding the APP’s work; and help alert the physician to problems or issues that may lower patient satisfaction.

**Keep geographic and other limitations in mind.**
When making a decision on whether to supervise APPs or move to a new practice or position within a practice, keep the supervision requirements in mind. Physicians are sometimes called upon to supervise APPs at facilities some distance away from their homes or primary practice location, or to supervise at multiple facilities. The details of such arrangements should be worked out in advance so that the physician is satisfied that he or she will be able to meet these supervisory obligations.

**Avoid patient confusion about a health care provider’s identity.**
Patients should always know if they are being seen by an APP or by the physician. To avoid confusion, name badges of APPs should clearly indicate “PA” or “APRN.” APPs should identify themselves by title, and use caution with uniforms (i.e. lab coats, scrubs, etc.) so that patients are not confused about which type of provider they are seeing. The physician who introduces the APP to the patient can clarify the roles of each provider and reassure the patient that he or she is in good hands.

Keeping accurate documentation is also important. For example, in many instances...
multiple providers provide input for or sign off on the same record, or an office visit may be primarily covered by an APP, with the physician stopping in for part of the visit. Providers should make an effort to document the specific provider completing each portion of the care in the record to avoid any confusion later.

**Create a culture that encourages questions.**

The new laws make it clear that a high level of collaboration is expected between physicians and APPs when it comes to patient care. Further, lawsuits against APPs and their supervising physicians frequently cite the failure of an APP to contact the physician. Some APPs may fear reprisal for unnecessarily disturbing their supervising physician, but both individuals must understand the collaborative nature of the relationship and eliminate any trepidation. An APP should always have reliable contact information for the supervising physician.³

In addition, the supervising physician should show respect for the education and professionalism of the APP, as well as take a role in the APP’s educational development. The physician should let the APP know that whenever they are in doubt, they should talk to the physician and that they will not be criticized or punished for asking too many questions.

**CONCLUSION**

As with any aspect of practice, providing optimal patient care is the ultimate goal. Having a good team of individuals, maintaining open lines of communication, and addressing challenges together are essential to the successful collaboration of physicians and APPs. Knowledge of and adherence to the various rules and regulations governing APPs build a good foundation for this relationship, ensure that patients receive quality care, and minimize potential risk for the physician.

**Sources**


Specifically, services performed by a physician will be reimbursed at 100% of the physician fee schedule amount, while practitioner services are reimbursed at 85% of the physician fee schedule amount for Medicare and 92% for Medicaid. However, practitioner services billed “incident to” a physician’s service will be reimbursed at 100%.


Federal court prohibits enforcement of new telemedicine rule

By David M. Walsh IV and Peter H. Anderson

On May 29, 2015, a Texas federal court prohibited the Texas Medical Board (TMB) from enforcing new Rule 190.8(1)(L) that would prevent a physician from writing prescriptions for a patient via telemedicine without first having an in-person or “face-to-face” visit with the patient. The rule, which would have gone into effect on June 3, 2015, asserts that prescribing dangerous drugs or controlled substances without first establishing a “defined patient-physician relationship” is a practice inconsistent with public health and welfare. The TMB is concerned that prescribing drugs to a patient without first conducting a “face-to-face” evaluation (as defined by TMB Rule 174) makes it difficult, if not impossible, to:

- ensure proper and accurate diagnosis and treatment;
- ensure that proper prescribing practices are followed;
- ensure that the drugs prescribed are therapeutic, i.e., the medications prescribed are actually needed and/or proper for the condition; and/or
- prevent overuse/abuse of drugs of any kind.1

The new rule requires a physician to establish a diagnosis through the use of acceptable medical practices, which include documenting and performing patient history, mental status exam, physical exam by in-person evaluation or face-to-face visit, and diagnostic/laboratory testing. In addition, online questionnaires or questions/answers exchanged through email, text, chat, or telephonic evaluations are considered inadequate to establish that relationship. Once a physician has made an initial diagnosis of a patient through a qualified encounter, the physician can then treat the patient for this condition via telemedicine for up to one year. A “qualified encounter” may be defined as either 1.) an in-person visit between the physician and the patient; or 2.) a consult via telemedicine between a physician and a remote patient with a qualified patient side presenter who may carry out an examination or other tasks on behalf of the physician, with appropriate equipment/technology to perform the evaluation.

The federal court injunction is the latest in a string of legal disputes between the TMB and Teladoc, Inc., a network of telemedicine providers. The dispute with Teladoc originally arose in 2011 over the TMB’s interpretation of the rule’s predecessor – that the rule required in-person exams in all cases, despite the rule’s text stating that an in-person exam was only one of several non-exclusive ways in which the patient-physician relationship could be
established. A Texas appellate court concluded that the TMB was misinterpreting the text, thereby rendering it an invalid rule amendment. The TMB quickly enacted an emergency rule that tracks the language of what is now the new rule. However, a Texas court struck that emergency rule down, finding there was no imminent peril to public health, safety, or welfare warranting emergency action.

Consequently, the TMB enacted the new Rule 190.8(1)(L) and made updates to Rule 174 to “clarify” that “face-to-face” or in-person exams are required before telemedicine prescriptions can be written. The TMB maintains that a lack of in-person or appropriately performed “face-to-face” examinations significantly hampers quality of care and increases the risk of misdiagnosis and mismanagement of patients and patient records. There are also concerns that prescribing dangerous medication without appropriate evaluations will significantly increase the risk of over-prescribing, inappropriate prescribing, drug diversion, and drug abuse.  

Questions regarding telemedicine and quality of care were again raised by a new study conducted by the RAND Corporation. The study analyzed patient appointments conducted via Teledoc in comparison to in-person physician visits. Among the findings was that antibiotics were prescribed as frequently by both telemedicine and in-person consults; however, Teledoc physicians were found to prescribe broad-spectrum antibiotics at a rate of 86% compared with 56% from in-person physician consults.

Among the TMB’s concerns is that overprescribing broad-spectrum antibiotics may point to an inability of telemedicine physicians to make a precise diagnosis and order precise treatment. Also, the judicious use of these broad-spectrum antibiotics can lead to antibiotic resistant organisms or “super bugs” and limited treatment options for antimicrobial illness.

In response to Rule 190.8(1)(L), Teladoc sued in federal court to prohibit the rule’s enforcement based on antitrust laws and constitutional grounds. The latest case alleges that the new rule prevents competition “from telehealth generally and Teladoc in particular” and harms the public by raising the cost of medical care and reducing access to physician services.

Teladoc’s lawsuit takes its cue from a recent United States Supreme Court case
involving a state licensing board (dental board) made up of active members of the profession (dentistry). The North Carolina State Board of Dental Examiners accused non-dentists of the unlawful practice of dentistry because they were providing commercial teeth-whitening services. The Federal Trade Commission (FTC), an agency that enforces federal antitrust law, held that the board’s accusation was in violation of antitrust law. The dental board maintained that they had sovereign immunity from antitrust law because they are a state agency.

The Fourth Circuit sided with the FTC and held that sovereign immunity does not apply to a state board that places restraints on a market when a majority of its members are active market participants in the occupation, unless: (1) the restraint on competition is a clearly articulated and affirmatively expressed state policy, and (2) the policy is actively supervised by the state. In the final analysis, the Supreme Court agreed with the Fourth Circuit and held that the dental board was not immune because it was comprised of decision makers (board members) who were active participants in the market (actively practicing dentistry and thereby benefiting from the rule that required dentists to perform teeth whitening). Also, the state had not actively supervised the Board’s efforts to exclude the non-dentists from providing those services.

Teladoc has framed its lawsuit to try to bring its claims against the TMB beyond the reach of sovereign immunity. It alleges that:

- the TMB is a non-sovereign actor regulating the practice of medicine;
- a majority of the TMB’s members are actively practicing physicians;
- the amended rule raises the cost of medical care and reduces access to physician services;
- there is no active supervision of the TMB’s rulemaking process by any state agency or the legislature; and
- no state agency has the authority to veto or modify the TMB’s rules.

Despite Teladoc’s allegations, the TMB’s conduct may be different than the North Carolina case because its actions affect all providers equally—every physician must have the in-person exam before prescribing via teledermology. In contrast, the North Carolina regulation affected non-dentists to the benefit of dentists.

Several interested groups weighed in on the dispute by filing amicus briefs (or friend of the court briefs) for and against the injunction. The Texas Medical Association, Federation of State Medical Boards, American Osteopathic Association, and Texas Osteopathic Medical Association aligned with the TMB. But the Texas Nurse Practitioners and Texas Association of Business backed Teladoc’s position.

In granting the preliminary injunction, the court analyzed the potential anti-competitive effect of the new rule and was persuaded by Teladoc’s evidence that harm would occur if the new rule went into effect. Teladoc established that its consultations were less expensive than typical office or ED visits. Additionally, research showed Teladoc’s services achieved lower monthly employee health care costs. Telemedicine would also increase access to health care, alleviating the existing shortage of Texas physicians, particularly in rural areas. Moreover, the quality of care should not be adversely affected because telemedicine physicians remain subject to the same standards of care and ethical rules that govern traditional office-based practice. Finally, physician assistants and on-call physicians are currently permitted to write prescriptions without seeing patients, creating a double standard with regard to telemedicine.

Significantly, the court was “troubled” by the TMB’s claims regarding a California study of Teladoc practices with a large public employer. The TMB claimed that the study concluded that telemedicine consults could lead to misdiagnoses and increased follow-up visits. But Teladoc produced affidavits from the researchers rejecting the TMB’s analysis and saying that the TMB “mischaracterized” their findings.

In the end, the court found that Teladoc effectively showed that they face a substantial threat of irreparable injury if Rule 190.8(1) (L) were enforced because its business model would be destroyed. Twenty-three percent of its revenues were from the would-be prohibited consults in Texas; investment
banks intended to withdraw a planned stock offering if the rule were put into effect; and Teladoc could not cost-effectively partner with other providers to conduct videoconferencing at established medical sites which the TMB had argued was possible under its other telemedicine rules.⁶

The injunction means that Rule 190.8(1)(L) cannot be enforced until the case proceeds to a full trial on its merits. The TMB did not assert sovereign immunity as a defense at the injunction stage, but may do so when TMB formally answers Teladoc’s complaint. A potentially significant question remaining is whether “the relevant market” for anti-competition is “telemedicine” or “medicine.” On its face, the rule does not limit its application to telemedicine consults; instead, it applies equally to all physicians who practice medicine in Texas. Unlike the Supreme Court case where non-licensed persons were excluded from entering the market, the TMB’s rule does not deny outright access to Teladoc. Thus, it remains to be seen whether Teladoc’s claims will survive. The preliminary injunction is meant to preserve the status quo while the ultimate merits of the case are litigated to conclusion.

- For a full look at TMB’s rules for telemedicine, including purpose, definitions, and acceptable evaluation and treatment of patients, please read Texas Medical Board Rules, Chapter 174, Telemedicine, available online at http://www.tmb.state.tx.us/idl/0887C012-11F5-D3DE-8D84-6734AE32A789.

- The full text of Rule 190.8(1)(L) is also found online. Please read Texas Medical Board Rules, Chapter 190. Disciplinary Guidelines, Subchapter B. Violation Guidelines, Section 190.8(1)(L) at http://www.tmb.state.tx.us/idl/0887C012-11F5-D3DE-8D84-6734AE32A789.

Sources

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Complications from pain management procedure

By Cathy Bryant, Senior Compliance & Risk Management Representative, and Wayne Wenske, Communications Coordinator

PRESENTATION

On April 4, a 53-year-old woman with severe headaches, persistent lower back pain, and numbness in both legs came to a pain management physician for treatment. The physician’s initial impression was that the patient suffered from cervical facet arthropathy and occipital neuralgia.

PHYSICIAN ACTION

After examination, the pain management physician diagnosed the patient with facet syndrome of the cervical and lumbar spine with multiple spinal nerve root injuries. She was prescribed hydrocodone/acetaminophen, tizanidine, and valdecoxib. The following week, the pain management physician performed a cervical nerve block at C2 through C7 to help alleviate the patient’s headaches. However, the patient reported that the procedure only provided relief for three days.

On May 2, the pain management physician performed cervical facet joint nerve rhizotomies of the left C2 through C7 on the patient. One week later, the same procedure was performed on the patient’s right side. After the rhizotomies were completed, sensory and motor testing was performed on the patient and the results were noted as unremarkable. The patient did not report any pain.

On May 18, the patient returned to the pain management physician for treatment of right shoulder pain and headache. He diagnosed the patient as having facet syndrome/cervical degenerative disc disease and right deltoid strain. The patient received a prescription for azithromycin and a follow-up visit was scheduled in two weeks.

On May 22, the patient consulted with an orthopedic surgeon due to continuing right shoulder pain. An MRI was ordered and the results were normal. The orthopedic surgeon diagnosed the patient with a spur in the right shoulder. She was given a cortisone shot for pain and physical therapy was ordered.

The patient returned to the pain management physician for a follow-up appointment on June 22, almost 6 weeks after their last visit. During this visit, hormone and saliva tests were conducted. The patient reported she was doing daily exercises, and her manual motor strength was noted as 5+/5 in shoulders, elbows, wrists, and fingers. On July 20, the patient returned with reports of continued headache and decreased range of motion and pain in her right shoulder. She was prescribed gabapentin and vitamin B complex.

On July 22, the patient returned to the orthopedic surgeon and reported that she was unable to perform standard arm motions on her right side, such as pulling, throwing, and lifting. An MRI was ordered and showed rapidly developing atrophy of the auxiliary nerve distribution of the right deltoid. The orthopedic surgeon referred her to a neurologist.

The patient told the neurologist that she had experienced severe, stabbing electrical pain shooting in her right arm during the second rhizotomy. The neurologist ordered electromyogram and nerve conduction studies. The studies indicated a C5 nerve root injury. The neurologist concluded that the patient’s injury was most likely a complication of the intraneural injection performed during the right side rhizotomy. Over the next several months, the patient slowly improved by attending
physical therapy and using a muscle stimulator, recommended by the neurologist.

A year later, the orthopedic surgeon noted that the patient still had weakness in the right shoulder, but strength was rated as 4+/5. The orthopedic surgeon felt that the condition would eventually stabilize and pain would lessen.

**ALLEGATIONS**

The patient filed a lawsuit against the pain management physician. Allegations included:

- failure to undertake a non-invasive approach to treatment before performing rhizotomies; and
- failure to follow current standards for denervation of a cervical facet.

**LEGAL IMPLICATIONS**

Two consultants reviewed the case for TMLT and agreed that the physician possibly damaged the nerve root during the rhizotomy. However, they also both noted that nerve damage is a known complication for this procedure and that otherwise the physician met the accepted standard of care.

The consultants criticized the physician for his documentation. EHR entries correlating with the dates of the rhizotomies were nearly identical, suggesting he copied notes from one date to the next. There was also evidence that the physician made an addendum to the records after receiving notice of the claim.

**DISPOSITION**

The case was settled on behalf of the physician.

**RISK MANAGEMENT CONSIDERATIONS**

**Informed consent discussion** — Multiple procedures were performed without any documentation that the physician had explained the procedure, risks, benefits, and available alternatives to the patient. In Texas, physicians cannot delegate the informed consent discussion before performing a procedure.

**Procedure notes templates** — Procedure notes should accurately reflect the details of the procedure performed, including any complications that occur. The patient had the same procedure (rhizotomy) performed on both the right and the left side. However, the procedure notes are identical, other than the date of the procedure and the notation of “right” versus “left” side. Additionally, there is no mention of the patient experiencing pain during the second rhizotomy, but the patient reported experiencing intense pain during the procedure to a subsequent physician.

**Untimely addendum to records** — Any addendum to the medical record should be made in a timely manner. Any changes to the medical record after a claim is known or suspected should be avoided.

**Texas Medical Board (TMB) Rules** — It is important for physicians who treat chronic pain to be familiar with the TMB rules, as they are the standard by which a physician will be reviewed in the event of a TMB complaint. TMB Rules, Chapter 170 regarding Pain Management states: “The treatment of pain is a vital part of the practice of medicine. Patients look to physicians not only to cure disease, but also to try to relieve their pain. Physicians should be able to treat their patients’ pain using sound clinical judgment without fear that the board will pursue disciplinary action. This Rule sets forth the board’s policy for the proper treatment of pain. The board’s intent is to protect the public and give guidance to physicians.”

The rules include information about:

- evaluation of the patient;
- treatment plan for chronic pain;
- informed consent;
- agreement for treatment of chronic pain;
- periodic review of the treatment of chronic pain;
- consultation and referral; and
- medical records.

Source


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A 20-year-old woman came to a minor emergency clinic with abdominal pain. The patient was obese with a body mass index of 38.4. She did not report any health issues and stated she was not taking any medications. At her last wellness exam three years earlier, the patient’s blood pressure was 145/72 mm Hg.

Physician Action

A physician assistant (PA) examined the patient and found her blood pressure, heart, and respiration rates were slightly elevated. The patient was found to have moderate abdominal pain without rebound or rigidity. She was diagnosed with gastroenteritis and given prescriptions for ciprofloxacin hydrochloride and dicyclomine. She was instructed to increase her fluid intake. No follow up visits were requested or scheduled.

The patient returned to the clinic the next day with continued abdominal pain. Her blood pressure was slightly elevated. The PA saw the patient and ordered a CT scan of the abdomen. The CT scan was obtained later that day and the results indicated extensive pancreatitis with free fluid.

The patient returned the next day and saw a family physician. (This family physician supervised the PA). Documentation indicated a normal abdominal exam; temperature of 99 degrees; pulse of 96; respirations at 24; and blood pressure of 140/98 mm Hg. The physician reviewed the results of the CT scan and documented a diagnosis of pancreatitis. He instructed the patient to avoid greasy foods and to follow up in 6 weeks.

One month later, the patient was admitted to the ICU of a large hospital with acute onset of abdominal pain, nausea, and vomiting. She reported a history of similar symptoms a month earlier that had resolved. The patient had stable vital signs and no fever; however, she had significant left upper quadrant pain. Labs showed an elevated white blood count; onset of diabetes with elevated glucose and A1C test results; extremely elevated triglycerides (2931); and elevated amylase (683). The patient was made NPO and started on IV fluids. A consult with a gastroenterologist was requested and a CT scan was ordered.

The patient was also started on an insulin drip, as there was an indication that she had been diabetic for a few weeks. The drip was later replaced by Sliding Scale Insulin therapy (SSI).

A gastroenterologist examined the patient and diagnosed moderate to severe pancreatitis with complications most likely due to hypertriglyceridemia; developing pancreatic pseudocyst; and ileus formation. The gastroenterologist ordered nasogastric intubation, blood cultures, and aggressive hydration. The patient remained in the ICU.

Over the next several days, the patient deteriorated with fluid retention, third space sequestration, hypoxemia, and multi-organ failure. One week after admission, the patient died. An autopsy revealed the cause of death as hemorrhagic pancreatitis, pneumonia, disseminated intravascular coagulation, congestive heart failure, and edema in the liver, lungs, and brain.

Allegations

The patient’s family filed lawsuits against the family physician, the PA, and the minor emergency clinic. Allegations included:

- failure of the family physician and the PA to properly and timely evaluate and treat acute pancreatitis;
• failure of the family physician to properly supervise the PA;
• failure of the clinic to create procedures and protocols that would promote proper supervision of the PA; and
• failure of the family physician and PA to maintain proper documentation.

LEGAL IMPLICATIONS
Two consultants reviewed the case for TMLT and were critical of the family physician and the PA. They noted that the family physician did not review the patient’s chart or discuss the case with the PA. One expert felt the patient’s care was mismanaged because they did not hospitalize the patient, order lab work to check for the cause or severity of the symptoms, and did not consult with a specialist. This expert also noted that the reading of the CT report was substandard.

Although the patient’s symptoms subsided after visiting the clinic, the improper evaluation and treatment by the family physician and the PA raised questions about whether the second and ultimately fatal episode could have been prevented. The consultants both felt that the performance of the family physician and the PA fell below the standard of care.

Another issue raised in the lawsuit and by the consultants was improper documentation. Two records existed for each visit: one copy that was handwritten and signed by the PA, and another EHR copy with the electronic signature of the family physician. Experts found the EHR documentation of the visits and lab reports to be minimal and inconsistent. While records suggest that only the PA examined the patient during the first two clinic visits, billing records reflect that the family physician examined the patient.

DISPOSITION
The case was settled on behalf of the family physician and the PA.

RISK MANAGEMENT CONSIDERATIONS
The lack of coordination and communication between the physician and the PA was a weakness in this case. When multiple providers in a practice see a patient, continuity of care becomes a greater and more crucial challenge. It was evident that the physician and PA were not conferring.

When physicians employ advanced practice providers (APP), they assume responsibility for the actions of that person. It is incumbent on the physician to develop a comprehensive job description and written protocols describing the delegation of duties for that person to follow. Documentation guidelines and when to consult with the physician should be well defined. To document events accurately, a physician can develop a protocol to review and co-sign the notes, indicating that a consultation occurred and that the notes are correct.

Documentation was also an issue in this case. A complete, comprehensive medical record not only provides a chronological history of patient care, but it may become the foundation for defending the physician and his or her staff if a lawsuit is filed. The Texas Medical Board (TMB) rules state that all licensed physicians shall maintain an adequate medical record for each patient that is “complete, contemporaneous and legible.”¹

Complete documentation can also help physicians and APPs know which patients they discussed. The notes of the APP are expected to include a notation that the patient’s condition was discussed and that the physician concurs with or alters the plan of care.

TMB guidelines for creating and maintaining adequate and complete patient medical records are found online at http://www.tmb.state.tx.us/id/094A431A-ACE1-8889-A052-9631EEE01EBA.¹

Source

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This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician’s defensibility. This study has been modified to protect the privacy of the physicians and the patient.
Windows 2003: the “biggest cyber security threat of 2015”

Microsoft pulls support from Windows 2003 servers on July 14; users will be non-compliant with HIPAA.

On July 14, 2015, Microsoft will no longer support its Windows 2003 servers, leaving systems still running on this platform open to malicious software and other cyber attacks. After July 14, Microsoft will no longer provide these servers with security patches or fixes for cyber security threats and vulnerabilities. This “end of life” for Windows 2003 has been called the “biggest security threat of 2015” due to the lack of awareness by users and IT professionals.¹

In addition to the cyber security threat, if a medical office or practice is still using a Windows 2003 server after this date, they will no longer be in compliance with the Health Insurance Portability and Accountability Act (HIPAA). This includes offices that may be using a combination of servers, one of which may be a Windows 2003 server. To stay compliant with HIPAA’s security rules, a covered entity must implement “procedures for guarding against, detecting and reporting malicious software.”² When Microsoft ends support for Windows 2003 servers, users will no longer have a routine way to safeguard the data on these servers. As a result, ePHI and other sensitive data may be exposed, damaged, or stolen.

HOW TMLT CAN HELP

Careful consideration and discussion with your IT consultant is essential. Some physicians are considering paying for Microsoft’s Premium Support. However, this service provides only critical patches that may not cover all vulnerabilities to your server.

TMLT’s Product Development and Consulting Services (PDCS) offers a Medical Privacy, Security, and Breach Notification Assessment of your servers. This compliance service was designed to provide your practice with a new awareness of how prepared you are and what steps you can take to mitigate...
risks. With this service, TMLT can help you develop a strong cyber security plan and educate your staff. Call Cathy Bryant or Stephanie Downing at 800-580-8658 for more information and pricing.

Sources
