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**ROP Conditions of Coverage**

**Reviewed by Betsy Kelley, Vice President of Product Management**

**Coverage for remote screening of ROP using telemedicine only is excluded in the OMIC policy.**

Telemedicine uses remote digital fundus imaging (RDFI) instead of a binocular indirect ophthalmoscopy (BIO) exam to evaluate an infant’s ROP status. Your OMIC policy does cover you to review images as part of the documentation of the ROP exam, or to provide a second opinion by reviewing photos taken in conjunction with another ophthalmologist’s BIO exam. However, if you will at times use photos instead of a live exam, you must apply separately for remote ROP coverage.

Infants screened using telemedicine only must have a BIO exam to confirm that they have met end-of-screening criteria. This BIO exam must take place either prior to discharge or in the outpatient setting within 72 hours of the last photograph if referral-warranted or within one week after the last photograph if not referral-warranted. Infants are eligible for an outpatient BIO exam only if the parent or legal guardian have signed an agreement to bring the child to all scheduled outpatient appointments; the parent or legal guardian have been notified that Child Protective Services (CPS) will be contacted if they don’t bring the infant as requested, and the ophthalmologist has a written protocol on how and when to contact CPS and report possible child neglect.

**Version 04/01/2022**

OMIC has created toolkits known as the ROP Safety Net. We are often asked to clarify which parts of the Safety Net are requirements that must be met as a condition of coverage, and which are recommendations to improve patient safety and decrease liability exposure. This document summarizes the conditions of coverage that appear in the ROP application; see that application for a complete discussion of the requirements. They do not appear here in the same order as in the application. Instead, they follow the process of care: tracking, exam, follow-up, and treatment.

## **Maintenance of clinical competency**

Insured ophthalmologists must take and pass the FocusROP course once every five years. OMIC pays the registration fee and offers a risk management premium discount. To enroll, please contact Risk Management Coordinator Linda Nakamura at [lnakamura@omic.com](mailto:lnakamura@omic.com) or 800-562-6642, extension 652.

# **Tracking of ROP care**

* The physician’s office **and** the hospital must maintain a system that tracks each infant.
  + Begin tracking at the time of the first visit (whether in the hospital or office)
  + Track the infant until:
    - The child has met the conclusion-of-acute-phase-ROP screening criteria.
    - You have formally transferred care to another ophthalmologist.
* The infant must be tracked by at least one person in the hospital and at least one person in the ophthalmologist’s office. We call these trackers the ROP coordinators; H-ROPC refers to the person in the hospital and O-ROPC the one in the office. The physician must be personally involved in tracking.
  + The ROPCs must be familiar with the 2018 AAP/AAO/AAPOS Policy Statement (PS)[[1]](#endnote-1) use it to review the appropriateness of follow-up intervals.
    - The H-ROPC tracks ROP appointments in the hospital and contacts the O-ROPC to schedule the first outpatient appointment.
    - The O-ROPC tracks ROP appointments in the hospital, and schedules, tracks, and follows up on ROP appointments in the office.
* The tracking system must be:
  + Updated every time the baby is evaluated or treated.
  + Evaluated by both ROPCs together **at least once a week** while infants are being actively screened or treated to ensure that all follow-up exams are scheduled and performed.

# **ROP exams**

* Include an ROP consult note in the infant’s chart at the time of each exam. Use ICROP (International Classification of Retinopathy, Third Edition)[[2]](#endnote-2) to classify, diagram, and record the retinal findings.
* Send a letter to the parent or legal guardian for each infant examined:
  + Prior to discharge from the hospital **AND** at the first outpatient appointment.
  + You may write an order for the H-ROPC to give the letter to the parent or legal guardian in the hospital.
  + Sample letters are included in the ROP toolkit.
* Screen until one of the following conditions has been met:
  + Both eyes have met the conclusion-of-acute-phase-ROP screening criteria
  + A treating ophthalmologist has verified that all treatment and follow-up examinations have been completed
  + Care has been formally transferred to another ophthalmologist
* Conduct and document a transfer-of-care discussion with the next ophthalmologist when referring or transferring care of any infant 55 weeks postmenstrual age (PMA) or younger.
  + Convey the urgency of the referral.
  + Ensure that the ophthalmologist has copies of/access to the records of prior examinations.
  + Confirm that the ophthalmologist has agreed to take over care in the necessary time frame.

# **Follow up of ROP care**

* Indicate the follow-up interval in the hospital or office medical record, and give both the interval and approximate date (e.g., in two weeks, on approximately 7/14/22).
  + The follow-up period must be consistent with the PS. It must not exceed 3 weeks.
* Schedule the next outpatient appointment before the parent or legal guardian leave the office.
* Review outpatient appointments on a daily basis.
* Notify the ophthalmologist immediately of any change in ROP appointments, including no-shows and cancelled or rescheduled appointments.
* Document all follow-up efforts in the medical record.

# **Treatment**

**Screening ophthalmologist’s obligations (if does not treat ROP)**

* Notify the neonatologist and/or H-ROPC when treatment might be needed, and document the recommendation.
* Write an order for an urgent consultation with a treating ophthalmologist, indicating that treatment must take place within 48 to 72 hours if it is needed.
* Conduct and document a transfer-of-care discussion with the treating ophthalmologist.

**Ophthalmologist’s obligations if infant is treated with anti-VEGF medication**

* Follow infants closely until at least 65 weeks PMA. At 65 weeks PMA, screening may end if either of these endpoints has been reached:
  + Full vascularization in close proximity to the ora serrata for 360° **OR**
  + The avascular retina has been successfully treated with laser (e.g., no skip areas).
* Use professional judgment on continued monitoring in the following circumstances if no treatment endpoint has been reached at 65 weeks PMA.
  + Low-grade disease that is clearly and slowly improving
  + Stage 1 disease that is unchanged for 2 months
  + No disease, no ROP, but incomplete vascularization
  + Infant has a DNR order

**Hospital obligations**

* Either have a treating ophthalmologist with staff privileges or have a standing agreement with a hospital that does have a treating ophthalmologist who can provide treatment within 72 hours.

**UNDERWRITING ASSISTANCE**

Contact your underwriter for any questions about coverage. [Find my underwriter](https://www.omic.com/policyholder-services/contact-my-rep/underwriting/) can give you the name, email address, and phone number of the underwriter for your state.

**RISK MANAGEMENT ASSISTANCE**

OMIC policyholders may obtain confidential risk management help by contacting OMIC’s Risk Management Hotline at 800.562-6642, option 4, or by emailing us at riskmanagement@omic.com

1. Fierson WM, American Academy of Pediatrics (AAP) Section on Ophthalmology, American Academy of Ophthalmology, American Association for Pediatric Ophthalmology and Strabismus, American Association of Certified Orthoptists. Screening Examination of Premature Infants for Retinopathy of Prematurity. [Policy Statement.] *Pediatrics*. 2018;142(6):e20183061. Available at: <http://pediatrics.aappublications.org/content/142/6/e20183061> (Accessed: 3/16/22) [↑](#endnote-ref-1)
2. Chang MF, Quinn GE, Fielder AR, Wu WC, Zhao P, Zin A, *et al*. International Classification of Retinopathy of Prematurity, Third Edition. *Ophthalmology*. 2021;128(10):E51-E68. Available at: <https://doi.org/10.1016/j.ophtha.2021.05.031> (Accessed: 3/10/22) [↑](#endnote-ref-2)