Winter 2009 Volume 19 Number 1 OPHTHALMIC MUTUAL INSURANCE COMPANY

Ophthalmic Risk Management Digest

OMIC DIGEST

Premium IOLs Come of Age

By Hans Bruhn, MHS
OMIC Senior Risk Management Specialist

Patient satisfaction can be difficult to obtain and easy to lose. Despite the initial level of deference and trust a patient usually brings to the physician-patient relationship, that trust can be lost due to miscommunication about the diagnosis or treatment goals. Out-of-pocket expenses, especially if they are significant, can increase patient expectations and set the stage for dissatisfaction or malpractice lawsuits. A current case in point is intraocular lenses (IOLs), judging by the number of calls on this issue to OMIC's Risk Management Hotline.

Prior to World War II, ophthalmologists and their patients had few lens choices following cataract surgery. The only way to replace the focusing power of the lens once it was removed was with a thick cataract glass (remember the coke bottle glasses that elderly people wore years ago?). Today, cataract patients are fortunate because ophthalmologists can replace the natural lens with an artificial, clear, plastic lens implant.

The use of lens implants became common practice in cataract surgery in the 1970s, but the discovery of these lenses actually occurred years earlier in the late 1940s. Howard Ridley was an ophthalmologist in the Royal Air Force treating former fighter pilots who had sustained eye injuries during the war when bullets striking the plastic canopy of their aircraft caused small shards of plastic to fly into their eyes. Dr. Ridley realized that the polymethylmethacrylate (PMMA) acrylic from the aircraft canopy was made of an inert material that was compatible with eye tissue. In 1949, he replaced a cataractous natural lens with the first artificial plastic lens.

Fast forward sixty years to the wide selection of IOLs now available to ophthalmologists and patients. Ophthalmologists can recommend lenses based on a patient's individual postoperative vision goals, and patients willing to pay extra can upgrade to "premium" IOLs for even better visual results. But, as with any commodity, availability of a "premium" product has its downside. In the case of premium IOLs, patients may have unrealistic expectations and because patients are personally responsible for the added cost, they may insist upon guaranteed results. Management of expectations is thus critical to satisfaction when helping a patient choose the right IOL.

continued on page 4

MESSAGE FROM THE CHAIRMAN

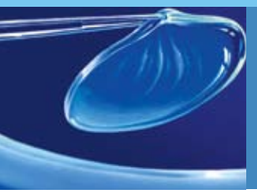
As I step into the role of OMIC chairman amid the upheaval in the financial services industry, I am very pleased to be able to report that OMIC has never been in a stronger financial position than it is now. OMIC remains operationally sound and financially stable. Since 2005, OMIC policyholders have received significant dividends representing a return of premium above what was needed to prudently operate our company, a rare return on investment during turbulent times. This year, OMIC member-insureds will share in the company's profitability by receiving a 20% dividend totaling $8.1 million and an overall average rate decrease of 8.5% on paid premium in 2009.

This good news is particularly remarkable given the current economic crisis. As other malpractice carriers post their year-end 2008 results, OMIC member-insureds can rest assured that once again OMIC will be at or near the top of the list in all major financial performance benchmarks. OMIC's combined and operating ratios, two indications of a company's ability to meet future obligations, beat almost all other malpractice carriers. As the largest insurer of ophthalmologists in the United States with close to 40% of the market, OMIC's

continued on page 2

IN THIS ISSUE

©2009 Ophthalmic Mutual Insurance Company, A Risk Retention Group Sponsored by the American Academy of Ophthalmology



Eye on OMIC

OMIC

The Ophthalmic Risk Management Digest is published quarterly by the Ophthalmic Mutual Insurance Company, a Risk Retention Group sponsored by the American Academy of Ophthalmology, for OMIC insureds and others affiliated with OMIC.

OMIC, not the Academy, is solely responsible for all insurance and business decisions, including coverage, underwriting, claims, and defense decisions.

OMIC owns the copyright for all material published in the OMIC Digest (except as otherwise indicated). Contact OMIC for permission to distribute or republish any Digest articles or information. The general information on medical and legal issues that OMIC provides in the Digest is intended for educational purposes only and should not be relied upon as a source for legal advice. OMIC will not be liable for damages arising out of the use of or reliance on information published in the Digest.

OMIC
655 Beach Street
San Francisco, CA
94109-1336

PO Box 880610
San Francisco, CA
94188-0610

Phone: (800) 562-6642
Fax: (415) 771-7087
Email: omic@omic.com
Web: www.omic.com

Timothy J. Padovese
Editor-in-Chief

Paul Weber, JD
Executive Editor

Anne Menke, RN, PhD
Managing Editor

Kimberly Wittchow, JD
Associate Editor

Hans Bruhn, MHS
Contributing Editor

Ryan Bucsi
Contributing Editor

Linda Radigan
Production Manager

Panoramic Eyescapes by Ophthalmic Artist & Medical Illustrator Stephen F. Gordon

OMIC Educational Alliances Expand Nationally

Since 1996, when OMIC formed its first educational alliance with the American Association for Pediatric Ophthalmology and Strabismus, OMIC has formed similar cooperative relationships with ophthalmic societies across the country, and thousands of ophthalmologists have participated in jointly-sponsored risk management seminars, audio conferences, and online or recorded courses.

Currently, OMIC works with five subspecialty societies, including AAPOS, the American Society of Ophthalmic Plastic and Reconstructive Surgery, the Association of University Professors of Ophthalmology, the Contact Lens Association of Ophthalmology, and Women in Ophthalmology.

OMIC also has agreements with ophthalmic societies representing 32 states, including Alabama Academy of Ophthalmology, Arkansas Ophthalmological Society, Arizona Ophthalmological Society, California Academy of Eye Physicians and Surgeons, Colorado Society of Eye Physicians and Surgeons, Florida Society of Ophthalmology, Georgia Society of Ophthalmology, Hawaii Ophthalmological Society, Illinois Association of Ophthalmology, Indiana Academy of Ophthalmology, Iowa Academy of Ophthalmology, Kansas Society of Eye Physicians and Surgeons, Kentucky Academy of Eye Physicians and Surgeons, Louisiana Ophthalmology Association, Missouri Society of Eye Physicians and Surgeons, Nevada Academy of Ophthalmology, New England Ophthalmological Society, Ohio Ophthalmological Society, Oklahoma Academy of Ophthalmology, Pennsylvania Academy of Ophthalmology, Tennessee Academy of Ophthalmology, Texas Ophthalmological Association, Utah Ophthalmology Society, Virginia Society of Ophthalmology, Washington Academy of Eye Physicians and Surgeons, West Virginia Academy of Ophthalmology, and Washington DC Metropolitan Ophthalmological Society.

OMIC policyholders who are members of these organizations have received over $6 million dollars in special premium discounts since our first cooperative agreement. Discounts are given for participation in joint risk management programs offered by OMIC to society members. Call Linda Nakamura at (800) 562-6642, ext. 652, for information on jointly-sponsored programs.

Message from the Chairman

continued from page 1

success is now integral to our industry and our specialty. I believe the following factors have contributed to OMIC's continued success.

Favorable Claims Trends. Although OMIC has seen a slight uptick in reported claims this year, overall trends remain positive, especially relative to the steady increase in policyholder count since 2005. OMIC's expanded risk management program and continued conservative underwriting philosophy are credited with keeping losses lower than expected.

Limited Exposure to Equities. OMIC has maintained a conservative investment philosophy for many years that maximizes returns while minimizing risk. Less than 5% of OMIC's investments are in equities, while more than 80% currently reside in tax-exempt municipal bonds, which historically have offered a safe place to invest while providing significant tax benefits.

Responsible Growth. OMIC's mission is to provide a reliable, competitive, and comprehensive source of insurance for members of the American Academy of Ophthalmology. We never pursue growth simply for growth's sake. Our philosophy, which remains consistent during good and bad market climates, is to write quality business at an adequate rate with a long-range focus.

Ophthalmic Expertise. OMIC is the premier resource for ophthalmic risk management education and works closely with most of the nation's ophthalmic state and subspecialty societies to deliver information that helps to reduce malpractice liability for everyone. Nearly 60% of insureds complete an OMIC risk management event each year, a very high participation rate in our industry. Surveys indicate that many ophthalmologists, both insureds and non-insureds, implement OMIC risk management recommendations in their practice.

Past performance is no guarantee of future success. We cannot be certain that OMIC will not feel some impact from the economic downturn; however, it remains the intent of the OMIC board, management, and financial advisors to continue our adherence to conservative operating principles and fiscally prudent investment strategies with the focus on the company's long-term financial viability.

Richard L. Abbott, MD
OMIC Chairman of the Board

Coverage for Use of Premium IOLs

By Kimberly Wittchow
OMIC Legal Counsel

While use of premium intraocular lens implants (IOLs) does not directly impact your policy coverage with OMIC, you should be aware of the policy provisions and underwriting requirements related to the use of IOLs and how they might vary for premium IOLs. There are two scenarios in which premium IOLs might be employed. The first is refractive lens exchange (RLE) surgery and the second is cataract surgery.

Refractive Lens Exchange

OMIC uses the term refractive lens exchange for refractive surgery in which IOLs (premium or otherwise) are used to replace a patient's natural lens in order to improve vision when visually significant cataracts are not present. All refractive surgery is excluded under the policy unless specifically added back on by endorsement.

If you seek coverage for refractive lens exchange, you must fill out a supplemental questionnaire and submit it to the Underwriting Department for review. In applying, you agree to abide by OMIC's general refractive surgery and specific RLE requirements.

If approved, an endorsement will be placed on your policy, adding coverage back for this procedure at full policy limits. (No additional premium is required.) This endorsement specifies that RLE is covered, but only when performed within OMIC's underwriting requirements or any exceptions to the requirements granted in writing by OMIC. If you seek an exception to the requirements, you may do so in writing to your underwriter. OMIC discourages exceptions except in extenuating circumstances and only grants exceptions on a patient-specific basis. Do not schedule surgery until your exception is granted.

RLE Underwriting Requirements

To see all of the refractive surgery and RLE-specific underwriting requirements, go to OMIC's web site at http://www.omic.com/products/bus_products/ref_guide_remaining.cfm#RLE. These requirements, along with the RLE supplemental application, address patient selection criteria, informed consent, operative procedures, postoperative care, and advertising.

One specific requirement to note is that RLE must take place in a hospital or outpatient surgical facility approved for cataract surgery and full sterile technique must be followed. RLE may not be performed in a physician's office, laser refractive center, or other facility that does not meet the standard for sterile conditions required for accreditation.

Other requirements specific to RLE are: (1) there must be an interval of at least a week between primary procedures, (2) all patients must undergo a retinal exam pre- and postoperatively and be advised of the increased risk of retinal detachment, and (3) patient selection guidelines for myopia and hyperopia (treatment of emmetropic patients is not covered) must be followed (see box).

The use of premium versus standard IOLs in RLE procedures does not make a difference as far as coverage is concerned, as long as, in using them, no underwriting requirements are violated. You are, though, required to address the specific IOL to be used in the informed consent process and explain its indications, risks, benefits, alternatives, and complications, as well as its off-label use for RLE.

Cataract Surgery

If the patient has selected the use of premium IOLs in cataract treatment, no special underwriting is required. Remember that a procedure is considered refractive surgery if the lens is completely clear or there are visible cataract changes that aren't visually significant and not associated with patient complaints about vision. Cataract surgery is automatically covered under the policy (under surgery class 3). As long as the use of premium IOLs is within OMIC's general policy requirements, no endorsement is required.

You should also note that the policy excludes coverage of clinical research or trials that are not conducted under and in accordance with an American IRB-approved protocol. Make sure that any premium IOL clinical trials you are involved in meet these standards in order to ensure coverage under your OMIC policy.

RLE UNDERWRITING REQUIREMENTS

Myopia. Patients must be presbyopic, age 40 or older, and have at least 6 diopters and not more than 15 diopters of myopia.

Hyperopia. Axial length must be at least 20 mm, and uncorrected visual acuity must be 20/40 or worse. Patients age 40 and older must be presbyopic and have at least 1 diopter and not more than 15 diopters of hyperopia. Patients under age 40 must have at least 4 diopters and not more than 15 diopters of hyperopia.

Premium IOLs Come of Age

continued from page 1

The choices are numerous. In addition to the standard monofocal lens, patients now have the option of a "multifocal" intraocular lens (the first one was approved by the FDA in 1997). "Multifocals" provide both near and far vision. Unfortunately, not all patients are eligible for "multifocals." Some patients who are fitted with "multifocals" may still need glasses or contact lenses for certain activities, such as those requiring near and extremely crisp, clear vision. In general, however, fewer need glasses and contacts when fitted with "multifocals" than they would with monofocals. Clinical studies have found that cataract patients who choose "multifocals" over monofocals express greater satisfaction and improved quality of life following surgery.

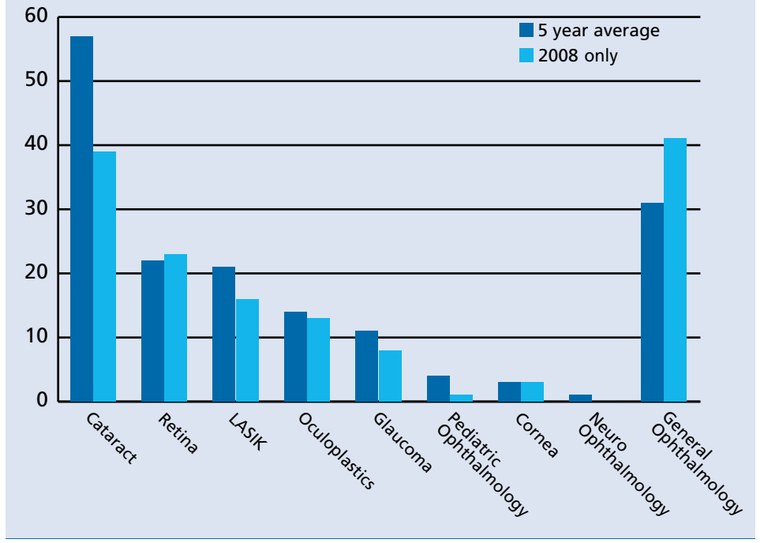
In addition to these benefits, each of today's available "multifocal" IOLs (ReStor, ReZoom, and Crystalens) have specific limitations that need to be communicated to the patient to reduce the potential for disappointment and dissatisfaction. To appreciate the need to move cautiously with premium IOLs, we'll examine OMIC's claims experience with cataract surgery.

Claims Experience Involving IOLs

Issues that surface with patients who undergo cataract surgery with placement of IOLs include the typical complaints of incorrect lens power, size, type, and position. Another source of claims are complications of surgery that were not handled promptly by the surgeon or referred on to a specialist in a timely manner; these include vitreous loss, retained and dropped lens material, stripped descement's membrane and other corneal problems, and choroidal hemorrhage.

As indicated in **Graph 1**, cataract surgery claims continue to be the most frequent type of claim against OMIC insureds. The high rate of cataract-related claims reflects the large number of cataract procedures performed each year in the United States. (Claims involving the use of IOLs in cataract surgery are included in the overall cataract column, but claims involving the use of IOLs in refractive surgery are fairly new and few have been reported so far.) While the *average* indemnity for cataract claims over the past five years ($113,000) is less than the average indemnity for all types of ophthalmology claims ($145,000), the *aggregate* indemnity for cataract claims is significant given their high volume.

GRAPH 1
NUMBER OF CLAIMS REPORTED TO OMIC BY SUBSPECIALTY



OMIC did experience a decrease in the number of cataract claims between 2005 and 2008 from 27% of all claims to 20% (see **Graph 2**). Whether this decline will continue during the current economic downturn remains to be seen. We are seeing an uptick in the number of small general ophthalmology claims, possibly the result of patients seeking financial compensation during hard economic times.

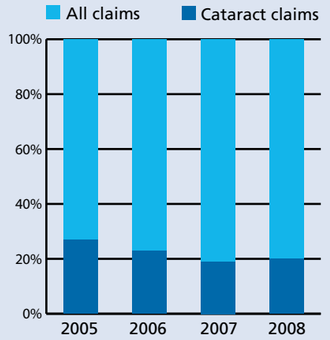
In order to decrease the risk of a claim and the amount of settlement or judgment if a claim is filed, the following risk management strategies are recommended for ophthalmologists who do IOL placement.

Manage Patient Expectations

Management of patient expectations with regard to cataract and refractive lens exchange surgeries begins with proper patient selection. Plaintiff attorneys and experts are quick to point out if the patient was a questionable candidate for surgery or if better alternatives existed for the patient's particular needs.

Know and follow the indications for surgery in the American Academy of Ophthalmology's "Preferred Practice Pattern on Cataract in the Adult Eye." Determine the role of the cataract in the patient's vision loss. Ask about near and distant vision under varied lighting conditions for activities that the patient views as important. Document the functional impairment using the patient's own words. Consider using a vision-specific

GRAPH 2
CATARACT AS A PERCENTAGE
OF ALL OMIC CLAIMS



questionnaire designed to help ascertain the impact of the cataract on activities of daily living, such as the Activities of Daily Vision Scale (ADVS)[1] or the Visual Function Index (VF-14).[2]

Identify whether there are other possible causes of the patient's visual problems besides cataracts. Evaluate the patient for medical comorbidities and medications that can influence the choice of anesthesia or affect the outcome of surgery (e.g., Flomax, anticoagulants).

Provide Thorough Informed Consent

In addition to a well documented medical record, a thorough and memorialized informed consent process will enable OMIC to mount a strong defense against a claim. Consent should be given in advance of surgery with time allowed for the patient to review this information and ask questions. Include a thorough discussion of the risks, benefits, alternatives, and complications of surgery and anesthesia. It is important to document the indications for surgery (e.g., for cataract surgery with premium IOLs, the need for near and distance VA and the impact of cataracts on the patient's daily life). Also disclose and document the impact of ocular and medical comorbidities on the outcome (e.g., removing a cataract will not cure other eye conditions such as glaucoma or AMD).

Your discussion with the patient should address the options for near vision and astigmatism reduction. If the IOL was recently approved, explain that there is a lack of information about long-term outcomes and the possibility of unforeseen complications. Patients should not feel pressured to choose a more expensive IOL option. Explain your rationale for recommending a particular IOL and provide information about it, including labeling information that a reasonable person would want to know.

More importantly, clarify that no guarantees can be made about postoperative visual acuity. Explain that the selection of the proper implant is based upon sophisticated equipment and computer formulas, but is not an *exact* science, and if the refractive result is considerably different than expected, there may be a need for glasses or contacts, additional refractive surgery, or lens repositioning or replacement. Also explain what will happen if the selected IOL cannot be placed due to problems that may arise during surgery. If the patient is at increased risk for a particular complication, disclose and document that (e.g., infection in a diabetic patient). More information on the informed consent process for cataract and refractive lens exchange surgeries can be found at http://www.omic.com/resources/risk_man/forms.cfm.

Handle Patient Complaints

Even patients with uncomplicated surgery may present with complaints after surgery. Unwanted visual images, residual refractive errors such as astigmatism, and overall poor quality vision may be cause for complaint. Manage these situations by being empathetic and reassuring to the patient. Emphasize that it may take time to adjust to visual changes and that you will be available to the patient throughout this process. If complaints persist, discuss the matter with OMIC's Risk Management Department.

Monitor Advertising

The ophthalmologist should personally review how IOL implants are being marketed to patients in the practice's advertising to ensure that patients are receiving "balanced" information on their risks and benefits. This will also help manage patient expectations before the patient presents in your office. OMIC's Risk Management Department will be happy to assist you in reviewing your advertising.

RISK MANAGEMENT RECOMMENDATIONS

- Assess impact of vision on patient's daily life.
- Recognize contraindications to surgery.
- Thoroughly explain risks and benefits of surgery, anesthesia, and chosen IOL.
- Make no guarantees as to outcome.
- Inform patient of intraoperative complications.
- Promptly manage complications and refer patient to a specialist if necessary.
- Ensure that your advertising is responsible and balanced.

1. Mangione CM, Phillips RS, Seddon JM, et al. "Development of the 'Activities of Daily Vision Scale.' A Measure of Visual Functional Status." *Med Care* 1992; 30: 1111-26.

2. Steinberg EP, Tielsch JM, Schein OD, et al. "The VF-14. An Index of Functional Impairment in Patients with Cataract." *Arch Ophthalmol* 1994; 112: 630-8.

Closed Claim Study

Case Work-Up Results in Denial of Patient's Cataract Claim

By Ryan Bucsi, OMIC Senior Litigation Analyst

ALLEGATION

Negligent performance of cataract surgery resulting in capsular bag dialysis.

DISPOSITION

Claim was denied and patient did not pursue litigation.

Case Summary

This elderly patient presented to an OMIC insured with complaints of decreased vision OU. Upon examination, the patient's vision was CCVA 20/100 OD and 20/50 OS. The diagnosis of a 3+ senile, nuclear, and brunescent cataract was made OD>OS. Informed consent was obtained and an extracapsular cataract extraction was planned OD. Two weeks later, the OMIC insured performed an extracapsular cataract extraction with an anterior vitrectomy and anterior chamber IOL implant OD. The procedure was complicated by a capsular bag tear that extended rapidly. On postoperative day 1, the patient was stable with eye pain OD with SCVA 20/100. The patient also complained of seeing a lot of "trash" floating around in the eye. By postoperative day 3, the patient's visual acuity was unchanged with some continuing pain OD. The patient informed the insured that he was extremely unhappy with his surgical outcome and described his vision in the right eye as "looking through a haze with tiny bubbles."

The patient refused to return to the insured, and on postoperative day 6, self referred to a retinal specialist due to his concerns about decreased visual acuity and a possible retinal tear post cataract surgery. The patient relayed to the retinal specialist that he had heard the OMIC insured state during the cataract surgery that the retina was torn. The retinal specialist diagnosed a vitreous hemorrhage that was likely to resolve and no retinal tears. Secondary corneal edema was diagnosed, but it was noted that it should resolve as the IOP improved. The patient was diagnosed with ocular hypertension OD and treated with Cosopt. A cataract fragment was noted inferiorly; however, it appeared to be cortical so observation was recommended.

Three months postoperatively, the pressures in the patient's right eye had returned to normal and the vitreous hemorrhage and corneal edema had resolved. The cataract fragments in the right eye had also resolved and visual acuity was corrected to 20/25+1.

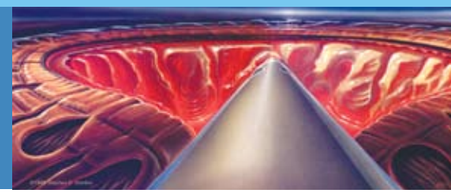
Analysis

After his vision improved, the patient wrote to the OMIC insured demanding compensation for the complicated cataract procedure and asked to speak with the insured's insurance carrier. A representative of OMIC's claims department telephoned the patient and requested release of all his ophthalmic medical records so a review could be performed by a board certified ophthalmologist. The patient was informed that no settlement negotiations would take place prior to an expert review and if the review was supportive of the ophthalmologist's care, the claim would be denied. The patient consented and his records were obtained from all treating ophthalmologists and sent to a board certified ophthalmologist for a standard of care review. The expert reviewer determined that there was absolutely no deviation from the standard of care by the insured. The OMIC claims representative telephoned the patient to discuss the points the reviewer had raised in defense of the insured and followed up with a letter denying the claim. The patient did not pursue the matter, and the case was closed without any type of indemnity payment and with minimal expense to OMIC.

Risk Management Principles

The surgeon in this case reacted properly to a known complication of cataract surgery and the patient ended up with good visual acuity. However, even with a poor visual outcome, the ophthalmologist's approach should remain the same. If this matter had not had the benefit of a supportive standard of care review and the surgeon had not acted appropriately, a small settlement or refund of some of the patient's out-of-pocket costs might have been recommended. Giving a patient a refund or agreeing to settle a case for a small amount is not an admission of liability, and such settlements can be arranged so they are not reportable to the National Practitioner Data Bank. Often, a partial refund or small settlement will avoid months or even years of litigation. When a small settlement or refund for services is negotiated between an OMIC insured and a patient, OMIC may recommend that the patient sign a full and final release of all future claims. This is not always necessary though, so a discussion with the Claims Department will help identify the best way to handle a particular situation. See the **Hotline** article.

Risk Management Hotline



Refunds, Fee Waivers, and Indemnity Payments

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

As the case example in the **Closed Claim Study** illustrates, patients who are not satisfied with their care outcome may refuse to pay their bill, request a refund, or ask for money for subsequent care. OMIC policyholders have many questions about the consequences of saying yes to these requests. Similarly, there are times when a physician would like to offer monetary support. This column gives a general overview of providing financial support to patients out of a physician's corporate or personal funds. Prior to taking any action in this regard, please call OMIC's Risk Management Hotline at (800) 562-6642, option 4, for individual assistance. Physicians who have received a written request for money or are notified of a lawsuit should call the Claims Department at ext. 629.

Q When I'm not able to help my patient understand and accept an outcome, I would like to have the option of refunding or waiving my own fees, or paying for a second opinion or care from another ophthalmologist. If I do any of these, am I admitting liability?

A Merely refunding or waiving fees or offering to pay for subsequent care is not an admission of liability *unless* you tell the patient that your care caused the outcome. If you feel you are responsible and would like to discuss this with the patient, please consult with OMIC first, both to comply with the cooperation clause of your policy and so that we can assist you in preparing for the discussion. Those providing support for other reasons are also encouraged to call us. After a thorough discussion of surrounding facts and circumstances, we may suggest using neutral language to explain the offer; for example, "I want all of my patients to be happy with their experience here. Since I haven't met your expectations, I would like to offer to waive/reduce/refund fees, pay for a second opinion, etc."

Q Will offering monetary support dissuade my patient from suing me?

A Not necessarily. Some patients accept such offers with gratitude, and continue to seek care from you. Others may conclude—regardless of what you say or do—that your generosity is "proof" that you did something wrong and proceed to consult with a medical malpractice attorney. You know your patients and are in the best position to decide how they might respond, and whether you would like to make such an offer.

Q Can I waive the patient's co-payment or deductible?

A Contracts with third-party payers (including Medicare) usually require that you collect co-pays and deductibles at the time of service, and they may limit your ability to waive or refund fees. Some plans allow a physician to waive a co-pay or deductible only after a patient has demonstrated financial need and to refund such payments only if the physician also refunds any fees paid by the third-party payer. It is important to review contracts and follow their provisions since you may be subject to allegations of insurance fraud or abuse if you violate them.

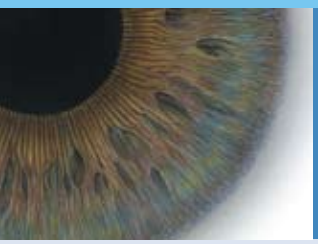
Q What types of monetary support do I have to report?

A Some reporting requirements differentiate monetary support given on the physician's own initiative or in response to an oral demand from money paid in response to a written request, claim, or lawsuit. Reporting to the National Practitioner Data Bank, for example, is only required if (1) there is "a written complaint or claim based on a physician's … provision of or failure to provide health care services" and (2) the payment is made by a business or corporate entity, including a business entity comprised of a solo practitioner (45 C.F.R. § 60.3). Payments in response to oral requests, fee waivers (when no money has changed hands), or those paid for out of personal funds are not reportable. State laws vary, so it is important to check what is required by speaking with OMIC and contacting your state medical board.

Q Should I ask the patient to sign an indemnity release in exchange for a fee waiver, refund, or payment?

A The answer will depend upon the particular patient and situation. Some patients readily agree, while others may become angry or feel you wouldn't ask if you hadn't been negligent. You should contact OMIC's Claims Department if you want the patient to sign a release, as these must comply with state law and require the assistance of an attorney. For additional information, please download the document "Responding to Unanticipated Outcomes" from the Risk Management Recommendations section of our web site, order the CD of the same name, or take this course online.

This article first appeared in the OMIC Digest *in Spring 2007.*



Calendar of Events

OMIC will continue its popular risk management programs throughout 2009. Upon completion of an OMIC online course, CD or MP3 recording, or live seminar, OMIC insureds receive one risk management premium discount per premium year to be applied upon renewal. For most programs, a 5% risk management discount is available; however, insureds who are members of a cooperative venture society (indicated by an asterisk) may earn an additional discount by participating in an approved OMIC risk management activity. Courses are listed below and on the OMIC web site, www.omic.com. CME credit is available for some courses. Please go to the AAO web site, www.aao.org, to obtain a CME certificate.

Online Courses *(Reserved for OMIC insureds/No charge)*

- **NEW!** *Now What Do I Do?*
- *Documentation of Ophthalmic Care*
- *EMTALA and ER-Call Liability*
- *Informed Consent for Ophthalmologists*
- *Ophthalmic Anesthesia Liability*
- *Responding to Unanticipated Outcomes*

CD Recordings *(No charge for OMIC insureds)*

- **NEW!** *Lessons Learned from Settlements and Trials of 2007 (2008).* This is also available on the OMIC web site as a downloadable file.
- *Medication Safety and Liability (2007)*
- *After-Hours and Emergency Room Calls (2006)*
- *Lessons Learned from Trials and Settlements of 2006 (2007)*
- *Lessons Learned from Trials and Settlements of 2005 (2006)*
- *Lessons Learned from Trials and Settlements of 2004 (2005)*

Go to the OMIC web site to download CD order forms, www.omic.com/resources/risk_man/seminars.cfm.

Upcoming Seminars

March

21 *Difficult Physician-Patient Relationships*
California Academy of Eye Physicians and Surgeons*
San Francisco Hilton, CA
Time: Afternoon session
Register with CAEPS at (415) 777-3937 or email CaEyeMDs@aol.com

April

5 *Preoperative Assessment Issues Identified in LASIK Claims Study*
American Society of Cataract and Refractive Surgery
Moscone Center,
San Francisco, CA
Time: TBA
Register with ASCRS at (703) 591-0614 or www.ascrs.org

20 *Dissatisfied Patients*
American Association for Pediatric Ophthalmology and Strabismus*
Hyatt Regency,
San Francisco, CA
Time: 2:00–3:30 pm
Register with AAPOS at (415) 561-8505 or email aapos@aao.org

May

1 *Difficult Physician-Patient Relationships*
Texas Ophthalmological Association*
Austin Convention Center and Hilton Hotel, TX
Time: 8:00 am
Register with TOA at (804) 261-9890 or email toa@txeyenet.org

17 *Difficult Physician-Patient Relationships*
Tri-State Annual Meeting for Arizona Ophthalmological Society,* Nevada Academy of Ophthalmology,* and New Mexico Academy of Ophthalmology
High Country Conference Center, Flagstaff, AZ
Time: 11:00 am–12 noon
Register with AOS at (602) 246-8901 or www.azeyemds.org

June

11 *Difficult Physician-Patient Relationships*
Kentucky Academy of Eye Physicians & Surgeons* and West Virginia Academy of Ophthalmology*
The Homestead,
Hot Springs, VA
Time: 8:00–9:00 pm
Register with KAEPS at kim@amplus.us or WVAO at www.wveyemd.org

12 *Difficult Physician-Patient Relationships*
Virginia Society of Ophthalmology*
Virginia Beach Convention Center, VA
Time: TBA
Register with VSO at www.vaeyemd.org

For further information about OMIC's risk management programs, or to register for online courses, please contact Linda Nakamura at (800) 562-6642, ext. 652, or lnakamura@omic.com.

OMIC
OPHTHALMIC MUTUAL INSURANCE COMPANY
(A Risk Retention Group)

655 Beach Street
San Francisco, CA
94109-1336

PO Box 880610
San Francisco, CA
94188-0610