



OPHTHALMIC MUTUAL INSURANCE COMPANY  
(A Risk Retention Group)

## COORDINATING CARE WITH OPTOMETRISTS

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### PURPOSE OF RISK MANAGEMENT RECOMMENDATIONS

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

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OMIC policyholders report on renewal applications that they are increasingly incorporating optometrists (ODs) into their practices. While optometrists are independent practitioners, there are differences in education and legal scope of practice between eye physicians/surgeons and ODs, as well as different scopes of practice among traditional optometrists and those with therapeutic certification. All these differences must be respected in order to comply with state laws and the standard of care. The ophthalmologist, optometrist, and group thus need to understand ways to best coordinate the care of the group's patients, and when and how they are liable for their own and each other's care. Together they can develop written policies and protocols that clarify the respective roles of all members of the health care team, reduce their liability exposure, and promote patient safety.

### Theories of Liability

Optometrists, like ophthalmologists, are **directly** liable for their own care. They must know and abide by their state practice act, and should have professional liability insurance to cover their liability exposure. The group or practice has responsibilities for which it can be held directly accountable. It must, for example, credential ophthalmologists and optometrists by verifying education, licensure, and training, and by monitoring ongoing competency. In addition, the group or practice needs to maintain policies and procedures that clarify the roles of all members of the healthcare team and ensure safe care.

The legal doctrine of **vicarious** liability assigns liability to a supervisory or controlling party for an injury caused by a subordinate party. The determination of vicarious liability depends in part upon the employment status of the optometrist. Optometrists and ophthalmologists may be hired

as either employees of the practice or as *independent contractors*, depending upon Internal Revenue Service (IRS) criteria and state law. Ophthalmologists and groups who employ optometrists are often held responsible for the employed OD's actions under the master-servant or "respondeat superior" theory of vicarious liability. This doctrine makes the person "higher up" responsible for the subordinate's actions, so long as these actions are performed within the scope of employment.

As a general rule, an optometrist affiliated with an ophthalmologist/group as an independent contractor is not seen as an agent, employee, or apparent partner of the ophthalmologist/group, thus reducing the likelihood of vicarious liability. Sometimes, however, courts reach different conclusions about the status of an optometrist than what the optometrists, ophthalmologist, or group intended, and rule that there is vicarious liability for the optometrist. First, they may review state laws and IRS regulations and conclude that the independent contractor is an employee. Second, they may determine that the optometrist is acting under the ophthalmologist/group's supervision, control, or direction, and deem him/her to be an agent. Finally, they may decide that an optometrist who is not an employee or independent contractor of the ophthalmologist/group, but who shares space, employees, or patients with an ophthalmologist/group, is an apparent partner of the ophthalmologist/group and hold the OD and the ophthalmologist/group liable for each other's acts (see OMIC's "Guide to Apparent Partnership" at [www.omic.com](http://www.omic.com) to reduce this risk). Ophthalmologists interested in hiring independent contractors will want to consult with an attorney in their state to ensure that the agreement and protocols comply with state law and will likely withstand a legal challenge.

### **OMIC Coverage Issues**

In order for coverage to extend to an OMIC-insured ophthalmologist or entity for vicarious liability arising from services rendered by an optometrist, the optometrist must be acting within the scope of his or her licensure, training, and professional liability insurance coverage (if applicable). Coverage may also apply directly to the optometrist if he or she is named in the Declarations. As in the case of vicarious liability coverage, the optometrist must be acting within the scope of his or her licensure and training. In addition, the optometrist must also be acting within the scope of his or her employment by the insured ophthalmologist/entity. Furthermore, OMIC-insured optometrists who take call are required as a condition of coverage to abide by a written protocol and have appropriate backup as described below.

### **Optometrist's Role in Patient Care**

Patient situations handled by ODs fall into three categories. The first category includes those types of care that their state-defined legal scope of practice allows optometrists to provide independently. In the second category, optometrists with additional types of training and certification are able to diagnose and treat patients with more complex eye conditions. Depending upon state law, these "therapeutic optometrists" may be required to consult with an ophthalmologist in certain situations. Finally, there are patients with diseases or findings that fall outside the first two categories. Such patients need to be referred to an ophthalmologist for diagnosis or management. Within a given practice, when protocols are in place and appropriately followed, care may **at times** be continued by the optometrist under the direct supervision of the ophthalmologists who then assumes responsibility for managing the case.

### **After-hours Care**

In addition to seeing patients during office hours, some practices ask their employed or contracted optometrists to help manage after-hour calls. Some practices may also participate in call groups that include optometrists from other groups. After-hours calls are inherently risky for all involved, as treatment decisions are based solely upon information exchanged during the

patient-provider conversation, without the benefit of medical records or examinations. In addition, the lack of an established physician-patient relationship when covering new patients in after-hours call situations creates additional risk. These risks are heightened when optometrists take call, as there are many situations they cannot independently manage. Just as during office hours, written policies and protocols are needed to ensure that care is delivered safely and according to state law.

### **Special Considerations Regarding ER Coverage**

Providing on-call coverage to a hospital emergency room presents additional risks. First, patients are likely to have more serious, vision-threatening conditions than those who call the office after hours and thus may require services that exceed the expertise and/or legal scope of practice of an optometrist. Moreover, physicians who serve on-call to the ER must comply with both state law governing emergency care as well as the federal law known as EMTALA—laws with which most optometrists are unfamiliar. Optometrists do not usually have hospital privileges and are usually not designated by the facility as able to take ER call (and if they do not have such privileges, ER call is not appropriate) or conduct EMTALA-compliant medical screening examinations. Practices should carefully consider these risks and regulations before delegating ER call to optometrists, and call OMIC's confidential Risk Management Hotline for assistance. For additional information on EMTALA and on-call responsibilities, see "EMTALA: An Overview" and "EMTALA: On-Call Duties" at [www.omic.com](http://www.omic.com).

### **Comanagement of Surgical Patients**

Surgical malpractice lawsuits scrutinize all aspects of the care process, from indications for surgery (preoperative evaluation and diagnosis), type of procedure planned (choice of procedure, technique, implant, equipment), candidacy for surgery (coexisting ocular and medical conditions, contraindications, known risk factors for complications and poor outcomes), informed consent (disclosure and documentation of risks, benefits, alternatives), performance of the procedure (technique, and recognition, management, and disclosure of complications), and postoperative care (discharge condition and instructions, postoperative visits and telephone calls, recognition and management of complications and poor outcomes).

While the surgeon is usually the main focus of a surgical malpractice case, the plaintiff attorney often also names as defendants the surgical facility, members of the operative team, and the surgeon's staff. Ophthalmologists and optometrists who comanage—that is, agree to share care for a particular patient during the perioperative period—can expect to be added to this list. There are patient safety and liability risks associated with comanagement, whether it takes place within a practice or outside of it. Indeed, studies have shown that patient hand-offs from one member of the team to another must be managed extremely carefully to avoid miscommunication and patient harm. In an analysis of "sentinel events," the term used to describe incidents that have the most serious outcomes, The Joint Commission found that the top factor contributing to medical error was not lack of knowledge or technical skills or inexperience. Rather, it was problematic communication: the information conveyed during care was incomplete, inaccurate, and/or misinterpreted. Ineffective communication occurred in 70% of the incidents. Fully half of the time, the harmful communication breakdown occurred during a patient hand-off.<sup>1</sup> Only careful development of protocols and regular, standardized communication among members of the healthcare team can keep patients safe.

The primary reason to comanage ophthalmic surgical care should be patient-centered.

<sup>1</sup> JCAHO. Improving Handoff Communications: Meeting National Patient Safety Goal 2E. *Joint Perspectives on Patient Safety*. 2006; 6(8):9-15.

Patients who are referred for surgery may choose to have their optometrist provide some of the care. Others may face difficulties traveling to the ophthalmologist's office if it is far from their home. Sometimes, the ophthalmic surgeon travels to an area to perform surgery, and is not as readily available for postoperative care. Comanagement that occurs on a routine practice or is done primarily for economic reasons is likely to be poorly viewed by a jury.

The comanagement protocol should detail the training required for comanagement, patient selection, indications and contraindications for surgery, the frequency and scope of postoperative visits, and the content of the report that should be sent to the surgeon after each visit. The protocol should clarify which aspects of pre- and postoperative care may be delegated to the comanager, and which must be performed by the surgeon ([see sample protocol later in this document](#)).

### **Scope of Practice, Credentialing, and Training**

Many practices schedule initial appointments with optometrists in addition to allowing optometrists to treat and follow their own patients. Some office visits and after-hours calls are relatively routine in nature; others may require medical or surgical treatment on an urgent or emergent basis. It is important, therefore, that the provider seeing the patient or taking the call be sufficiently qualified and legally able to provide the care needed and willing to immediately refer the patient to a qualified provider who is readily available should the need arise. Because scope of practice laws vary from state to state, and may even vary within a state from one provider to another based upon the optometrist's Diagnostic or Therapeutic Pharmaceutical Agent (DPA or TPA) certification status, the practice must carefully assess whether the optometrist has the legal authority to treat certain patients and/or take call. Should an optometrist exceed his or her legal scope of practice, not only would he or she be subject to potential licensure action, but the ophthalmologist might be subject to disciplinary action as well. The fact that an activity legally falls within the optometric scope of practice in a given state is not, on its own, assurance that it is appropriate to allow the optometrist to handle the situation or participate in after-hours call. Members of the practice must be confident that the optometrist possesses the adequate training, skills, and experience to accurately diagnose and treat the conditions that are likely to be presented, as well as the willingness to seek advice from an ophthalmologist whenever necessary. If the person handling call lacks the proper qualifications, costly misdiagnoses, delays in diagnosis or treatment, or other medical mishaps may result.

### **Protocols and Backup**

Just as optometrists cannot manage all situations or conditions during office hours, they may not take call for an ophthalmologist without appropriate backup and protocols. OMIC recommends that all practices that utilize optometrists in any capacity (whether employees, contractors, or participants of a call group) have a written protocol that clarifies conditions and situations that optometrists may manage independently (i.e., those conditions an optometrist in solo practice could handle), those requiring consultation with an ophthalmologist, and those that must be referred to an ophthalmologist for management. OMIC requires such a protocol if the optometrist handles after-hour calls.

An ophthalmologist must always be available to take patient referrals in the event a situation that exceeds the optometrist's scope of expertise or legal scope of practice arises: the ophthalmologist should always be immediately available by telephone for consultation and be available within a reasonable time to personally examine a patient if needed. Furthermore, each provider who communicates with the patient should identify him/herself to the patient, and use the appropriate title.

All members of the practice should be given the opportunity to review and comment on the proposed protocol before it is adopted. Once implemented, the protocol should be reviewed and updated on a regular basis. **See the end of the document for a sample protocol.**

**Risk Management Assistance**

OMIC-insured practices are invited to contact OMIC's risk management department at (800) 562-6642, ext. 641 (option 4 from the main menu) for advice and assistance in developing or refining their written protocol.

## **PROTOCOL FOR OPTOMETRISTS AT \_\_\_\_\_ PRACTICE**

### **OPTOMETRIST'S EDUCATION, LICENSURE, CERTIFICATION**

- Dr. \_\_\_\_\_, who is an \_\_\_\_\_ (employed optometrist, independent contractor, community optometrist), received his/her Degree of Optometry from \_\_\_\_\_ on \_\_\_\_\_. [Add any fellowship or additional training in \_\_\_\_\_ from \_\_\_\_\_ on \_\_\_\_\_.] Confirmation of the diploma and training are attached.
- The laws in the state of \_\_\_\_\_ can be found [in Appendix A or give web address and date accessed].
- Dr. \_\_\_\_\_ is licensed as an optometrist [and certified for therapeutic optometry]; his/her license number is \_\_\_\_\_, and is valid until \_\_\_\_\_. He/she also has a DEA license \_\_\_\_\_ valid until \_\_\_\_\_. Copies of the licenses and certifications are attached.
- The laws and regulations require consultation with an ophthalmologist under the following circumstances: [insert a copy of this section of the Optometry Practice Act or regulations].
- The laws and regulations require referral to an ophthalmologist for management under the following circumstances: [insert a copy of this section of the Optometry Practice Act or regulations].
- Dr. \_\_\_\_\_ has professional liability insurance for \_\_\_\_\_ (state limits) with \_\_\_\_\_ (state company). A copy of the declarations page of the policy is attached.

### **OPTOMETRIST'S ROLE DURING OFFICE HOURS**

Our patients have conditions that fall into three groups:

- Patients who can be managed independently by the optometrist according to the scope of practice for optometrists in our state. Examples include but are not limited to [give examples].
- Patients whose condition requires a consultation with an ophthalmologist. Examples include but are not limited to: [give examples].
  - The optometrist will inform the patient of the need for the consultation, and document his/her own examination of the patient and communication with the ophthalmologist.
  - The ophthalmologist will then document his/her examination of the patient and any communication to the optometrist.
- Patients whose condition requires management by the ophthalmologist. Examples include but are not limited to: [give examples].
  - The optometrist will inform the patient of the need for the ophthalmologist to take over care, and document his/her examination of the patient and communication when transferring care to the ophthalmologist.

The optometrist's responsibilities in the practice include:

- [list responsibilities]

## **OPTOMETRIST'S ROLE IN AFTER-HOURS CALL**

- After-hours, our practice takes call for [our own patients, our call group which includes \_\_\_\_\_, etc.]
- When patients call the office after hours, they [are given instructions on how to contact the on-call optometrist or ophthalmologist, are forwarded to an answering service, etc.]
- While covering call, the optometrist will follow the same guidelines as during office hours, as noted above.
- The optometrist will take primary call for [our practice only, our call group only, etc.]
- At all times, an ophthalmologist [from our practice, from our call group] will be available by phone for consultations. If necessary, the ophthalmologist is available to examine and treat the patient.
- The optometrist will use the “After-hours contact form” (**on following page**) to document the conversation. He/she will send a copy to the patient’s ophthalmologist.
- The ophthalmologist will review, date, and sign the form when next in the office and place the signed sheet in the patient’s medical record

## **OPTOMETRIST'S ROLE IN COMANAGED SURGICAL CARE**

- General requirements
- Dr. \_\_\_\_\_ OD received training in comanagement of surgical patients from Dr. \_\_\_\_\_ MD/DO.
- Patients have the right to receive treatment from the surgeon at all stages of care.
- The ophthalmologist is notified when any patient requests to see him/her.
- Patients eligible for comanagement include those undergoing [give types of surgeries that may be comanaged].
- Indications and contraindications for \_\_\_\_\_ surgery include [state the type of surgery and list the indications and contraindications].
- The ophthalmologist and optometrist know and comply with coding and billing requirements of Medicare and other payers.
- Preoperative care
- The optometrist may perform the following aspects of preoperative care: [state role, tests, examinations, educational efforts, etc.].
- The surgeon must personally:
  - Review all tests and examinations conducted by the optometrist\*
    - OMIC’s Refractive Surgery Requirements state that the ophthalmologist must review topography, pachymetry, pupil size, and refractive stability (other requirements denoted by \*)
  - Perform and document an independent evaluation of the patient’s eligibility for surgery, including a slit lamp exam\* and assessment of the clinical status as well as physiological, social, emotional, and occupational needs of the patient
  - Discuss monovision option for presbyopic patients\*
  - Determine the procedure to be performed

- Obtain the patient's informed consent for the surgery\*
- Document in the medical record that the risks, benefits, alternatives, and complications were discussed\*
- Offer the patient a copy of the procedure-specific consent form\*
- Obtain the patient's consent for planned comanagement prior to surgery
  - OMIC's professional liability policy excludes coverage for postoperative care unless one of the following conditions is satisfied:
    - The insured operating ophthalmologist or an on-call or *locum tenens* ophthalmologist performs the patient's postoperative care throughout the patient's recovery period OR
    - The insured operating ophthalmologist
      - Refers the patient to a licensed ophthalmologist or other licensed physician as appropriate and
      - Obtains the patient's informed consent for planned comanagement prior to surgery OR
    - The insured operating ophthalmologist
      - Arranges for a portion of the outpatient postoperative care to be rendered by a non-physician provider who is clinically competent and lawfully able to provide that care AND
      - Obtains the patient's written informed consent for planned comanagement prior to surgery AND
      - Provides supervision for such delegated postoperative care (see below)
- Postoperative care
- The surgeon
  - Performs the post-procedure discharge evaluation and provides written postoperative care instructions
  - Determines when a patient is stable and can be referred to an optometrist for planned, comanaged postoperative care
  - Performs the first postoperative visit for refractive surgery patients\*
  - Remains available throughout the postoperative period to see the patient when requested by the patient or comanager
  - Reviews, dates, and signs reports of each visit or patient contact from the comanager
- The comanaging optometrist
  - Evaluates patients at the following intervals
    - [Give frequency of follow-up visits for each type of surgery that will be comanaged]
  - Performs the following tests and examinations [give the scope of the follow-up visits for each type of surgery that will be comanaged]
  - Evaluates patients for the following complications [give signs and symptoms of common complications for each type of surgery that will be comanaged]
  - Consults the ophthalmologist under the following circumstances [give examples of when the ophthalmologist should be consulted]

- Refers the patient to the ophthalmologist under the following circumstances [give examples of when the optometrist should refer the patient back to the ophthalmologist]
- Completes and sends a written report of each visit and patient contact to the ophthalmologist [report should address the scope of the follow-up visit, evaluation for complications, etc.]

### After-hours/On-call Telephone Contact

Patient name: \_\_\_\_\_ Date/time of call: \_\_\_\_\_

OD/Ophthalmologist \_\_\_\_\_

Chief complaint: \_\_\_\_\_

Progression (circle one) Improving                      Stable                      Worsening

Vision (circle one):                      Stable                      Decreased

Pain (circle one):                      None                      Mild (0-3/10)                      Moderate (4-7)                      Severe (8-10)

Related symptoms: \_\_\_\_\_  
\_\_\_\_\_

Recent tests/procedures/surgery: \_\_\_\_\_  
\_\_\_\_\_

Previous phone calls or visits to other healthcare professionals about this or related complaints:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies: \_\_\_\_\_

Current medications: \_\_\_\_\_

Other significant ocular/medical history: \_\_\_\_\_  
\_\_\_\_\_

Advice or instructions given/treatment or medication ordered \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Follow-up plan: \_\_\_\_\_

Above information provided to primary M.D. (M.D. who is being covered):

M.D. name: \_\_\_\_\_

Date/time information communicated: \_\_\_\_\_

On-call OD/MD/DO signature/initials: \_\_\_\_\_

## CONSENT FOR COMANAGEMENT AFTER EYE SURGERY

Patient Name: \_\_\_\_\_

Dr. (name of surgeon) will be performing (type of surgery) on me. Because of (state reason), I would like Dr. (name of comanaging ophthalmologist/optometrist) to perform my postoperative follow-up care. I have discussed this postoperative selection with my surgeon.

Doctor (name of surgeon) has informed me that an optometrist may lawfully provide postoperative care under applicable state law. I understand that my comanaging ophthalmologist/optometrist Dr. (name of comanaging ophthalmologist/optometrist) will contact my surgeon immediately if I experience any complications related to my eye surgery. I understand that I may also contact Dr. (name of surgeon) at any time after the surgery.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

### **Comanaging Ophthalmologist/Optometrist Confirmation**

I have agreed to provide follow-up care for (patient's name). I will see the patient after surgery when Dr. (name of surgeon) notifies me that she/he is releasing the patient to my care. I agree to notify Dr. (name of surgeon) immediately should complications arise and to provide written progress reports during my portion of the postoperative period.

Comanaging Ophthalmologist/Optometrist: \_\_\_\_\_ Date: \_\_\_\_\_