



# PRACTICAL TIPS TO AVOID licensing action

## Compliance

By Robert Iwrey

Having a medical license to practice in the state of Michigan is not a right but a privilege, and it can be taken away or restricted for failing to abide by various statutory bases set forth within the Michigan Public Health Code (MPHC).

As such, compliance with the MPHC is the key to avoiding a licensing action.

In order to facilitate such compliance, physicians are encouraged to actively participate in an effective compliance plan at their respective work site.

If the physician is a solo provider or member of a group that does not have a compliance plan, he or she should develop, implement and maintain an active compliance plan that includes:

- (1) Designating a compliance officer or contact;
- (2) Implementing written standards and procedures;
- (3) Conducting appropriate training and education;
- (4) Developing open lines of communication;
- (5) Conducting internal monitoring and auditing;
- (6) Responding appropriately to detected offenses and developing corrective action; and
- (7) Enforcing disciplinary standards through well-publicized guidelines.

Although each of these elements plays a role in facilitating compliance, emphasis should be placed on conducting internal monitoring and auditing, as this can help identify a previously unknown issue and provide one with an opportunity to take proactive, prophylactic measures to address the issue prior to the issue resulting in a licensing investigation.

In addition, emphasis must be

placed on appropriate documentation of the medical record. The majority of licensing actions are based, at least in part, upon a lack of appropriate documentation in the medical record.

For example, if a patient is non-compliant with the physician's instructions, such non-compliance should be documented.

If not, a subsequent review of the physician's medical records may lead the reviewer to conclude that the physician, not the patient, failed to follow up.

Moreover, while there is no standard form utilized by all physicians for documenting patient encounters, incorporating the S.O.A.P. format (i.e., subjective, objective, assessment and plan) is strongly advised, as record reviewers will look to see if each of these elements is present in the documentation.

Importantly, as of December 2006, a physician is required to maintain a record for each patient for whom he or she had provided medical services, including a full and complete record of tests and examinations performed, observations made and treatments provided.

Furthermore, with the recent push towards adopting and meaningful use of electronic health records (EHR), physicians should be mindful of issues such as self-populating record fields, which can result in significant inconsistencies in the medical record.

For example, due to a self-populating field, the medical record may state in one area: "Patient has no complaints of pain," but in another area state: "Patient presents with severe pain." In some cases, EHR systems may automatically generate a prescription, including strength and form, based on the notes in the record.

In such instances, the physician must take care on two levels. First, the physician must ensure that the prescription generated by the EHR system is appropriate for the patient. Though the system is convenient in generating the prescription, nothing

can substitute for the professional judgment of the physician.

Second, if the physician does, in fact, change the EHR system-generated-prescription, the physician must ensure that such alterations also are reflected in the exam note itself. Other health care licensees will rely on that exam note to make future decisions on refilling the prescription or prescribing another medication.

Liability also can arise by missing simple spelling errors, despite spell check (e.g., writing "care" instead of "case"). The ease with which certain tasks can be completed with an EHR system can result in increased carelessness where such mistakes could have much greater implications, including risks of patient safety, medical-malpractice claims or audit activity — all of which could lead to a licensing action.

Lastly, due to the growing epidemic in Michigan regarding prescription drug abuse, there has been an increase in actions against physicians for illegitimate prescribing of controlled substances.

Administrative Complaints may issue against a health care licensee for (i) a "violation of general duty, consisting of negligence or failure to exercise due care ... whether or not injury results ..." or (ii) "incompetence."

Both of these bases essentially allow a licensing action for not following the applicable standards of care.

The applicable standards of care, while not delineated by statute, have been developed by the various health care licensing boards (including the Boards of Medicine, Osteopathic Medicine & Surgery and Pharmacy) to include a consideration of the following:

- (1) Michigan Guidelines for the Use of Controlled Substances for the Treatment of Pain, developed by the Michigan Board of Medicine and the Michigan Board of Osteopathic Medicine and Surgery;
- (2) Michigan Board of Pharmacy

Guidelines for the Use of Controlled Substances for the Treatment of Pain;

- (3) Responsible Opioid Prescribing: A Guide for Michigan Physicians — a book endorsed by the Michigan Department of Licensing & Regulatory Affairs (LARA) as representing the standard of care in Michigan; and
- (4) The use of the Michigan Automated Prescription System (MAPS).

Physicians who prescribe controlled substances are well-advised to familiarize themselves with these publications and the standards of prescribing controlled substances in Michigan.

Moreover, with regard to MAPS, while not required by statute or administrative rule, prescribing licensees are "encouraged to register to MAPS Online to request prescription data on patients ... [since] using MAPS Online before and during treatment ... can alert [the licensee] to any past 'doctor shopping' or questionable behavior."

Physicians should not take this "encouragement" lightly.

Michigan's Bureau of Health Professions and both state and federal law enforcement have taken the position that the applicable standards of care require physicians to perform MAPS queries regularly on patients for whom they prescribe controlled substances, and that failure to do so is a breach of the applicable standard of care.



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