2019 Texas Professional Responsibility Course

UNIVERSITY OF HOUSTON COLLEGE OF OPTOMETRY
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Financial Disclosure

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The following activity planners have no relevant financial interests in this lecture:

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Welcome to the Professional Responsibility Course sponsored by the University of Houston College of Optometry. As you know, this course is a requirement for Texas license holders. What you may not know is that all fees associated with this course are devoted to permanent projects that are important for the future of the profession.

Thank you for choosing UHCO for your continuing education.

The development and production of the 2019 Professional Responsibility Course is underwritten by the Harris Lee Nussenblatt Lecture Series Endowment. This endowment was established in 1992 by the Nussenblatt Family in memory of former Associate Professor Harris Nussenblatt, OD. The Lecture Series focuses on issues related to professional ethics, public health and practice administration.

Preface

The content of the Professional Responsibility Course is at the discretion of the Texas Optometry Board. This year, the Board asked that we discuss the items on the agenda. These items will set the entire agenda of the 2019 course. Once again, some of the items are issues covered in more than one prior PR course.
AGENDA – TEXAS OPTOMETRY BOARD

- Legal responses to social media issues
- Display of doctor’s name
- Use of photography in satisfying minimum competency
- Prescribing information
- Understanding controlled substances
- Use of Prescription Monitoring Program
- Ethical prescribing

Social Media Issues

This is NOT a comment on the social media use from a practice management standpoint – it is a statement of the LEGAL application and use of social media in your practice.

There are two main questions to answer:

1. What are the legal ways we can respond to patients using social media
2. One rule and some suggestions for responding to patient social media postings

Legal Patient Communication

- Other than optical Rx release and marketing issues, there are NO restrictions on communicating with patients by telephone or fax
- There are NO restrictions on communicating with patients by text as long as the text system is secured equivalent to encryption (HIPAA rule and CMS rule) – which means they must be encrypted (Weave, Solution Reach, etc)
- There ARE restrictions on communicating with patients by email – they are covered in HIPAA
Legal Email Communications with Patients

OPTION ONE
Use only secured, encrypted email systems (Hushmail, Citrix, Google Pro, secured EMR patient portal, domain based email)
This is ALREADY the law...time is coming when you will be required to use only patient portal systems

OPTION TWO
Obtain authorization from the patient. Per HIPAA regulations you must:
- Inform the patient the communication is not secured
- Educate the patient of the consequences of non-secured email communications
- Obtain authorization from the patient to use non-secured email

Suggestions on how to do this...

Is this really a big deal?
- 2017, Dallas clinic was fined $2.3 million for failure to encrypt patient emails – and there was NO breach of patient information
- The Texas Optometry Board is obligated to ensure licensees are following ALL laws (including HIPAA) and can take action against you for not complying with HIPAA or other laws
Responding to patient posting

General Points

➢ There is nothing wrong with communicating with patients on social media – AS LONG AS THERE IS NO RELEASE OF PATIENT INFORMATION (but there almost always is)

➢ Patient started the communication, isn’t that implied consent?

Responding to patient posting

Specific Situations

➢ Posting pretty pictures of them in their new glasses
➢ Responding to their post that I am an awful doctor
➢ Posting on professional blogs

Displaying Doctor’s Names

Let’s talk about office inspections….

➢ Office inspections are a requirement of the Board per State law
➢ Inspections typically include checking for compliance with:

➢ Statute 351.353/Rule 277.7 (minimum competency requirements) and other issues such as proper identification as an optometrist, proper display of doctor’s names, display of license, display of patient compliant poster and/or brochure, etc.
Now, displaying those names *(refer to Rule 279.10)*

(a) To protect the public health and provide a means for the patient to identify a licensee in a complaint filed with the Board, §351.362 of the Act requires an optometrist or therapeutic optometrist to display the doctor's name so that the name is visible to the public before entry into the office reception area. This requirement does not apply to an optometrist or therapeutic optometrist practicing at a location on a temporary basis, as defined in subsection (b) of this section.

*(my emphasis)*

Now, displaying those names *(refer to Rule 279.10)*

(b) Temporary basis is defined as the practice of optometry or therapeutic optometry at an office for no more than two consecutive months. For example, an optometrist or therapeutic optometrist practicing at a location one day per week during a three month period is not at that location on a temporary basis, and the doctor's name must be displayed as required in §351.362 of the Act.

Now, displaying those names *(refer to Rule 279.10)*

(c) Section 351.458 of the Act prohibits the display of an optometrist or therapeutic optometrist's professional designation if the intent of the display is to mislead the public that the named optometrist or therapeutic optometrist owner regularly practices at that location. Therefore an optometrist or therapeutic optometrist practicing at an office in which the doctor has no ownership interest, must display the doctor's name as licensed by the Board, regardless of the percentage of time spent at that office, unless the doctor's practice meets the definition of temporary basis in subsection (b) of this section.
Minimum Competency Issue – Big One

Board Rule 279.3
(a) The optometrist or therapeutic optometrist shall, in the initial examination of the patient for whom ophthalmic lenses are prescribed:

1. Personally make and record, if possible, the following findings of the conditions of the patient as required by §351.353 of the Act:

   A. Biomicroscopy examination (lids, cornea, sclera, etc.), using a binocular microscope.

   B. Internal ophthalmoscopic examination (media, fundus, etc.), using an ophthalmoscope or biomicroscope with fundus condensing lenses. Videos and photographs may be used only for documentation and consultation purposes but do not fulfill the internal ophthalmoscopic examination requirement.

Specific to this Board rule...

In relation to our state law, this rule only applies to the minimum competency requirement....which means it ONLY applies:

✓ To the INITIAL examination of the patient
✓ In which an optical prescription is generated

But there’s more...

- Dilation USUALLY required to bill 92004/14 medical – ALWAYS for EM internal examination elements
- Dilation required for diabetics and at risk patients – per VSP and EyeMed
- Cannot substitute photo or photo review for internal examination per VSP, CMS and multiple medical payers
- BUT MOST IMPORTANT - when indicated, dilation - not photos - is a standard of care issue
OPTOS are AMAZING, but...

Initial SYMPTOMATIC presentation – great OPTOS picture

One month later....

Ophthalmology 2014: Up to 26% of acute PVDs have an associated retinal break or detachment at the time they present. After that the risk is less than 5%

Prescribing Issues

We have to talk about:

- What are controlled substances
- How the Prescription Monitoring Program (PMP) works
- How PMP effects us as optometrists
- Judicious prescribing issues

Controlled Substances

- Controlled substances are defined by the Drug Enforcement Agency at the Federal level but most States have their own controlled substance classifications
- Federal law applies when State laws do not exist
- Texas has its own controlled substance definition and classification system – defined by the Texas Controlled Substances Act under the Health & Safety Code, Chapter 481
- Drug classifications are updated and new drugs added once a year with the new classification typically release in February
What are controlled substances?

*Here is the biggest misconception...*

Controlled substances are just narcotics that require special prescriptions and optometrists in Texas cannot prescribe them anyway.... So we don’t have to worry about any monitoring program?

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Controlled Substances

Controlled substances are ANY prescription deemed by the Drug Enforcement Agency or applicable State agency to have “the potential for abuse that can lead to physical or psychological dependence”

Controlled substances are NOT just Schedule I and II narcotic agents. *There are controlled substances in every Schedule – I through V*

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Schedule I Controlled Substances

- These are the drugs with the MOST potential for dependency
- There are actually thousands of them
- The common ones would be heroin, LSD, marijuana and potent, often experimental, psycho-active agents – NEVER an application to primary eye care
Schedule II Controlled Substances

This is the category receiving the most attention in the US right now. There is a SEVERE issue with opioid narcotic over-use that predominantly stems from opioid narcotic over-prescribing.

While ODs in Texas have not / can not legally contribute to this problem under existing law, it is essential we understand the problem and how we can help solve the problem.

Schedule II Controlled Substances

**Narcotics** - Opium and opiate derivatives
- The main culprits – morphine and morphine derivatives (meperidine/Demerol, methadone, fentanyl); oxycodone (Oxycotin, Percocet, Percodan); hydrocodone (Vicodin, Norco, Lortab, Lorcet, Norcet, Loracet)
- **Stimulants** – mainly from the amphetamine family but also includes cocaine
- **Depressants** – mainly from the barbiturate family
- **Hallucinogens**

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A word about cocaine...

(JJ Cale said "it don't lie"...but that's three words)

- Cocaine has application as a diagnostic agent in evaluation of pupil anomalies
- Texas ODs have right to possess and administer cocaine for diagnostic use

**BUT...really**

- The regulations are stifling
- The legal issues are stifling
- Storage and reporting issues are complicated
- There are “almost as good” alternatives
Five tips to spotting the “addicted” patient

- Inconsistencies in reported symptoms or history
  - Over-rated explanations of injuries; symptoms persisting well beyond injury; over-rated pain in relation to cause

- Unusual behaviors
  - Patient is obsessive, agitated, irritable, fails to keep appointments then wants in for “emergency” care, overly complimentary of physician

- Lack of correlation between symptoms and signs from examination

- Failure to accept non-narcotic recommendations (“I tried that before, it didn’t work…but Vicodin did!”)

- Request for dosages or refills in excess of the problem – losing prescriptions

Schedule III Controlled Substances

Narcotics - Opium and opiate derivatives
The main culprit is codeine: aspirin or acetaminophen + codeine (#2 – 15mg codeine; #3 – 30mg codeine; #4 – 60mg codeine)

Depressants – barbiturate family with less dosage than Schedule II

Anabolic steroids and hormones

NOTE: One problem occurred when doctor tried to claim Vicodin is a Schedule III drug…Vicodin was re-classified as Schedule II narcotic in 2014.
Schedule IV Controlled Substances

**Non-narcotic pain medications**
- Ultram (tramadol)
- Darvon (dextropropoxyphene)

**Stimulants** – just a few

**Depressants** – tons of them
- Common culprits include: Xanax (alprazolam); Klonopin (clonazepam); Valium (diazepam); Ativan (lorazepam); Ambien (zolpidem); Centrax (prazepam); Dalmane (flurazepam)

So, a word about corneal pain

- Corneal and ocular pain can be / is often VERY severe
- Pain medications, even Schedule II narcotics, have minimal effect on curbing this pain
- Bandage lenses have far more pain controlling power than narcotics
- Does the ibuprofen/acetaminophen cocktail really work?

Schedule V Controlled Substances

A plethora of drugs that would rarely or never be used in eyecare – most common application is cough suppressants

Does include some synthetic codeine preparations (low dose dihydrocodeine) that have pain moderating effects but are used more for their anti-tussive properties
So, all that info and in Texas we cannot use many of those drugs, much less the bad ones. Why bother?

While true, being aware and involved is important because:

- ODs can help identify problems with addictive patients
- ODs can help identify problems with addictive colleagues
- We can prescribe some of these medications now
- We hopefully will change the current law to allow more access to needed medications

SO WHAT IS WITH THIS PRESCRIPTION MONITORING PROGRAM ANYWAY

Texas Prescription Monitoring Program (PMP)
- Implemented in 2008 – only for Schedule I and II reporting
- Amended in 2016 to include all Schedules with required reporting requirements for all Texas pharmacists and any physician prescribing opioid derivatives, benzodiazepine (many sedatives), barbiturate or carisoprodol (Soma) – regardless of the Schedule
- This means under current law we are required to use the PMP with any prescription for codeine or tramadol containing medications
Side point...

Every licensed practitioner has a profile in PMP accessible by any pharmacist in Texas. Your prescribing patterns are being recorded and monitored whether you elect to participate in the PMP program or not.

More information on the Texas Prescription Monitoring Program can be found at: www.pharmacy.Texas.gov

So, do I HAVE to participate?

No, but...

- If you hold a –TG license in Texas, you must register to prescribe any opioid or opioid-derived medication – in ANY Schedule
- If you hold a –TG license in Texas, you SHOULD register. This is strongly encouraged by the Texas Optometry Board
- If you do not hold -TG license in Texas, you SHOULD

How do I participate?

First, register https://texaspmaware.net

Instructions are easy – you will need a DEA number to register

Wait, I have to have a DEA?

✓ You do to register for the PMP
✓ You do if you want your patient’s prescriptions filled without additional hassle
Then... **IT’S JUST THAT EASY....**

Effective September 1, 2019, before writing any applicable prescription you must login and check the registry regarding the patient’s history. Then make a determination if you want to continue with the prescribed medication based on:

- The prescription data and history related to the patient, if any, contained in the Prescription Monitoring Program
- A determination whether the planned decision would constitute a potentially harmful prescribing pattern or practice.

**One other important prescribing decision**

Is it legal and/or ethical to provide care, including supply of medication prescriptions to myself, my family or close friends?

**Let’s start with this...**

- There is nothing in the Texas Optometry Act or Texas Optometry Board rules that prohibits you treating yourself, your family or your close friends.
- Although present in many other states, there is nothing in the laws of Texas that prohibit you treating yourself, your family or your close friends.
- There ARE issues and opinions from the American Medical Association and Texas Medical Association that would be wise to consider.
### AMA Ethics Opinion 9.6.6

**Regarding prescription decisions in general**
- Prescription decisions should be based solely on medical necessity, patient need and a reasonable expectation of the effectiveness of the treatment.
- Physicians should not dispense medications in office unless it is totally for the primary benefit of the patient.
- In making prescriptive decisions, physicians should avoid any direct or indirect influences that would result in financial gain to the physician.

### AMA Code of Medical Ethics - Opinion 8.19

“Physicians generally should not treat themselves or members of their immediate family.”

**Some exclusions**
1. Routine care  
2. Minor care  
3. Emergency care

### Other AMA Code of Medical Ethics considerations

When making a decision to treat yourself, friend or family member, consider:
- Is the treatment within your level of training and expertise?  
- Have you discussed the primary recommendation that the individual seek care from another physician?  
- Is the proposed treatment the same as you would recommend for any other patient?  
- Have you created a proper medical record for the encounter?
Texas Medical Association position

There is no prohibition on physicians treating themselves or members of their family

**BUT...**

*Physicians are prohibited from prescribing controlled substances for themselves or immediate family member unless it constitutes an immediate need. Even in that case, the prescription dosing is limited to a 72 hour supply.*

Bottom line...

Self treatment and treatment of immediate family, unless for routine, minor or emergency care, is likely a very bad idea and should be avoided

Thank you for your attention and have a great 2019

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