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Although relatively infrequent, claims against ophthalmologists arising from the screening for or treatment of ROP can be costly. There have been several published accounts of multi-million dollar awards and settlements in recent years, and OMIC’s average payout for ROP-related claims is significantly higher than the average settlement for any other ophthalmic activity. A large ROP judgment or settlement against you could have devastating effects on you.

**To reduce your risk of ROP-related claims and improve our ability to defend you should one arise, the company has developed underwriting requirements for physicians who render ROP services to infants less than 50 weeks post-menstrual age (gestational age plus postnatal age).**

**1** Describe your training and experience specific to ROP, including fellowship training (if any). Date completed

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**2** You must complete at least one clinical course specific to ROP every five years. List all continuing education courses specific to ROP that you have completed during the past 5 years: Date completed

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OMIC has identified and evaluated an online ROP course that provides training in the ocular findings and clinical considerations critical to ROP management. The course was created by FocusROP at [www.focusrop.com](http://www.focusrop.com) and offers 3 AMA PRA Category 1 credits. The fee for this course is \$150; however, we will pay the fee on behalf of OMIC insureds who successfully complete the course. Participation in FocusROP is voluntary. If you are interested in completing this course, please contact Paul Weber, JD, ARM, OMIC VP of Risk Management, at [pweber@omic.com](mailto:pweber@omic.com) or (800) 562-6642, ext. 603, to begin the registration process. Completion of this course qualifies insureds for a risk management discount.

**3** Which ROP services do you render to infants less than 50 weeks post-menstrual age? (Check all that apply.)

live screening – primary screener     
  live screening – backup screener     
  live screening – on rotation  
 remote screening\*     
  treatment

\*OMIC’s professional liability policy extends coverage to ophthalmologists who provide ROP services when they use binocular indirect ophthalmoscopy (BIO) to determine an infant’s ROP status. Ophthalmologists who provide care at hospitals with retinal cameras may use the cameras as part of their documentation of the ROP exam. Coverage also applies to insureds who provide second opinions by reviewing retinal photographs taken in conjunction with another ophthalmologist’s BIO exam. However, the policy specifically excludes coverage for “remote screening” (i.e., evaluation of an infant’s ROP status by reviewing retinal photographs taken in the absence of a BIO exam.)

**Coverage for “remote screening” is available only by special endorsement** and is subject to review and approval of a supplemental questionnaire and adherence to OMIC’s underwriting requirements applicable to remote ROP screening.

- 4
- A. If you are the primary screener, who provides backup? \_\_\_\_\_
- B. If you are the backup screener, who provides primary screening? \_\_\_\_\_
- C. If you screen on rotation, who are the other screeners? \_\_\_\_\_
- D. Do you supervise residents or fellows involved in ROP screening or treatment?  Yes  No

5 Indicate your approximate ROP volume below:

	Next 12 Months	Last Year	Past 5 Years
A. Screenings – live	_____	_____	_____
B. Screenings – remote	_____	_____	_____
C. Treatments	_____	_____	_____

Volumes above reflect the number of  infants  exams/treatments

6 For each hospital for which you provide ROP services, please indicate in the chart on page 3 the following information:

A. The NICU level. The official definition of NICU designations may vary from state to state. The following descriptions are provided as examples only. **Please list the highest level that applies.**

**Level 1** Well-newborn nursery that provides basic care to low-risk infants.

**Level 2** Nursery that provides specialty care to mildly ill infants who are at moderate risk of serious complications but whose problems are expected to resolve quickly. **Level 2B** can provide mechanical ventilation for short durations or continuous positive airway pressure. **Level 2A** nurseries do not have the capability to provide assisted ventilation except on an interim basis.

**Level 3** Nursery that provides subspecialty intensive care to high-risk infants. **Level 3A** nurseries provide care for infants with birth weights > 1000 grams and gestational age > 28 weeks. Continuous life support can be provided but is limited to conventional ventilation. **Level 3B** nurseries can provide comprehensive care for extremely low birth weight infants ( $\leq 1000$  g and  $\leq 28$  weeks gestation), advanced respiratory care, on-site access to pediatric medical specialists, and advanced imaging and have pediatric surgical specialists on-site or at a closely related institution. **Level 3C** facilities have the same capabilities as **3B** and are located within institutions that can provide ECMO (extracorporeal membrane oxygenation) and surgical repair of serious congenital cardiac malformations.

B. The approximate number of screenings and/or treatments you performed at this hospital within the past year.

C. Whether the hospital has a written protocol assigning responsibility for each task in the ROP process. OMIC has developed sample protocols for both hospital- and office-based screening. "Retinopathy of Prematurity: Materials for Creating a Hospital ROP Safety Net" and "Retinopathy of Prematurity: Materials for Creating an Office ROP Safety Net" are available at [www.omic.com](http://www.omic.com). Please contact OMIC's Risk Management Hotline for assistance at (800) 562-6642, option 4.

D. Whether the hospital maintains an ROP tracking system.

E. Whether the hospital has a qualified ROP coordinator (ROPC). An ROPC is a person with clinical knowledge and understanding of ROP, such as a NICU nurse or neonatologist, who assumes the responsibility for tracking infants until they meet end-of-screening/treating criteria (per the Policy Statement) or have been transferred to the care of an ophthalmologist in the office or another hospital. The ROPC should be someone other than the screening ophthalmologist. A sample Hospital ROPC Job Description is included in Appendix C of "Retinopathy of Prematurity: Materials for Creating a Hospital ROP Safety Net."

F. Whether you are notified by the neonatologist prior to discharge or transfer of infants who meet screening or treatment criteria so that you can make and document follow-up recommendations.

G. Whether the hospital has a treating ophthalmologist on staff (OS) or a formal standing transfer agreement (STA) with a hospital with an ophthalmologist who can treat the infant:

Hospital	A. NICU level	B. Screened (#)	B. Treated (#)	C. Written Protocol (Y/N)	D. Tracking System (Y/N)	E. ROPC (Y/N)	F. Discharge/transfer notification (Y/N)	G. Treating MD on staff or by transfer (OS/STA)

(Continue on a separate page, if needed.)

H. Please explain your “no” responses for Question 6C-G:  Not applicable (all responses are “yes”)

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7 Do you have a written protocol for office-based ROP services?  Yes  No  Not applicable (do not provide office-based services)

OMIC has developed sample protocols for both hospital- and office-based screening. “Retinopathy of Prematurity: Materials for Creating a Hospital ROP Safety Net” and “Retinopathy of Prematurity: Materials for Creating an Office ROP Safety Net” are available at [www.omic.com](http://www.omic.com). For assistance, contact OMIC’s Risk Management Hotline at (800) 562-6642, option 4.

8 Are office staff members who answer phones:

- A. Aware that you evaluate and/or treat premature babies with ROP?  Yes  No
- B. Aware of the consequences of a delay in screening or treatment?  Yes  No
- C. Trained how to identify calls about patients who might need ROP screening or treatment so they can be scheduled appropriately (i.e., do they ask if the infant is premature)?  Yes  No

A sample Office ROP Contact Form is available in OMIC’s “Retinopathy of Prematurity: Materials for Creating an Office ROP Safety Net” (Form 1).

9 Do you ever use Avastin in the treatment of ROP?  Yes  No  Not applicable (do not treat)

**If yes**, in approximately what percentage of treatments? \_\_\_\_\_%

**To be eligible for coverage of ROP services, you must comply with the following underwriting requirements (items 10–19, below). Please initial each item to confirm your understanding and agreement to abide by these requirements. Failure to comply with OMIC’s underwriting requirements (other than deviations specifically approved by OMIC) or to notify OMIC promptly of changes in your ROP protocol may result in uninsured risk or termination of coverage.**

10 You must **use the International Classification of Retinopathy of Prematurity (ICROP) Revised** to classify, diagram, and record the retinal findings. ICROP Revised is published in Appendix B of OMIC’s “Retinopathy of Prematurity: Materials for Creating a Hospital Safety Net” and “Retinopathy of Prematurity: Materials for Creating an Office ROP Safety Net,” both of which are available at [www.omic.com](http://www.omic.com).

Initial: \_\_\_\_\_

11 The attached **“Dear Caregiver” letter** (Form 2 of OMIC’s “Retinopathy of Prematurity: Materials for Creating a Hospital Safety Net and Form 3 of OMIC’s “Retinopathy of Prematurity: Materials for Creating an Office ROP Safety Net”) **or a similar form must be completed** for each infant examined, and the caregiver should be asked to sign the form, prior to the infant’s discharge from the hospital and upon the initial outpatient examination. The handout is intended as a supplement to, and not a replacement for, communication with the caregiver. It serves as an important educational tool to explain the ROP process and the importance of timely follow-up. OMIC believes that use of a handout and associated parent education will help reduce the possibility of missed appointments.

Initial: \_\_\_\_\_

12 Unless care has been duly transferred to another ophthalmologist as outlined below, you must **screen each infant until both eyes have met the conclusion-of-acute-phase-ROP screening criteria or until a treating ophthalmologist has verified that treatment and all follow-up examinations have been completed** (based upon criteria established in “Screening Examination of Premature Infants for Retinopathy of Prematurity,” the Policy Statement issued by the American Academy of Pediatrics (AAP) Section on Ophthalmology, the American Association of Pediatric Ophthalmology and Strabismus (AAPOS), and the American Academy of Ophthalmology (AAO). Originally issued in 1997 and updated in 2001 and 2005, the Policy Statement is published in *Pediatrics* (Volume 117, Number 2, 2006, [www.pediatrics.org/cgi/doi/10.1542/peds.2005-2749](http://www.pediatrics.org/cgi/doi/10.1542/peds.2005-2749).)

Not applicable (do not screen)

Initial: \_\_\_\_\_

13 The **maximum time interval between exams** for infants less than 42 weeks post-menstrual age must be no longer than 3 weeks (in accordance with the Policy Statement).

Not applicable (do not screen)

Initial: \_\_\_\_\_

14 When referring or transferring care of any infant 50 weeks postmenstrual age or younger to another ophthalmologist (such as from inpatient screener to outpatient screener or from screener to treater), you must **conduct and document a transfer-of-care discussion** with the next ophthalmologist, conveying the urgency of the referral, and ensure that he/she has copies of the patient’s previous examinations and has agreed to provide the care in the necessary time frame.

Not applicable (do not refer or transfer care)

Initial: \_\_\_\_\_

15 You must personally **maintain a system that tracks each infant** from the time of the first visit (whether in the hospital or in the office) until the child has met the end-of-acute screening criteria of the Policy Statement or you have formally transferred care to another ophthalmologist. Studies have shown that redundancy creates safety. To create a “safety net” and minimize the risk of an infant being lost to follow-up, tracking must *also* be done by someone else in your office *and* in the hospital. Your tracking system must include the following elements:

- A. Your practice must have an assigned office staff coordinator who is responsible for tracking ROP appointments in the hospital, scheduling ROP appointments in the office, and tracking no-shows. This ROP coordinator must be familiar with the Policy Statement and use it to review the appropriateness of follow-up intervals. OMIC has developed a sample Office ROPC Job Description, available in Appendix C of “Retinopathy of Prematurity: Materials for Creating an Office ROP Safety Net.”
- B. Your tracking system must be updated each time the baby is evaluated or treated.
- C. Your tracking system must be evaluated on a routine basis (at least once a week while infants are actively being screened or treated) to ensure that all follow-up appointments are scheduled and kept.
- D. You must indicate the follow-up interval in the office chart. This should be expressed both in terms of time interval and date (e.g., two weeks, around May 2, 2010). The interval must be consistent with the Policy Statement: the longest period is 3 weeks, but many infants will need to be seen sooner than that.
- E. The next office appointment must be scheduled before the caregivers leave the office.
- F. Appointments must be reviewed on a daily basis, and you must be notified immediately of any changes in ROP appointments, including non-shows and cancelled or rescheduled appointments.
- G. All follow-up efforts for missed, cancelled, or rescheduled appointments must be documented. (See Form 4 of “Retinopathy of Prematurity: Materials for Creating an Office ROP Safety Net” for a sample “missed appointment” letter.)

Initial: \_\_\_\_\_

**The following requirements (16–19) apply to hospital-based ROP care.**

Not applicable (no hospital-based care rendered)

**16** You and your office must **track ROP appointments** (see number 15 above). Initial: \_\_\_\_\_

**17** You must **include an ROP consult note** in the infant's hospital chart at the time of each examination or treatment using the terminology of ICROP Revised. Initial: \_\_\_\_\_

**18** You must **indicate the follow-up interval** in the hospital chart. This should be expressed both in terms of time interval and date (e.g., two weeks, around May 2, 2010). The interval must be consistent with the Policy Statement: the longest period is 3 weeks, but many infants will need to be seen sooner than that. Initial: \_\_\_\_\_

**19** You must **personally notify the neonatologist and/or ROP Coordinator and document the recommendation** to begin treatment in the hospital record. If you do not provide treatment, you must conduct and document a transfer of care discussion with the treating ophthalmologist. If the hospital does not have a treating ophthalmologist on staff, you must write an order for an urgent consultation with a treating ophthalmologist so that the infant may receive treatment within 48 to 72 hours, consistent with the Policy Statement. To prevent a delay in treatment, the hospital must have a formal transfer agreement with an area hospital that does provide treatment. Initial: \_\_\_\_\_

OMIC has developed the following ROP resource materials, available online at [www.omic.com](http://www.omic.com), to assist ophthalmologists. OMIC policyholders may also call the Risk Manager for confidential assistance at (800) 562-6642, extension 641 (option 4 from the main menu).

Retinopathy of Prematurity: Materials for Creating a Hospital Safety Net

Retinopathy of Prematurity: Materials for Creating an Office ROP Safety Net

Office ROP Contact Form

Sample ROPC Job Descriptions (NICU and office)

"A 'Watchful Eye' on ROP" (Lead article, Winter 2010 *Digest*)

"ROP Case Defines Legal Duty of Care to Patients" (Lead article, Summer 2005 *Digest*)

"Shared Liability Limit for ROP Screening" (Policy Issues article, Fall 2003 *Digest*)

"Staggering ROP Awards Scaring Doctors Away" (Lead article, Summer 2001 *Digest*)

The "Watchful Eye," a hospital-based program for timely screening and follow-up of ROP developed by St. Luke's Hospital & Health Network in Bethlehem, PA, is also available at [www.omic.com](http://www.omic.com).

Please initial the statement below that describes your compliance with the above underwriting requirements:

\_\_\_\_\_ I have read and currently comply with OMIC's underwriting requirements specific to retinopathy of prematurity (ROP).

\_\_\_\_\_ I have read and currently comply with OMIC's underwriting requirements specific to retinopathy of prematurity (ROP), with the exception of the following:

Item Number	Explanation
_____	_____
_____	_____
_____	_____

I expect to be in full compliance by \_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Name (Please type or print.)

## "Dear Caregiver" Letter

*Note to Ophthalmologist: Place on Letterhead*

Dear \_\_\_\_\_,

At the request of the neonatologist (baby doctor) caring for your baby, I performed an eye exam on your infant. I am part of a group of ophthalmologists (eye doctors) who help the hospital care for premature infants. This information explains why this eye exam was necessary, and when the baby will need to be examined again.

### What is Retinopathy of Prematurity (ROP)?

The eye functions much like a camera. The front of the eye contains the structures which focus the image and regulate the amount of light that enters the eye, similar to the lens and shutter of a camera. The retina in the back of the eye functions like the film in the camera. Without film, a camera cannot take a picture, and without a functioning retina, the eye cannot see.

ROP is a potentially blinding disease that affects several thousand premature babies each year in the United States, usually the smallest, youngest, and sickest infants. When a baby is born prematurely, the retina is only partially formed. The blood vessels have grown into the retina at the very back of the eye but not into the rest of the retina. The first stage of ROP is when the blood vessels stop growing and form a line that separates normal from premature retina. In the second stage, the line of separation takes on substance as an elevated ridge of tissue. As the ROP advances into the third stage, fragile new abnormal blood vessels grow toward the center of the eye. At this point, the eye is still capable of repairing itself. If this third stage advances even more, the normal vessels dilate, indicating that the ROP may not go away on its own. This is known as "plus disease." If enough retina has third stage ROP and "plus disease," then treatment is needed. If untreated, ROP can cause the retina to pull away from the back of the eye (a retinal detachment), which can lead to blindness.

### When ROP develops, one of three things can happen:

1. In most babies who develop ROP, the abnormal blood vessels will heal themselves completely, usually during the first year of life.
2. In some babies, the abnormal blood vessels heal only partially. In these infants, nearsightedness, lazy eye, or a wandering eye commonly develops. Glasses may be required in early life. In some cases, a scar may be left in the retina, resulting in vision problems that are not entirely correctable with glasses.
3. In the most severe cases, which occur in the youngest, smallest, and sickest infants, the abnormal blood vessels form scar tissue, which pulls the retina out of its normal position in the back of the eye. This problem results in a severe loss of vision. Fortunately, there is treatment to minimize severe vision loss. In about 1 out of 4 babies, despite all treatment, this condition can lead to blindness.

### What About Your Baby's Eyes? (Read the paragraph checked below.)

\_\_\_\_\_ Your infant's eyes have mature blood vessels and are at a low risk for developing ROP. He/she should have another eye exam by an ophthalmologist in **six months** on about \_\_\_\_\_ (**approximate date**). Other eye diseases, such as cross-eyes, lazy eye, and extreme nearsightedness, occur more frequently in premature infants and may only become apparent when the infants are 8 to 12 months of age.

**It is your responsibility to arrange this follow-up eye exam for your baby. Please ask your pediatrician for a referral.**

\_\_\_\_\_ Your baby does not have ROP but could develop problems later because the retinal blood vessels are still not fully mature. Your baby should have an ROP exam again in \_\_\_\_\_ **days** or \_\_\_\_\_ **weeks** on \_\_\_\_\_ (**date**).

\_\_\_\_\_ Your baby has early ROP. The ROP is not severe and does not require treatment at this time. To watch for possible serious developments, your baby should have an ROP exam again in \_\_\_\_\_ **days** or \_\_\_\_\_ **weeks** on \_\_\_\_\_ (**date**).

\_\_\_\_\_ Your baby has active ROP and is being monitored closely, at least once a week, to see if treatment is needed. If your baby needs treatment, it must be provided within 48 to 72 hours. Your baby should have an ROP exam again in \_\_\_\_\_ **days** or \_\_\_\_\_ **weeks** on \_\_\_\_\_ (**date**).

\_\_\_\_\_  
*Ophthalmologist's Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Ophthalmologist's Name (Please type or print.)*

**HOW THOSE CARING FOR A PREMATURE BABY CAN HELP**

**ROP can develop very rapidly, so this appointment should not be changed or rescheduled.**

**Please call our office right away if you cannot keep the appointment (for example, if your baby is sick at the time).**

**Missing this appointment may result in blindness in your baby.**

I have read and understand the information on this sheet:

\_\_\_\_\_

*Parent/Caregiver/Guardian's Signature*

\_\_\_\_\_

*Date*

\_\_\_\_\_

*Parent/Caregiver/Guardian's Name (Please type or print.)*

**Parent/Caregiver/Guardian: This is your copy to keep**