

Failure to diagnose normal pressure hydrocephalus

by Robin Desrocher, senior risk management representative

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 physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physicians' defensibility. The ultimate goal in presenting this case is to help physicians practice safe medicine. An attempt has been made to make the material more difficult to identify. If you recognize your own claim, please be assured it is presented solely to emphasize the issues of the case.

Presentation

A 62-year-old woman with a history of a 45-pound weight loss, change in personality, and stooped posture came to Neurologist A. Neurologist A performed a physical examination and mini-mental exam. He diagnosed personality change and memory loss. The differential diagnoses included dementia, depression, and metabolic/structural abnormality. Neurologist A ordered an MRI of the head, labs, EEG, carotid ultrasound, and a neuro-psychiatric evaluation.

Two days later, the MRI was performed and read by Radiologist A, a defendant in this case. Radiologist A interpreted the MRI as showing no acute abnormality. She felt the study showed mild chronic-appearing periventricular white matter compatible with microangiopathy. She noted the ventricles and cisterns were normal in appearance. This was Radiologist A's only involvement with the patient.

Neurologist A did not review the films, but relied on Radiologist A's report of the imaging studies. The carotid ultrasound showed normal flow velocities with less than 40 percent internal carotid artery stenosis bilaterally. The EEG revealed a normal awake and drowsy record. All testing ordered by the Neurologist A was completed except for the neuro-psychiatric evaluation. According to the medical records, the patient did not go for the neuro-psychological testing. A follow-up appointment was scheduled, but the patient did not return to Neurologist A.

One year later, the patient fell at home and fractured her hip. The fracture was repaired, and following that surgery, the patient exhibited symptoms of depressed mood, weight loss, psychomotor retardation, fatigue, and feelings of worthlessness. Amyotrophic lateral sclerosis and multiple sclerosis were mentioned as differential diagnoses in the medical record.

An MRI was ordered and Radiologist B noted the ventricles were stable when compared to the previous study. He also noted mild periventricular white matter hypersensitivities consistent with aging. There was a small defect noted that might represent a small, non-acute lacunar infarct that had developed since the prior study.

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Following a course of therapy for her hip, the patient was referred to Neurologist B for an evaluation. From there, the patient was referred to a neurosurgeon. The most recent MRI was reviewed, and hydrocephalus with enlargement of the third ventricle and severe cervical stenosis were noted. The neurosurgeon performed a cervical laminectomy at four levels. The neurosurgeon inserted a low-pressure VP shunt two months later. The patient reported that her balance and gait improved. She followed up with the neurosurgeon and made progress neurologically.

Over the next few months, the patient's health declined. She was walking clumsily and used a wheelchair most of the time. She developed peripheral vascular disease, and circulation to her feet was compromised. A cardiology work up revealed an abnormal nuclear stress test. A few weeks later, a repeat MRI revealed progressive ventricular dilatation compared to the previous study. A shunt revision was performed. A CT angiogram revealed extensive calcified atherosclerotic plaque throughout the vascular tree. The left external iliac artery was occluded, while the left superficial femoral and profunda femoral arteries were supplied with collaterals. Anticoagulation therapy was started. The patient ultimately required amputation of a toe. She continued to experience falls and incontinence, according to the medical records.

Allegations

Lawsuits were filed against Neurologist A and Radiologist A. The allegations against Radiologist A included failure to properly interpret the MRI and both physicians were sued with failure to diagnose normal pressure hydrocephalus (NPH). As a result of this alleged delay, the patient claimed that her memory loss was permanent and that her condition deteriorated.

Legal implications

Three consultants for the defense reviewed this case and were generally supportive of the interpretation made by Radiologist A. One consultant acknowledged that NPH is rare, and Radiologist A would have been a "hero" to make this diagnosis. Even though a diagnosis of NPH would have been correct, Radiologist A's interpretation that this study showed normal findings was not completely unreasonable. One defense expert was critical and

felt the NPH could be seen on the MRI. The plaintiff's attorney retained experts who were critical of the interpretation. The plaintiff's experts felt that the MRI showed dilatation of the horns of the lateral ventricles, and this should have led to a diagnosis of hydrocephalus.

Risk management considerations

Normal pressure hydrocephalus (NPH) is a complex clinical diagnosis characterized by abnormal gait, urinary incontinence, and dementia.¹ Initial misdiagnosis remains a pitfall in many radiology claims. The Physician Insurers Association of America collects closed claim data from more than 20 physician insurance companies. PIAA radiology claims data reported between January 1, 1985 and December 31, 2008 showed the most prevalent medical misadventure was error in diagnosis. Error in diagnosis remains one of the top reasons claims are filed against radiologists.²

When reviewing images, it is important for radiologists to have a full clinical picture of the patient's condition. This may require the radiologist to contact the ordering physician to develop a diagnosis and/or differential diagnoses. While attempts to obtain this information may be time consuming, documenting the request for additional information in the patient's medical record can assist in the radiologist's defense.

Disposition

This case was settled on behalf of Radiologist A. The case against Neurologist B was also settled.

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3. **You may have to purchase tail coverage.** Unless your new carrier is providing prior acts coverage, you will have to purchase tail coverage. Your new employer may not cover the cost for tail coverage. Additionally, you may lose the free tail coverage that you had earned with your current carrier as well as your accrued claim-free discounts.
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Highlighting HIPAA and HITECH — changes enacted to privacy rules

by the TMLT risk management department

As part of the American Recovery and Reinvestment Act of 2009, Congress passed the Health Information Technology for Economic and Clinical Health (HITECH) Act. This legislation contains provisions that strengthen and expand HIPAA's privacy and security requirements and offers a number of financial incentives to promote the adoption and meaningful use of electronic medical records. It also makes significant changes to existing patient privacy laws and imposes increased civil and criminal penalties for their violation. (Civil penalties for each violation range from \$100 to a \$50,000 minimum.)¹

This article will address data breaches involving protected health information (PHI) and the new requirements for business associates. Physicians are strongly urged to review their privacy policies and procedures to assure compliance and avoid significant fines.

Background

In 1996 the U.S. Department of Health and Human Services (HHS) issued the Privacy Rule, establishing for the first time national standards for the protection of certain health information. The Privacy Rule — also known as HIPAA — was originally enacted to help employees maintain their health insurance coverage during a time of job change; to establish privacy and security rules for PHI to set standards for electronic billing of health care services; and to develop a national provider identifier system. Most physicians and medical practice staff are all too familiar with the standards related to protecting the use and disclosure of patients' PHI.

Protecting PHI

The new legislation requires physicians to review current practices related to the use and disclosure of PHI and make any necessary revisions. Prior to this legislation, a covered entity (e.g. physician's office, hospital, clinic, etc.) was only required to mitigate the effects of an unauthorized disclosure. This may or may not have included notifying the patient. Under the revised law, with few exceptions, a covered entity is required to notify a patient of an unauthorized disclosure of unsecured PHI if a significant risk of "...financial, reputational or other..." harm exists when a breach of unsecured PHI has been discovered.¹

Notification must occur without reasonable delay — no more than 60 days after the breach is discovered. Any notification to the patient must include:

- a brief description of what happened;
- the type of PHI disclosed;
- steps the patient should take to protect him or herself;
- what the covered entity is doing to investigate and mitigate the breach; and

- information concerning whom to contact for additional information.

"Notification must be in writing by mail (or by phone in urgent cases) or electronic means if the patient has consented to electronic notification. If the breach involves more than 500 patients (e.g. the loss of a laptop containing unsecured PHI), local media outlets must be notified. In addition the HHS secretary must be notified immediately for breaches involving more than 500 patients and annually for others."²

Please note that notification is only required if the breach involved unsecured PHI. HHS has issued guidance about the definition of "secured" PHI. Information is deemed secured if rendered "... unusable, unreadable, or indecipherable ..." to unauthorized individuals.³

If the breach involved information that is secured, then notification is not required. This rule applies to two categories of secured PHI: electronic PHI that meets specified standards of encryption and PHI stored or recorded on media that has been destroyed. Adoption of this rule provides a significant incentive for physicians to encrypt PHI.⁴

Securing PHI involves two main components. The first involves encrypting electronic PHI by using software that renders the information unreadable until the intended recipient unlocks it (with a smart card and password). Elements that should be encrypted include:

- practice management systems;
- electronic medical records;
- documents containing PHI (e.g. claims payment appeals);
- scanned images, such as copies of remittance advices;
- e-mails containing PHI;
- PHI transmitted electronically, such as claims sent to clearinghouses; and
- PHI made available through the Internet.

The second component involves properly destroying the media on which the PHI is stored or recorded, such as shredding paper records or purging electronic information.⁵

Additional information about encryption can be found at the American Medical Association web site, <http://www.ama-assn.org/ama1/pub/upload/mm/368/hipaa-phi-encryption.pdf>

Business associates

Effective February 17, 2010, business associates are required to comply with the revised regulations, and are subject to the same requirements as covered entities for implementing administrative,

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physical, and technical safeguards for PHI. Business associates must also revise written policies and procedures covering these requirements, and will be subject to the same civil and criminal penalties as covered entities.

The Office for Civil Rights (OCR) is the federal agency responsible for enforcing the federal privacy rule. According to Sue McAndrew, deputy director for health information privacy for the OCR, “Business associates can be directly liable for a breach of unsecure protected health information (PHI) and could have to pay OCR directly.”⁶

Both covered entities and business associates must review all relationships with contractors to assess whether business associate agreements are in place and are compliant with the new requirements.⁵

TMLT as a business associate

As a professional liability carrier, TMLT is considered a business associate of its policyholders. As such, TMLT will appropriately safeguard any protected health information it receives or creates on behalf of physicians. To assist physician practices in complying with the revised rules, TMLT has developed a new Business Associate Agreement. The revised agreements were recently mailed to all policyholders, and are also available on the TMLT website at: <http://www.tmlt.org/hipaa>.

Policyholders are urged to complete the revised agreement, and return it by fax to 512-425-5999. The form can also be mailed to TMLT Underwriting Services, PO Box 160140, Austin, TX 78716-0410. Signed agreements will remain on file in the TMLT Underwriting Services Department.

Conclusion

HIPAA rules, regulations, and standards will continue to change under the direction of the federal government. It is important that practices’ policies and procedures are periodically reviewed and updated to reflect these changes. Initial training of new staff members and ongoing re-training of current staff is required under these revised regulations.

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