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Ophthalmic Risk Management Digest

OMIC DIGEST

Assuring Safe Passage Through the Healthcare System

By Anne M. Menke, RN, PhD
OMIC Risk Manager

During our recent OMIC Forum on "Shared Care" at the AAO annual meeting, Dr. Steven Brown presented the following case involving four competent, experienced physicians. A primary care physician (PCP) referred an elderly gentleman to a comprehensive ophthalmologist (CO) for evaluation of a grey spot in his eye. After diagnosing a melanoma, the CO referred the patient to a retina specialist for confirmation and treatment options. The retina specialist offered the patient a choice between radiation and enucleation, and reported back that the patient chose enucleation. The CO then referred the patient to an oculoplastic surgeon for the procedure, which was completed two weeks after the initial ophthalmological evaluation. So far, the patient had received timely, effective, well-coordinated care. Nonetheless, when the patient died from metastatic disease that was diagnosed by his PCP eight months after his eye was removed, his family requested the medical records and concluded that the care was negligent. They reached their conclusion after finding a report from the retina specialist to the CO, advising him of the need for tests to monitor for metastasis. The family proceeded to sue the PCP, CO, and oculoplastic surgeon, alleging failure to follow-up and coordinate care. Investigation revealed that all three physicians knew the patient was at risk for metastatic disease, and knew which tests to order to monitor for it. Yet no one took the responsibility to clarify who was in charge, and none of them ordered the necessary tests. The oculoplastic surgeon testified that he had explained the need for follow-up to the patient but did not provide his recommendations in writing or document them in his record. No doubt the patient was not able to truly hear these care instructions while facing a new diagnosis of cancer and recovering from an enucleation.

Patient "Hand Off" A Critical Moment In Care

The Joint Commission (TJC) receives regular reports of medical errors that occur at the hospitals, ambulatory surgery centers, and other healthcare organizations that it accredits. By analyzing the problems, TJC hopes to understand not only which errors occur but more importantly what causes them. What TJC determined echoes the findings of the OMIC case. The top factor contributing to medical error was not lack of knowledge or technical skills

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MESSAGE FROM THE CHAIRMAN

When the Centers for Medicare & Medicaid Services (CMS) announced earlier this year that Medicare reimbursement for Bevacizumab (Avastin®) would decrease from $35 to $7 a dose, it sent shock waves through the retina community. Although ophthalmologists, like other physicians, have grown accustomed to lower fee reimbursements across the board, this particular action posed such a significant threat to our ability to provide care to our patients that it was imperative it be reversed.

Major ophthalmic societies, including the American Academy of Ophthalmology, the American Society of Retina Specialists, the Macula Society, and the Retina Society, united in a coordinated effort to convince Medicare to reverse the decision. Key members of OMIC's Board, including Dr. David W. Parke II, CEO of the American Academy of Ophthalmology, and Dr. George A. Williams, a leading retina surgeon at William Beaumont Hospital in Royal Oak, MI, contacted Medicare officials to help educate those involved of the unintended consequences of such a fee decrease. Ironically, these included increased cost to Medicare if doctors suddenly switched to

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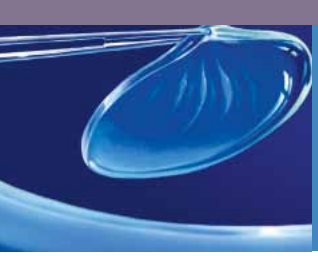

Eye on OMIC

OMIC

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OMIC Expands Regulatory Protection for Policyholders

Ten years ago, OMIC was among the first malpractice carriers in the United States to cover policyholders for regulatory exposures, such as fraud and abuse "billing errors" allegations by Medicare and commercial payers. Since then, more than 250 claims and incidents have been reported to OMIC for these and other regulatory proceedings.

As a benefit of membership, OMIC provides $35,000 in Broad Regulatory Protection (BRPP) coverage as part of your professional liability policy (see section VII.B. of your policy for more information). This expanded coverage, effective January 1, 2010, applies to fraud and abuse claims related to billing errors, HIPAA privacy proceedings, and violations of Emergency Medical Treatment and Active Labor Act (EMTALA) and STARK Act regulations, including reimbursement of legal expenses, fines, and penalties (where allowed by law). This policy also covers legal expense reimbursement for alleged violations of DEA and covered licensing proceedings. A $10,000 sublimit is now available to pay patient notification costs due to Red Flag rules violations (see section VII.C. of your policy for more information).

OMIC has arranged several purchasing options for additional coverage to supplement the $35,000 Broad Regulatory Protection OMIC has provided to you. Excess limits of $40,000 and $90,000 may be purchased as a standard BRPP upgrade; limits of $250,000, $500,000, and $1 million are available as a BRPP Plus upgrade. (This excess coverage is provided under a separate policy issued by NAS/Lloyds of London underwriters and is in addition to OMIC's $35,000 limit included as part of your professional liability policy.)

Those policyholders who have already purchased excess BRPP coverage will automatically be given renewal terms for the 2010 expanded policy approximately 60 days prior to your current BRPP policy expiration, including the new liability limits now available through Lloyds of London underwriters.

A copy of OMIC's professional liability policy can be downloaded from the Members Area of OMIC's website at www.omic.com. You will need your insured name and risk number to log in. This information is located on your policy declarations page. Applications for increased BRPP or BRPP Plus limits are also available online.

Call your OMIC underwriter or the NAS/Lloyds BRPP administrator at NAS Insurance Services, Dana Pollard at (818) 808-4468, for assistance.

Message from the Chairman

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Lucentis and millions of elderly patients were unable to afford the copayment for this much more expensive drug.

This is where OMIC's risk management team excelled in communicating with ophthalmologists about this issue. OMIC's 2007 recommendations for intravenous Avastin warned practitioners that the drug must be prepared by a licensed and trained professional in a compounding or hospital pharmacy to avoid the liability risks associated with off-label ophthalmic use.

Coming from the nation's largest insurer of ophthalmologists and retinal subspecialists and disseminated via OMIC.com, one of the most frequently visited ophthalmic websites in the U.S., OMIC's recommendations were influential. In concert with other actions initiated by the AAO and the three retina societies, OMIC provided background information that helped in the effort to persuade CMS to reverse its decision. In November, CMS directed practitioners to "return to their previous reporting practice for small intraocular doses of Bevacizumab (Avastin®) furnished prior to October 1, 2009."

Dr. William L. Rich, AAO's Medical Director for Health Policy, expressed it best, "The AAO, all three retinal societies, Congress, and our patients are all very thankful for this reversal. It benefits patients, doctors, and taxpayers."

I am proud of OMIC's role in the success of this collective endeavor. When we work together, we can achieve significant advancements for the ophthalmic community and our patients. We can reduce our risks, minimize threats to our livelihood, and protect the quality of care for our patients. Victories such as this are not just "feel good" stories about ophthalmologists working together to effect change, but also examples of the strategic and financial advantages we have gained by creating our own ophthalmic malpractice carrier.

Richard L. Abbott, MD
OMIC Chairman of the Board