Medical Malpractice Practice Risk Assessment (Brief)

****It is not feasible to review every possibility for malpractice risk in the time allowed for this assessment. We will endeavor to give as much information as possible about areas reviewed and those not reviewed that appear to pose potential risk, but cannot guarantee that every malpractice risk will be identified.**

Practice: _____ **Date:**_____

_____	_____	_____
Reviewer	Time Start	Time Stop

Practice Compliance Plan (What is Contained)

- ☐ Code of Conduct
- ☐ Written Policies and Procedures
- ☐ Designated Compliance and Privacy Officers
- ☐ Lines of Communication (Reporting of Fraud & Abuse, Sexual Harassment, Impaired Physician, OSHA Issues)
- ☐ Disciplinary Enforcement (For All Employees – Including Providers)
- ☐ Routine use of OIG Exclusion Lists In New Hire Process
- ☐ Compliance with Federal Anti-Kickback Statute (In contractual arrangements, and billing areas)
- ☐ Compliance with Stark I & II

Internal Audit Process – Review Results

- ☐ Physically Audit sampling of records for NCQA & HEDIS documentation standards as well as documentation
- ☐ See NCQA Documentation Standards Sheet
- ☐ Results of Audit:

CLIA

- ☐ Certificate appropriate for level of labs performed (if appropriate)
- ☐ Employee education and training
- ☐ Qualified lab oversight
- ☐ Calibration of Equipment & Quality Assurance

Human Resources

- ☐ All practitioners (physicians, NPP's, Allied Health Professionals) duly licensed and/or certified
- ☐ Employee Manual Existence
- ☐ Content and Distribution – Last Updated

HIPAA Compliance & Record Maintenance

- ☐ Records Disposal Protocol
- ☐ Charts Not Removed From Office

Chart Documentation

- ☐ All patient contacts (phone calls, faxes, etc.) documented in Medical Record
- ☐ Chart entries signed and dated
- ☐ Chart corrections made appropriately
- ☐ Existence of Signature Log For Practice
- ☐ Compliance with Prescription Drug Marketing Act
- ☐ Prescription Sample Storage – Process for Eliminating and Destruction of Outdated Samples
- ☐ Documentation that results of tests were reviewed by ordering physician
- ☐ Documentation Supports Level of Service Billed (part of physical audit)

Patient Care

- ☐ Policies and Procedures For Triage
- ☐ Emergencies (In Office and By Phone) (Physician Involvement?)
- ☐ Length of Time For Acute Appointment
- ☐ Length of Time For Non-Acute Appointment
- ☐ Prescription refills (including name and dosage of drug, pharmacy, who refilled, etc.)
- ☐ Prescription Pad storage – out of patient reach?
- ☐ Process For Tracking Ordered Tests
- ☐ Mechanism to notify patient of results
- ☐ Process for tracking missed appointments
- ☐ Communication regarding patient's condition, status, etc.:
- ☐ Documented by the physician, NPP or ancillary staff in the medical record.
- ☐ Such communications are dated and timed.
- ☐ Equipment Safety & Maintenance
- ☐ Sterilization Logs
- ☐ Incident Reports for Patients and Staff

Patient Relations

- ☐ Process For Addressing Patient Non-Medical Concerns and Issues
- ☐ Patient Satisfaction Survey? Last Done? Changes Made?
- ☐ Discharge of patient from the practice complies with non-abandonment criteria (in writing to the patient – time to find alternative care – written warning of ongoing health problems that require follow up)
- ☐ Coverage process and after hours contact process

OBSERVATIONS:_____

RECOMMENDATIONS: _____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Reviewer Date

☐ Copy to Practice