Thomas P. DiNapoli
COMPTROLLER

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**OFFICE OF THE NEW YORK STATE COMPTROLLER**

**DIVISION OF STATE GOVERNMENT ACCOUNTABILITY**

# DEPARTMENT OF HEALTH

# OFFICE OF PROFESSIONAL MEDICAL CONDUCT COMPLAINTS AND INVESTIGATIONS PROCESS

## Report 2005-S-21

## AUDIT OBJECTIVES

Our audit objective was to determine whether the Department of Health's (Department) Office of Professional Medical Conduct (OPMC) has effective controls in place for identifying, tracking and investigating complaints of alleged physician medical misconduct. We also reviewed the extent to which OPMC obtains and uses malpractice information as a source for investigations of potential misconduct.

## AUDIT RESULTS - SUMMARY

OPMC was established to investigate cases of suspected misconduct on the part of physicians, physician assistants and specialist assistants and, where appropriate, take disciplinary action. We found that OPMC is thorough in its investigation of cases of potential misconduct, and generally does effectively track complaints. However, OPMC management concentrates little effort on proactively identifying cases of potential misconduct or ensuring that they have received all complaints from the various outside and internal reporting sources. In addition, OPMC needs to improve the timeliness of some of its investigations.

An important source of complaints about potential misconduct is a referral from sources outside of the Department, including the public, other medical professionals, or governmental agencies. We identified instances where OPMC did not receive complaints from outside reporting entities, including instances involving potential fraud on the part of the licensee. As a result, these complaints may not receive the required investigation by OPMC, which potentially places patients in jeopardy of receiving substandard care. [Pages 4-5]

OPMC is not proactive in seeking to identify instances of potential misconduct, but instead relies primarily on referrals from other entities. For example, the Medicaid and Medicare programs maintain listings of providers who committed an action which is sufficient to exclude them from participating in these programs. We determined that OPMC does not routinely review these listings as a source of potential misconduct cases. We identified licensees that appeared on these listings that OPMC did not investigate. [Pages 5-6]

A judgment or settlement in a medical malpractice case does not constitute misconduct in and of itself. In such a case, OPMC would have to determine whether the facts of the case constitute an act of misconduct, as defined by the State Education Law. OPMC's policy is to investigate a licensee in situations involving potential malpractice based on certain criteria. We found that for the period April 1, 2003 through July 31, 2005, OPMC did not open an investigation for 177 licensees who met the criteria for malpractice investigation. We also found the malpractice database that OPMC maintains is incomplete when compared to similar information maintained by the Office of Court Administration (OCA). As a result, OPMC does not have complete information for cases involving potential malpractice that may require investigation. [Pages 6-7]

In New York, there is no legal requirement to investigate licensees who have a high incidence of malpractice judgments or settlements to determine whether these actions constitute medical misconduct. Some states initiate an investigation when a licensee has more than three malpractice payments during a five-year period. Applying a similar criterion to OPMC's malpractice database, we identified 12 licensees who had 3 or more malpractice payments during the period April

1, 2003 through July 31, 2005. OPMC did not initiate an investigation for 3 of these 12 licensees. [Pages 6-7]

We also found that OPMC has not developed formalized time standards for completing its investigations. We identified approximately 340 cases which have taken over one year to investigate, and the investigation still remained opened at the time of our testing. In addition, we found another 429 cases which were open and closed during our audit period, but took over one year to complete. When investigations are not completed timely, the public is at risk of receiving substandard care. [Pages 7-10]

Our report contains five recommendations for improving OPMC operations.

This report, dated August 9, 2007, is available on our website at: http://www.osc.state.ny.us.
Add or update your mailing list address by contacting us at: (518) 474-3271 or
Office of the State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, NY 12236

## BACKGROUND

OPMC's mission is to protect the public though the investigation of professional misconduct issues involving physicians, physician assistants and specialist's assistants, collectively referred to in our report as licensees. Where appropriate, OPMC is responsible for taking disciplinary action in cases involving professional misconduct. The State Education Department oversees the licensing and disciplining of other health care professionals.

Section 6530 of the State Education Law defines the various acts that constitute professional misconduct. There are 47 different acts of misconduct. Examples of misconduct include obtaining a medical license fraudulently, or practicing the profession while impaired by alcohol, drugs, physical disability or mental disability. Any licensee found guilty of such misconduct is subject to penalty, which may include censure and reprimand, fines and revocation of their medical license.

Section 230 of the Public Health Law makes OPMC responsible for investigating all complaints that it receives regardless of the source, and gives them the authority to investigate any suspected misconduct. A judgment or settlement in a medical malpractice case does not constitute misconduct in and of itself. In such a case, OPMC would have to determine whether the facts of the case constitute an act of misconduct, as defined by the State Education Law. OPMC's policy is to investigate a licensee in situations involving potential malpractice based on certain criteria. OPMC typically begins an investigation based on a complaint received from the public, other medical professionals, or governmental agencies. OPMC relies on these outside reporting entities to provide OPMC with the majority of the cases they investigate. However, OPMC will independently open an investigation if it determines one is needed. For example, OPMC opens cases of potential misconduct if a medical malpractice case meets OPMC's selection criteria. These actions would increase the investigation period.

OPMC's investigations range from a few days to those that take over several years to complete for a full investigation. For example, a complaint of having to wait a long time to see a physician would be resolved in a short period of time as the complaint does not meet the legal requirements of misconduct. However, a complaint which alleges a

physician was practicing medicine in a substandard manner, may typically require reviewing medical records, and reviews by other medical professionals.

OPMC has a central office and six field offices (Albany, Buffalo, New Rochelle, New York City, Rochester and Syracuse). OPMC maintains a centralized database of all complaints received. This database is used to track the status of each complaint. Typically, full investigations are usually conducted by staff at the field offices, based on the geographic location of the licensee's place of business, while central office typically handles the less complex cases. Annually, OPMC receives approximately 7,000 complaints of which about 400 result in action being taken against the licensee. During the 2004-05 fiscal year, OPMC expenditures were approximately $21.7 million and an additional $2.2 million was spent on the Physician Profile and Patient Safety Center, created by legislation in 2000 to disseminate physician profiles, hospital report cards and health car plan quality assurance reports.

## AUDIT FINDINGS AND RECOMMENDATIONS

### *Need for Complete Information and Proactive Efforts*

Medical professionals are required by State law to report colleagues whom they suspect are guilty of misconduct. Governmental agencies, while not statutorily required to report, do report to OPMC cases which might be potential misconduct. For example, OPMC receives complaints from several State agencies including the Department's Office of Medicaid Management (OMM), the Department's Bureau of Hospital Services (BHS), and the New York State Attorney General (AG). In addition to the complaint information, OPMC receives medical malpractice information, and has access to several other sources of data in order to assist in the investigation of a complaint. Also, OPMC can begin an investigation based on information which it uncovers itself.

OPMC is responsible for determining whether a complaint falls under its jurisdiction, and the extent of the investigation needed to determine whether the licensee committed an act of misconduct.

We found OPMC management concentrate the majority of their efforts on ensuring that known cases involving immediate danger to the public are handled timely, and that all cases are investigated thoroughly. However, we determined that OPMC management concentrates little effort on proactively identifying cases of potential misconduct or ensuring that they have received all complaints from the various referral sources. To ensure public safety, OPMC should have procedures in place to determine whether it is receiving all of the complaints from each source. In addition, OPMC should be proactive in identifying and obtaining cases for investigation and not relying primarily on outside sources to provide potential cases.

#### Fraud

State Education Law has established 47 different acts which define professional medical misconduct. For example, a licensee who practices the profession fraudulently (e.g., billing for services not provided) has met one of the 47 acts of misconduct. The Department and the AG both are responsible for fraud detection within the Medicaid program. The Federal Department of Health and Human Services is responsible for detection of fraud within the Medicare program. These programs provide health care to millions of individuals in New York State and throughout the nation.

To determine whether OPMC has received all Medicaid fraud complaints, we requested all fraud cases identified by the Department for the period April 1, 2003 to March 31, 2006. Department officials refused to provide us with this information, citing this request was outside the scope of our current audit. However, they did provide us with a listing of 34 cases they claim were referred to OPMC during our audit period. We found that 25 of 34 cases were for providers whose licenses are under the jurisdiction of OPMC. The other nine cases were for providers whose licenses are not under the jurisdiction of OPMC. We determined that the 25 cases were properly handled by OPMC.

Subsequent to the end of our fieldwork (March 31, 2006), OMM officials did provide us with the information pertaining to the fraud cases identified by OMM. In total, there were 247 fraud-related cases they had investigated. Because of the timing of when we received this information, we did not review this information in sufficient detail to conclusively determine whether any of these cases should have been referred to OPMC for further action.

OPMC also receives cases from the AG for investigations. For the period April 1, 2003 through July 31, 2005, the AG referred 14 cases to OPMC. One of the complaints was not investigated by OPMC.

In addition to receiving information from various sources, OPMC should take a proactive approach to identify potential cases of fraud for investigation by reviewing listings of providers who have been suspended from the Medicare and Medicaid health insurance programs. Currently, OPMC does not use these sources of information in the investigation of misconduct. Each program maintains a listing of providers of medical service who committed an action which is sufficient to exclude them from participating in the program. Examples include billing fraudulently or practicing outside medical norms. Typically, these acts are sufficient to be considered misconduct.

### Medical Malpractice

Medical malpractice insurance companies are required to report cases of potential malpractice to OPMC, which maintains this information in a database. OPMC's policy is to open an investigation against a licensee if one of the following three criteria is met:

- Settlement amount is greater than $500,000;
- Judgment against the licensee; or
- Death of a mother or child during child birth.

In November 2005, OPMC began using its malpractice database as the main source of information for identifying cases involving potential malpractice and initiating an investigation. Prior to November 2005, OPMC received a report on malpractice cases every month from the National Practitioner Database (NPDB), and used this information in determining whether to open an investigation based on OPMC's malpractice criteria. (The NPDB is an organization that receives data from various sources and acts as a clearinghouse of information.) OPMC officials indicated that the timeframe for receiving information from the NPDB could exceed a year, and therefore began using its own malpractice database to open investigations more quickly.

We reviewed OPMC's malpractice database to determine whether all cases meeting OPMC's criteria were being investigated. We found that for the period April 1, 2003 through July 31, 2005, OPMC did not initiate

an investigation for 177 licensees out of the 596 that met the criteria for investigation. During this period, OPMC was relying primarily on malpractice information from NPDB. These 177 cases need to be investigated by OPMC.

To determine the completeness of the malpractice information OPMC is using, we compared OPMC's malpractice database with another source of information. The OCA maintains a database of malpractice cases which have been filed within the State court system. Currently, there is no process to share information between OCA and OPMC. We compared the OPMC and OCA databases and identified 154 licensees (from over 17,000) who appeared on OCA's database during the period April 1, 2003 through July 31, 2005, but did not appear on OPMC's malpractice database. As a result, OPMC's malpractice database does not contain complete information.

During our audit, we determined that OPMC investigated 37 of the 154 licensees, based on complaints it had received from other sources. However, without having the information available from OCA, there is no assurance that OPMC had all of the necessary information to properly investigate the cases and reach correct conclusions. For the remaining 117 licensees, OPMC did not initiate an investigation during the period April 1, 2003 through July 31, 2005. The information available from OCA for the 117 licensees may have been important in determining whether an investigation was appropriate for these licensees.

In addition, we surveyed ten states to determine how they use malpractice data in investigating misconduct cases. We selected these states because each had over 30,000 licensees in their state. We received information from eight of the ten states. We found that three of the states (Massachusetts, Michigan and Ohio) have procedures for initiating an investigation when a licensee has more than three malpractice payments in five years.

We applied a similar criterion to OPMC's malpractice database to determine whether any potential misconduct cases are going uninvestigated. Our approach was more conservative than the one used by the other states, in that we identified instances involving three malpractice lawsuits over a 28 month period, rather than five years. We believe that if a complete five-year period were used for analysis, additional cases would be identified.

We found that for the period April 1, 2003 through July 31, 2005, 12 licensees had 3 or more malpractice lawsuits, but 3 of these licensees were not investigated by OPMC during this period. The remaining nine licensees did have complaints investigated by OPMC. However, we did not determine whether these investigations were related to the malpractice lawsuits.

### Hospital Services

BHS is responsible for investigating complaints arising in a hospital. BHS maintains it own database of complaints, including the severity of the event. We obtained 258 cases from BHS for the period April 1, 2003 through July 31, 2005, where the hospital indicated that the physician had a role in a serious event such as a patient's death or impairment of a bodily function. Of these 258 cases, we identified 4 cases where OPMC was not informed of these complaints. Therefore, no investigation was undertaken, potentially allowing a licensee who may have committed an act of misconduct to continue to practice.

In responding to our preliminary audit findings, OPMC officials determined that three of the cases were investigated jointly between BHS and one of OPMC's field offices. However, OPMC central office was unaware of these investigations as they were not recorded in OPMC's tracking system. The remaining case is currently being looked into to determine how it went undetected by OPMC. OPMC and BHS informed us they have established new procedures to prevent cases from going unreported and uninvestigated in the future.

### *Thoroughness and Timeliness of Investigations*

To accomplish its mission of protecting the public, OPMC should ensure that all cases of potential misconduct are investigated in a thorough and timely manner. When conducting investigations of potential misconduct, OPMC follows a standardized process, typically including information gathering, interviewing, and supervisory review stages. OPMC has several different levels of reviews ranging from the field office supervisory level to central office review. This standard process is intended to ensure both thoroughness and timeliness of investigations.

To determine if cases were being investigated thoroughly, we visited the New York City, Syracuse and New Rochelle field offices. We judgmentally selected 75 cases (25 in each office) from the total of 2,000 cases these field offices received during the period April 1, 2003 through August 31, 2005. We selected our cases based on a cross-section of various types of complaints received. We found that completed investigations were conducted in a thorough manner, as all stages of the investigations were well-documented and organized. However, we found that 16 investigations (New Rochelle - 5, New York City - 5 and Syracuse - 6) were not completed within one year.

Though officials at the field offices encourage investigative staff to complete investigations within one year of receipt, OPMC has not formalized time standards for completing investigations. Although the progress of the investigations is continually monitored by the various levels of OPMC supervisory reviews, there is no defined time period investigators should take for various stages of investigations. A formalized time standard would establish a uniform benchmark which all employees would be aware of and strive to meet. In responding to our preliminary audit findings, OPMC officials stated they have a policy in place which requires investigators to complete investigations of impairment cases within 90 days. Impairment cases are allegations that the licensee is either physically or mentally unable to perform the required functions. For example, practicing the profession while impaired by alcohol, drugs, physical disability, or mental disability would be classified as impairment.

During our audit period, OPMC initiated an investigation for approximately 7,600 of the 16,556 complaints they received, with approximately 6,000 of these cases being closed within the 29-month period. The remaining 1,600 cases were still open as of November 2005, based on the most recent data at the time of our audit fieldwork, provided by OPMC. Cases for investigation are assigned to either the central office or the field offices depending on the issue involved. According to OPMC officials, cases assigned to the central office should typically take less time as they are less complex in nature.

Using computer-assisted audit techniques, we identified approximately 340 cases of the 7,600 cases which have taken over one year to investigate, and the investigation still

remained opened. In addition, we found another 429 cases which were open and closed during our audit period, but took over one year to complete. Cumulatively, the 769 cases represents about 10 percent of the about 7,600 complaints OPMC investigated. We used information from OPMC's complaint tracking system as of November 2005 to identify the cases in excess of one year. We did not include any of the time that OPMC central office staff may have needed to record the complaint and make a determination that a full investigation was needed. Therefore, our analysis addresses the effort OPMC is expending on cases it has determined fall within its jurisdiction and need investigation.

The following table shows the breakdown by the field and central offices of the over 6,000 closed investigations which were initiated based on complaints received between April 1, 2003 and August 31, 2005. We did not include any of the cases which were still open as of November 2005. In addition, we did not include cases which were opened prior to our audit period, and may have been closed during our audit period. However, we are aware of cases opened prior to our audit period which have remained open over four years. We also included in the table the average caseload per investigator according to OPMC officials as of September 30, 2004 (the latest information available).

| **Field Office** | **Cases Closed within 1 Year** | **Cases Closed between 1 and 2 Years** | **Cases Closed After more than 2 Years** | **Average Number of Days to Close a Case** | **Average Caseload per Full-Time Investigator as of September 30, 2004** |
|---|---|---|---|---|---|
| Albany | 261 | 46 | 4 | 201 | 35 |
| Buffalo | 156 | 36 | 2 | 237 | 50 |
| New Rochelle | 173 | 107 | 6 | 327 | 60 |
| New York City | 398 | 99 | 6 | 257 | 27 |
| Rochester | 182 | 20 | 3 | 194 | 36 |
| Syracuse | 143 | 46 | 2 | 275 | 48 |
| Central Office | 4,204 | 52 | 0 | 84 | N/A |
| **TOTAL** | **5,517** | **406** | **23** | N/A | N/A |

**N/A: Not Applicable**

When investigations are not completed timely, the public is at risk of receiving substandard medical care. According to OPMC officials, a manageable caseload per full-time investigator is between 35 and 40 cases at any given time. OPMC officials told us that staffing shortages and high staff turnover at the field offices have impacted on their ability to timely close cases.

### Funding the Operations of OPMC

Physicians are required to pay a biennial registration fee, which funds the operations of OPMC. In 1996, the Legislature increased the fee from $330 to $600. The fee was originally intended solely for OPMC purposes for investigating cases of potential misconduct.

In 2000, the Legislature passed the Patient Health Information and Quality Improvement Act. This act required the Department to

create a statewide system for the dissemination of physician profiles, hospital report cards and health care plan quality assurance reports. This act created the Physician Profile and the Patient Safety Center within the Department. The justification for these two initiatives was that patients needed more dependable information about their physicians in order to make better decisions about the quality of their health care. The act specifically indicated that monies earmarked for OPMC operations were not to be diverted to fund these activities. However, this aspect of the act was rescinded by legislation passed in 2003, and some of the funding was used to initiate and maintain the Physician Profile and Patient Safety Center, rather than for OPMC.

While the Physician Profile and Patient Safety Center are being funded from the fee as allowed in law, this shift of funding potentially may be limiting OPMC's ability to accomplish its mission of protecting the public from substandard care provided to licensees by providing timely investigations. OPMC needs to develop standards for the timely completion of investigations and do a cost benefit study to determine the resources needed to meet the standards, including the need for any organizational changes. The study should result in an action plan to address all identified needs.

## Case Tracking

Currently, OPMC is using its Case Management Information System (CMIS) to monitor the progress of investigations. CMIS is utilized by OPMC staff to enter data about cases, track cases, and to look up a physician's history with OPMC. In an effort to better track and monitor the progress of investigation, OPMC plans to implement a new complaint tracking system, referred to as TRAKKER. OPMC plans to have this tracking system operational at all of the field offices by the end of 2007. OPMC officials indicated that TRAKKER is an organizational tool for tracking complaints and storing all documentation that accompanies complaint investigation. Officials also believe that TRAKKER will improve overall efficiency and timeliness.

During our audit we did not evaluate TRAKKER, as it was not fully operational. However, an adequate tracking system would allow OPMC to determine the amount of days each stage of an investigation is taking, allow for supervisory sign-offs at each stage, and produce investigation reports for management and supervisors to review and evaluate. OPMC should ensure that when TRAKKER is implemented across the state, it includes all attributes of an adequate tracking system and can be used to oversee OPMC's productivity.

**Recommendations**

1. Take steps to ensure that all complaints are received from the various reporting entities. To accomplish this OPMC needs to establish a method of informing and reminding reporting entities of the importance of properly referring all cases of potential misconduct to OPMC, and
2. Make better use of malpractice information as part of the investigation of potential cases of misconduct by:

- opening investigations into all cases which meet OPMC's existing malpractice criteria, including the 177 instances we identified during the audit,
- modifying the existing malpractice investigation criteria to include a frequency standard for the number of malpractice cases or payments a licensee may have,

- obtaining and using the OCA malpractice information as a source of malpractice information, and
- ensuring the use of comprehensive information when investigating cases involving malpractice.

3. Establish procedures through which OPMC could proactively identify potential cases of misconduct for investigation.

4. Take steps to help ensure cases of potential misconduct are investigated in a timely manner. At a minimum, management should:

- develop a formalized time standard for investigations, and
- include as part of the new tracking system, adequate features to allow management to measure and compare field offices' caseload, staffing and production.

5. Perform a cost benefit study to determine the resources needed, as well as any other changes, to meet the standards developed for timely completion of investigations. The study should produce an action plan to address all identified needs.

## AUDIT SCOPE AND METHODOLOGY

We did our audit according to generally accepted government auditing standards. We audited the effectiveness of OPMC's controls relating to the identifying, tracking and investigation of complaints of alleged physician medical misconduct and obtaining and using malpractice information as a source for investigating potential misconduct, for the period April 1, 2003 through March 31, 2006. We examined applicable sections of the Public Health Law, State Education Law and Department policies and procedures; interviewed officials at the Department and three field offices (Albany, New York City and Syracuse); interviewed officials from OCA and the AG; contacted representatives from the physician discipline program in ten states (California, Florida, Illinois, Massachusetts, Michigan, New Jersey, North Carolina, Ohio, Pennsylvania and Texas) and analyzed relevant program information maintained by OPMC. We also selected a judgmental sample of 75 OPMC complaint investigations at the New York City, Syracuse and New Rochelle field offices we visited. We selected these cases because they represented a cross section of the different types of complaints OPMC handles. In addition, using computer assisted audit techniques, we analyzed case management information maintained by OPMC as well as information pertaining to malpractice settlements and judgments maintained by both OPMC and OCA.

Practicing the medical profession fraudulently is professional misconduct and we sought to determine whether the Department had sufficient procedures in place for referring such cases to OPMC for further action. During the course of the audit, Department officials only provided us with information pertaining to the 34 referrals they indicated they made to OPMC during our audit scope. However, they would not provide us with any information related to fraud investigations they did not refer to OPMC. Subsequent to the conclusion of our audit fieldwork, officials did provide us with the information pertaining to the fraud cases identified by OMM. However, because of the timing of when we received this information, we did not review this information in sufficient detail to conclusively determine whether any of these cases should have been referred to OPMC for further action.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

## AUTHORITY

The audit was done according to the State Comptroller's authority under Article V, Section 1 of the State Constitution and ArticleII, Section 8 of the State Finance Law.

## REPORTING REQUIREMENTS

We provided a draft copy of this report to Department officials for their review and comment. Their comments were considered in preparing this report, and are included as Appendix A. Appendix B contains State Comptroller's Comments, which address certain matters in the Department's response.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising of the steps that were taken to implement the recommendations it contained, and/or the reasons certain recommendations were not implemented.

## CONTRIBUTORS TO THE REPORT

Major contributors to this report include William Challice, David R. Hancox, Richard Sturm, Al Kee, Ed Durocher, Paul Alois, Jonathan Deeb, Lucas McCullough, Brianna Redmond and Paul Bachman.

## Exhibit A

Source Of Complaints OPMC Received Between
April 1, 2003 and August 31, 2005

| Number of Complaints | Description |
|---:|---|
| 8,840 | General Public |
| 2,102 | Out of State Actions (State Medical Boards, AMA) |
| 1,012 | Insurance - Malpractice |
| 943 | Education Department (General) |
| 692 | OPMC |
| 591 | Public Attorney |
| 531 | Bureau of Hospital Services |
| 376 | Hospital |
| 352 | Physician |
| 232 | Insurance Companies - Health |
| 225 | Anonymous |
| 117 | News Media |
| 88 | Other Health or licensed professionals |
| 61 | State (General) |
| 53 | Island Peer Review Organization |
| 40 | Medical Society State New York |
| 40 | Police Agency (State, County, City) |
| 34 | Other Health facilities |
| 31 | Special Prosecutor/Medicaid Fraud |
| 31 | Federal (General) |
| 29 | City/County (General) |
| 28 | Bureau of Controlled Substances |
| 21 | Physician Profiling |
| 20 | Bureau of Long Term Care |
| 19 | Courts Probation Department |
| 19 | Pharmacists |
| 9 | Police Agency (Federal) |
| 8 | OHSM/OPH general |
| 8 | Other licensed professionals |
| 3 | Department of Social Service (obsolete) |
| 1 | Bureau of Alternative Delivery Services |
| 16,556 | Total Complaints |

## APPENDIX A - AUDITEE RESPONSE

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
*Commissioner*

Dennis P. Whalen
*Executive Deputy Commissioner*

September 25, 2006

William P. Challice
Audit Director
Division of State Services
State Audit Bureau
123 William Street – 21st floor
New York, New York 10038

Dear Mr. Challice:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's (OSC) draft audit report on "Office of Professional Medical Conduct Complaints and Investigations Process" (2005-S-21).

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

cc: Mr. Graziano
Mr. Griffin
Mr. Howe
Mr. Murphy
Ms. O'Connor
Mr. Reed
Mr. Seward
Ms. Shure
Mr. Wollner

**Department of Health**
**Comments on the**
**Office of the State Comptroller's**
**Draft Audit Report 2005-S-21 on**
**"Office of Professional Medical Conduct**
**Complaints and Investigations Process"**

The following are the Department of Health's (DOH) comments concerning the recommendations contained in the Office of the State Comptroller's (OSC) draft audit report (2005-S-21) on "Office of Professional Medical Conduct Complaints and Investigations Process".

**Recommendation #1:**

Take steps to ensure that all complaints are received from the various reporting entities. To accomplish this OPMC needs to:

- establish a method of informing and reminding reporting entities of the importance of properly referring all cases of potential misconduct to OPMC, and
- routinely confirm with reporting entities that all cases have been received.

**Response #1:**

Of the two cases referred by the Department's Office of Medicaid Management (OMM), it was determined that one was fully investigated by Office of Professional Medical Conduct (OPMC) as a result of a complaint from a source other than OMM. In the second case, OMM acknowledged that it referred the matter to OPMC in error.

* Comment 1

The finding that OPMC did not investigate one of the 14 cases referred by the Office of the Attorney General (OAG) is not correct. OPMC received the referral from the OAG and appropriately reviewed the case. It appears that the referral was made to OPMC after the period of the audit. However, new procedures have been implemented with the OAG's office to ensure that all referrals are properly tracked and reconciled.

* Comment 2

OPMC reviewed the eight cases where an individual licensee was excluded from practicing under Medicare or Medicaid and OPMC had not taken action. Our analysis indicated that only one of the eight individuals is a New York State licensed physician. This physician was disciplined by the Board for Professional Medical Conduct based on charges of filing false claims to the Department of Social Services. The remaining seven individuals are licensees regulated by the Education Department. OMM is now providing OPMC with all "Notices of Immediate Agency Action," thereby negating the

* Comment 1

* See State Comptroller's Comments, page 23

need to review the Medicaid and Medicare web sites. All referrals will be routinely reconciled between the two programs.

Upon re-review of the 247 related fraud cases, OMM determined that their initial assessments were appropriate and no additional cases needed to be referred to OPMC.

As indicated in the response to the OSC's third preliminary report, OPMC staff at the regional office level appropriately reviewed three of the four cases at the time the complaint was filed. There was no failure to investigate the three referenced cases; there was a lapse in communicating the existence and appropriate disposition of the cases to OPMC central office for logging into the Case Management Information System (CMIS). The remaining case has since been closed.

Prior to 2006, the Bureau of Hospital Services (BHS) utilized a decentralized intake process to log complaints. Beginning in April 2006, the BHS implemented a centralized intake process for all complaints. OPMC and BHS developed procedures to ensure that hospital complaints will be appropriately referred to OPMC central intake. These procedures include measures for logging the complaint into OPMC's CMIS and reconciling all referrals between the programs.

The report implies that BHS and OPMC established new procedures as a result of the problems identified with the system that was in place during the time the referenced cases were received. Independent of the audit, BHS initiated programmatic changes to centralize its complaint intake system. Both programs recognized the potential for developing improved reporting relationships and began a dialogue to accomplish this common goal. The timing of the audit was a coincidence.

**Recommendation #2:**

Make better use of malpractice information as part of the investigation of potential cases of misconduct by:

- opening investigations into all cases which meet OPMC's existing malpractice criteria, including the 177 instances we identified during the audit,
- modifying the existing malpractice investigation criteria to include a frequency standard for the number of malpractice cases or payments a licensee may have,
- obtaining and using the OCA malpractice information as a source of malpractice information, and
- ensuring the use of comprehensive information when investigating cases involving malpractice.

**Response #2:**

In recognition of the need for more timely and accurate medical malpractice information, OPMC invested considerable effort and resources to develop and implement a web based Medical Malpractice Data Collection System (MMDCS) in 2003. This system is used by all required reporters to submit medical malpractice claim information to the Department. Prior to November 2005, OPMC relied on the National Practitioner Data Bank (NPDB) as the primary source for medical malpractice information.

Of the 177 cases identified as not being investigated by OPMC, the Department randomly reviewed 40 (25%) cases to determine if these cases were properly handled. We found that one-third of these cases were properly handled in our investigative operations. For the remaining two-thirds, we did not receive information from the NPDB; however, all remaining cases will be thoroughly examined.

We examined all of the 154 licensees who appeared on the Office of Court Administration (OCA) database and were not identified on MMDCS. Our analysis indicates that 107 licensees appear on MMDCS (53 of which match the licensee and plaintiff and 54 that match the licensee; the plaintiff information was not available).

Based on our understanding of the OCA data, we believe this data source is of limited value to OPMC. For example, the OCA data are utilized primarily as a court tracking system and are not archived. Once a case is settled, the information is deleted from the OCA database and is not recoverable. More importantly, the OCA data do not include clinical, event, severity and payment information.

* Comment 3

We supplement MMDCS with information from E-law to obtain a copy of the court docket that names all defendants. OPMC searches for other physicians and physician assistants to determine if any prior investigation of the incident has been conducted. E-law is derived from OCA data.

Based on the information reported by OSC, the MMDCS lacked malpractice data on nine tenths of one percent (154 of 17,000) of the potential licensees. We will continue to work with insurers and the Insurance Department to ensure reporting compliance with existing statutes.

During the past year, DOH has re-evaluated the criteria used to select medical malpractice cases for further review. We expect to modify the criteria to include a dollar threshold by physician specialty. We examined the frequency of claims, but have not yet decided if and how this variable may be implemented.

* See State Comptroller's Comments, page 23

**Recommendation #3:**

Establish procedures through which OPMC could proactively identify potential cases of misconduct for investigation.

**Response #3**

During the audit period, the OPMC received in excess of 16,000 complaints and completed 15,840 complaint investigations. The average complaint investigation was completed within 3.5 months and OPMC initiated nearly 700 investigations involving suspected professional misconduct based on information received from various sources.

OPMC has spent considerable effort the last several years evaluating and modifying investigative procedures to ensure that complaints are handled in an appropriate and timely manner. The Department receives in excess of 7,000 complaints per year. After a preliminary evaluation, those cases that appear to require limited time and resources are identified and resolved early in an investigation. Those cases that involve significantly more issues (such as those described in response to the fourth recommendation) require lengthier and generally more complex investigation.

The policies and procedures for initiating complaint investigations comply with our statutory obligation set forth in the Public Health Law. Specifically, Public Health Law section 230(10)(a)(i) states: *The board for professional medical conduct, by the director of the office of professional medical conduct, may investigate on its own* *<u>any suspected professional misconduct</u>* (emphasis added), *and shall investigate each complaint received regardless of the source.* As mentioned earlier, OPMC initiated nearly 700 investigations of suspected professional misconduct based on information received from various sources.

During the audit, OPMC asked for clarification and/or specific examples of procedures that OSC would recommend to enable OPMC to become more proactive in identifying and obtaining cases for investigation. While none were provided, it is our belief that OSC intends OPMC to be more proactive in "mining" various data currently used or some other yet unidentified data source to identify or profile physician practices without a suspicion that a physician may have committed misconduct. Currently, OPMC practice is to query various data sources only when other information of suspected misconduct has been identified.

* Comment 4

OPMC has been and will continue to be proactive in educating and making it easier for stakeholders to make complaints. Information is posted on OPMC's web site to provide easy access to information including complaint forms and brochures describing the physician discipline process. In addition, complete copies of final disciplinary actions are posted along with links to the New York State Physician Profile and Education Department web sites. A toll-free telephone number provides the public with

* See State Comptroller's Comments, page 23

convenient and affordable access to OPMC staff to receive information and complaint forms. Citing the importance of mandatory reporting, the Commissioner of Health has periodically written to all New York State hospitals reminding them of their statutory obligation to report suspected medical misconduct to OPMC.

We are not aware of any additional data systems or new procedures that can be implemented at this time that would provide a legal predicate for OPMC to initiate an investigation based on suspected professional misconduct.

Without specific recommendations from OSC, we will continue to assess our policies and procedures to ensure that all suspected cases of misconduct are identified and that they comport with existing statute.

**Recommendation #4:**

Take steps to ensure cases of potential misconduct are investigated in a timely manner. At a minimum, management should:

- develop a formalized time standard for investigations, and
- include as part of the new tracking system, adequate features to allow management to measure and compare regional offices' caseload, staffing and production.

**Response #4:**

The report indicates that approximately 7,600 complaints were received during the period. However, as indicated in Exhibit A of the report the number of complaints received during the period was 16,556. OPMC completed nearly 16,000 complaint investigations during this period and the average complaint investigation was completed within 3.5 months.

* Comment 5

The audit also found that 769 cases remained open for over one year and in some instances over two years before being resolved. Since case review procedures are structured on an annual basis, a better measure of open cases is our year-end data. As of December 31, 2005, 522 cases remained open for greater than one year.

We acknowledge that staff turnover/retirements has been an issue, especially in the New Rochelle Office, that resulted in excessive caseloads per investigator and delays in completing case investigations. Steps have been taken to remedy the staffing issues in New Rochelle and we expect staffing levels to return to normal levels in 2006. The audit identifies a manageable caseload per investigator of 35 - 40 cases. OPMC uses a target caseload of 40 - 45 cases per investigator for budgeting and personnel purposes.

* See State Comptroller's Comments, page 23

While OSC focused their review on quantifying the "age" of cases, no objective assessment was made to determine whether the timeframes for cases taking greater than a year were appropriate. As indicated in the audit, we have an informal target to resolve all cases within a year; however, we expect that a certain percentage of cases will appropriately take longer than a year to complete. Standardized case review procedures, which are described in more detail below were designed to identify inappropriate time lapses and take corrective action when appropriate.

* Comment 6

At first glance, mandating a timeline for investigating every complaint has appeal. However, our many years of experience investigating professional medical conduct has shown that many factors, some within our control and others which are not, significantly impact the time required to complete an investigation.

Our investigative approach is based in part on a model typically found in law enforcement and comports with statutory obligations. In lieu of establishing arbitrary, across-the-board or targeted time frames for all case investigations, our approach is based on a commonly accepted investigative premise. Each case presents a unique fact pattern and the resulting investigative "blueprint" needs to take into account those factors.

The examples noted below, while not exhaustive, need to be considered with respect to their impact on the timeframe for completing an investigation.

- Number of subject physicians involved in an investigation
- Number of alleged cases of misconduct to be investigated
- Coordination of investigative activities with other offices/agencies including law enforcement
- Availability, number and cooperation of witnesses to be contacted and interviewed
- Number, volume and availability of medical records to be secured and reviewed
- Retention of legal counsel by respondent
- Potential legal challenges especially with respect to requested information
- In the case of alleged negligence – the complexity of medical care involved in the case
- Availability and volume of collateral information/material
- Availability of medical experts to review and opine on a case in a timely manner
- Availability of medical experts in certain specialties (e.g., heart and liver transplant experts, pediatric neurologists)
- Retention of multiple experts
- Additional complaints received during the course of an ongoing investigation

* See State Comptroller's Comments, page 23

OSC notes that OPMC follows a standard investigative process, typically including information gathering, interviewing and supervisory review stages. While accurate in the broad sense, these general activities are assessed for each case based on the unique facts presented and an investigative strategy is then developed.

Requests for medical records, witness interviews, subject interviews and expert reviews are performed regularly; however, the amount of time to complete each activity varies considerably from case to case. While these activities translate into standardized functions for staff and are highly inter-related, the time to complete each activity is specific to the needs of each investigation.

For example, investigation of a complex clinical case may involve multiple physicians, patients, facilities and specialists, each of which must be considered and may require additional time and effort. In these cases it would not be appropriate to expect that an expert can review selected cases and return a final report to OPMC within 30 days. An expert's review is impacted in part, by his availability, the number of cases selected for review, the complexity of the medical care (i.e. organ transplant care vs. primary care) and interview of the subject which may have occurred in several sessions over a multi-month period. Our procedures require that an expert be engaged immediately upon a determination that the case needs to be reviewed by an expert.

In cases of alleged fraud or sexual abuse, decisions regarding the timing of interviews (subject, complainant or witnesses) are directly related to the specific allegations and fact patterns developed during the investigation. These are but a few of the many examples that illustrate the complexities or nuances associated with establishing arbitrary timelines for various stages of the investigation.

OPMC has implemented a series of procedures during the past several years that are designed to ensure that cases are thoroughly investigated and completed in a timely manner. These procedures allow management to objectively determine for every case whether key investigative functions were performed adequately and timely.

In 2003, OPMC implemented an initiative referred to as "streamlining." The objective of streamlining is to identify early in the investigative process (within 120 days) those cases that have potential for prosecution and marginal cases that do not. As part of this initiative, procedures were put in place that formally delegated authority to the program director/unit supervisor, in concert with the assigned investigator, for making these determinations based on the unique circumstances presented.

Case assignments and investigative decisions are generally made at the local/unit level. The program director/unit supervisor is tasked with making the decision to proceed with an investigation, administratively close a case or present the case to an investigation committee of the Board for Professional Medical Conduct. We require reviews of cases and caseloads by the program director/unit supervisor every 120 days.

The Director and Assistant Director of Investigations annually conduct on-site case reviews with investigative staff and program directors statewide. The focus of these reviews is to provide management with the opportunity to meet face-to-face with investigators and program directors to evaluate the following: case progress, impediments to timely case completion and appropriateness of investigative activities. These case reviews include a 100% review of all open cases in each area office, statistical accomplishments and an assessment of compliance with OPMC policies and procedures. The results are shared with the directors of the Department's area offices.

* Comment 6

The Department disagrees with OSC on developing formalized time standards for case investigations. We believe that the formal case management and review protocols cited above provide far greater protection to the public for ensuring thorough, objective and timely completion of investigations than arbitrary timelines.

**Recommendation #5:**

Perform a cost benefit study to determine the resources needed, as well as any other changes, to meet the standards developed for timely completion for investigations. The study should produce an action plan to address all identified needs.

**Response #5:**

The safeguards and operational procedures that have been implemented adequately protect the public. OPMC continually assesses resource needs and actively strives to deploy the necessary resources to meet our objectives. OPMC will perform a cost benefit study to re-assess our resource needs in relation to anticipated caseloads.

* See State Comptroller's Comments, page 23

## APPENDIX B - STATE COMPTROLLER COMMENTS ON AUDITEE RESPONSE

1. Certain matters included in this draft audit report were changed or deleted based on the Department's response.

2. Neither during the audit, nor as part of its response, did the Department provide any evidence that the case in question, was, in fact, investigated. Nevertheless, we are pleased to see that the Department is taking action to ensure that all referrals are properly tracked and reconciled.

3. Department officials are correct that the Office of Court Administration's (OCA) malpractice data does not contain clinical, event, severity and payment information. However, the OCA information does contain malpractice information on licensees who are subject to review and discipline by OPMC. We therefore recommend that OPMC use this information to supplement the information it is already receiving on malpractice actions.

4. Data mining is a primary tool that we believe OPMC could use to proactively identify cases that warrant investigation for potential misconduct. We maintain that OPMC's practice to query data sources only when information of suspected misconduct has been identified can allow a licensee who potentially committed an act that rises to the level of misconduct, to go undetected.

5. We clarified our report to reflect that OPMC initiated an investigation for approximately 7,600 of the 16,556 complaints it received.

6. We agree that the cases OPMC investigates are unique. We recognize that there will be cases that will take longer to complete but these should be the exception rather than the norm. However, absent any formal time standards, OPMC management is not in a position to evaluate the efficiency and effectiveness of its operations. We therefore recommend that OPMC take steps to ensure cases of potential misconduct are investigated in a timely manner, and, more specifically, that they develop formalized time standards for investigations.