Ophthalmology

Claims Data Snapshot

2023

MedPro Group

MLMIC
MLMIC Insurance Company
a Berkshire Hathaway company

Introduction

This publication begins with insight into frequency and financial severity profiles by specialty. Then follows an analysis of aggregated data from clinically coded cases opened between 2012-2021 in which Ophthalmology is identified as the primary responsible service.

Keep in mind…

A clinically coded malpractice case can have more than one responsible service, but the “primary responsible service” is the specialty that is deemed to be most responsible for the resulting patient outcome.

Our data system, and analysis, rolls all claims/suits related to an individual patient event into one case for coding purposes. Therefore, a case may be made up of one or more individual claims/suits and multiple defendant types such as hospital, physician, and other healthcare professionals.

Cases that involve attorney representations at depositions, State Board actions, and general liability cases are not included.

This analysis is designed to provide insured doctors, healthcare professionals, hospitals, health systems, and associated risk management staff with detailed case data to assist them in purposefully focusing their risk management and patient safety efforts.

Specialty benchmarking

Specialties have different frequency and financial severity profiles which combine to produce differing risk levels.

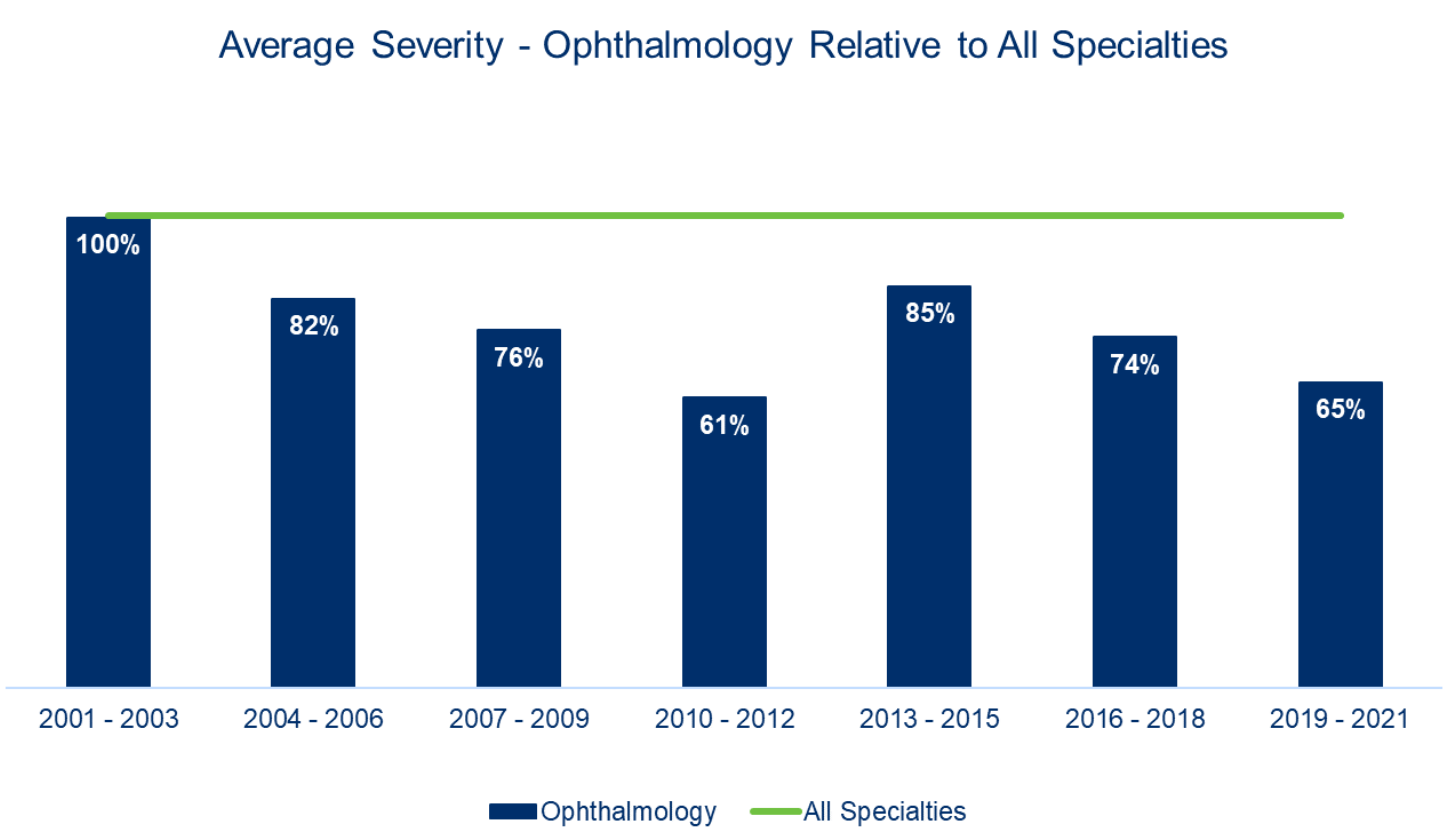
Severity Tier	Low Frequency	Medium Frequency	High Frequency
High	Hematology/Oncology, Pathology, Pediatrics	Anesthesiology, Neurology	Emergency Medicine, Neurosurgery, OB/GYN
Medium	Family Medicine, Nephrology, Physiatry, Urgent Care	Cardiology, ENT, Gastroenterology, Internal Medicine	Cardiovascular Surgery, General Surgery, Orthopedic Surgery, Radiology, Urology
Low	Allergy, Dermatology, Occupational Medicine, Psychiatry, Rheumatology	Ophthalmology, Plastic Surgery, Pulmonology	Hospitalists

Frequency Tier

Source: MedPro Group Physician & Surgeon Claim Experience & Analysis

Specialty trends – Ophthalmology

Ophthalmology has a lower financial severity per case and an average claim frequency compared to all specialties.



Frequency Tier
High
Medium
Low

Source: MedPro Group Physician & Surgeon Claim Experience & Analysis

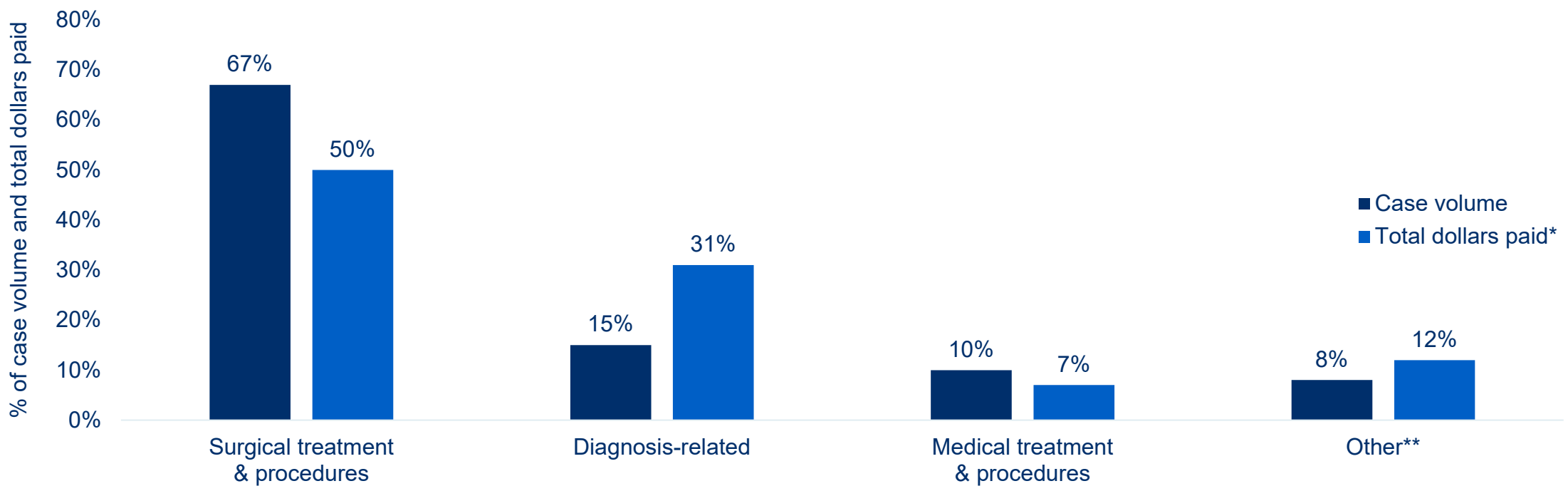
Key Points - Clinically Coded Data

- **Surgical allegations account for more than two-thirds of Ophthalmology case volume and half of total dollars paid*.** Performance-related allegations account for half of those, with the majority involving lens/cataract-related procedures. **Cases involving the management of surgical patients, including pre-, intra-, and post-operatively**, are often related to the surgeon's response to developing complications. While complications of procedures may have been the result of procedural error, the failure to timely recognize and/or monitor/manage the issue prevents the opportunity for early mitigation of the risk of serious adverse outcome
- **Diagnosis-related allegations** account for 15% of Ophthalmology case volume. These most commonly reflect missed/delayed diagnoses of retinal detachments, infections, glaucoma and other eye diseases. **These cases commonly reflect breaks in the diagnostic process of care**, most often including inadequate assessment and evaluation of patient symptoms, a narrow diagnostic focus, delays or failures in ordering diagnostic testing, delays in obtaining consults or referrals, and sub-optimal communication among providers on the patient's care team.
- **Contributing factors, which are multi-layered issues or failures in the process of care that appear to have contributed to the patient's outcome**, and/or to the initiation of the case, provide valuable insight into risk mitigation opportunities. Technical skill factors, including the management of known complications and poor procedural technique, clinical judgment factors related to diagnostic decision-making, inadequate staff training, and insufficient documentation which can lead to a more difficult defense of subsequent medical malpractice actions, are key drivers of both clinical and financial Ophthalmology case severity.

MedPro Group + MLMIC cases opened 2012-2021, Ophthalmology as responsible service (N=703); *Total dollars paid = expense + indemnity

Major Allegations & Financial Severity

Each case reflects one major allegation category. Categories are designed to enable the grouping and analysis of similar cases and to drive focused risk mitigation efforts. The coding taxonomy includes detailed allegation sub-categories; insight into these is noted later in this report.



MedPro Group + MLMIC cases opened 2012-2021, Ophthalmology as responsible service (N=703); *Total dollars paid = expense + indemnity; **Other includes allegations for which no significant case volume exists

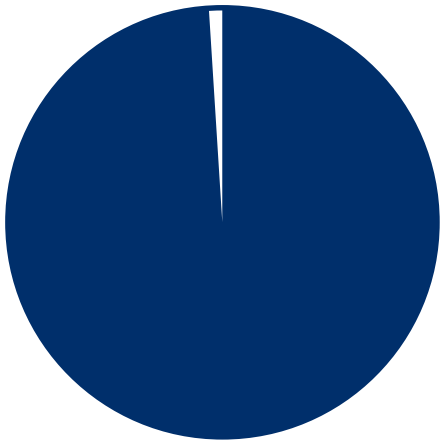
Clinical Severity*

Clinical Severity Categories	Sub-categories	% of case volume
LOW	Emotional Injury Only	3%
	Temporary Insignificant Injury	
MEDIUM	Temporary Minor Injury	54%
	Temporary Major Injury	
	Permanent Minor Injury	
HIGH	Significant Permanent Injury	43%
	Major Permanent Injury	
	Grave Injury	
	Death	

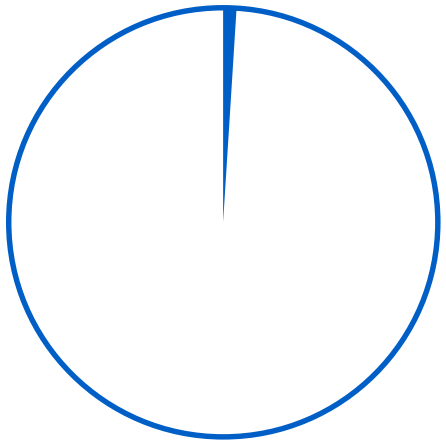
Typically, the higher the clinical severity, the higher the indemnity payments are, and the more frequently payment occurs.

MedPro Group + MLMIC cases opened 2012-2021, Ophthalmology as responsible service (N=703); *Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

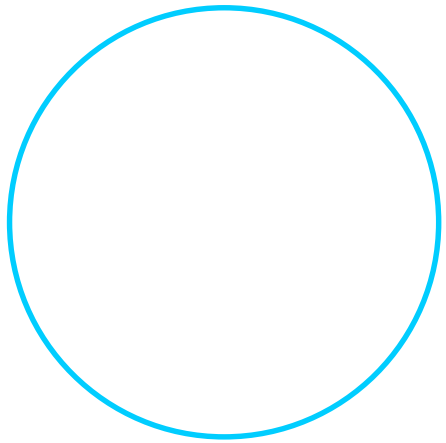
Claimant Type & Location



Ambulatory
99%



Inpatient
1%



Emergency
0%

Top Locations	% of case volume
Ambulatory surgery	49%
Office/clinic	43%
Inpatient surgery	6%

MedPro Group + MLMIC cases opened 2012-2021, Ophthalmology as responsible service (N=703)

Contributing Factors

"Contributing factors reflect both provider and patient issues. They denote breakdowns in technical skill, clinical judgment, communication, behavior, systems, environment, equipment/tools, and teamwork. The majority are relevant across clinical specialties, settings, and disciplines; thus, they identify opportunities for broad remediation."

CRICO Strategies. (2020). The Power to Predict: Leveraging Medical Malpractice Data to Reduce Patient Harm and Financial Loss. Retrieved from https://www.candello.com/Insights/Candello-Reports/Power-to-Predict.

Contributing Factors

Despite best intentions, processes designed for safe patient outcomes can, and do, fail.

Contributing factors are multi-layered issues or failures in the process of care that appear to have contributed to the patient's outcome, and/or to the initiation of the case, or had a significant impact on case resolution.

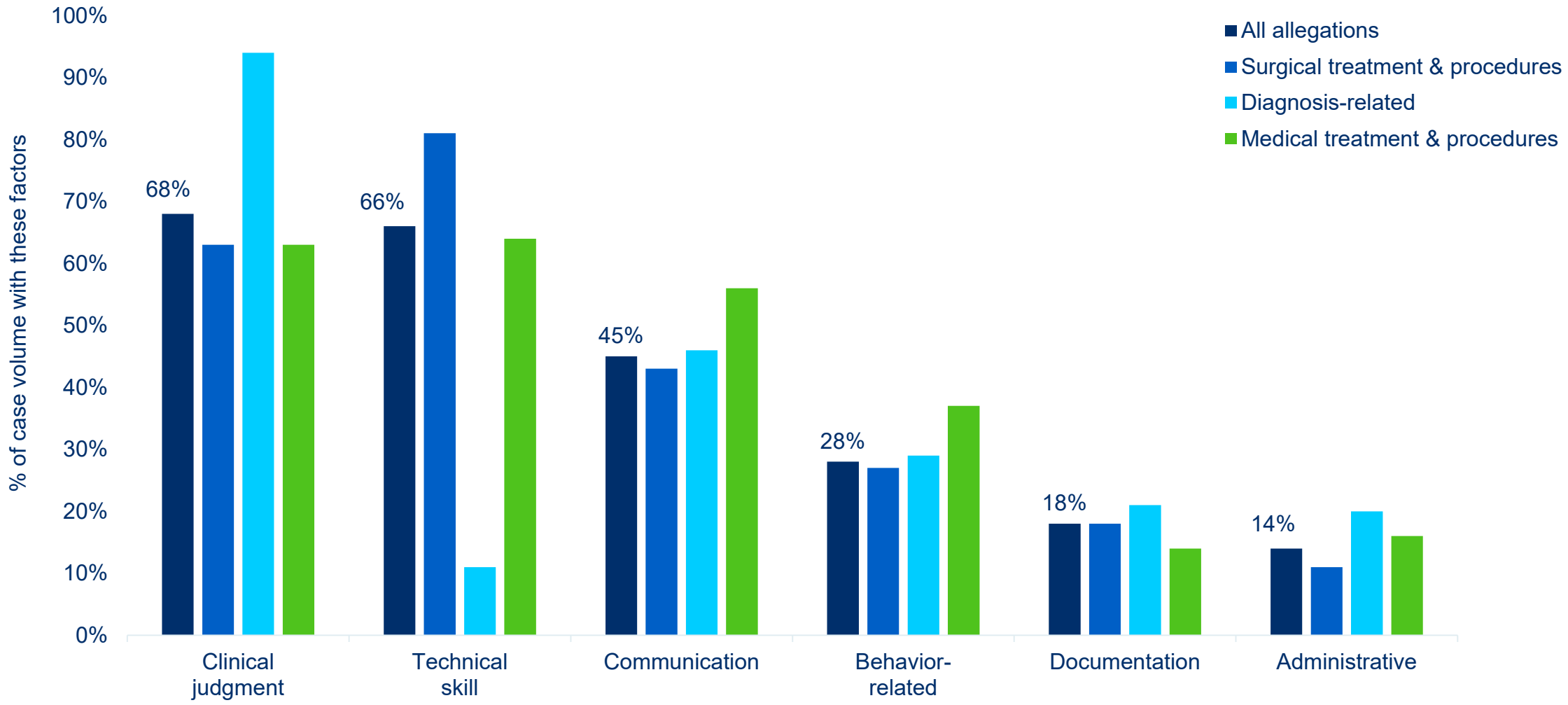
Multiple factors are identified in each case because generally, there is not just one issue that leads to these cases, but rather a combination of issues.

Administrative | Behavior-related | Clinical environment | Clinical judgment | Clinical systems | Communication | Documentation | Supervision | Technical skill

Contributing Factor Category Definitions

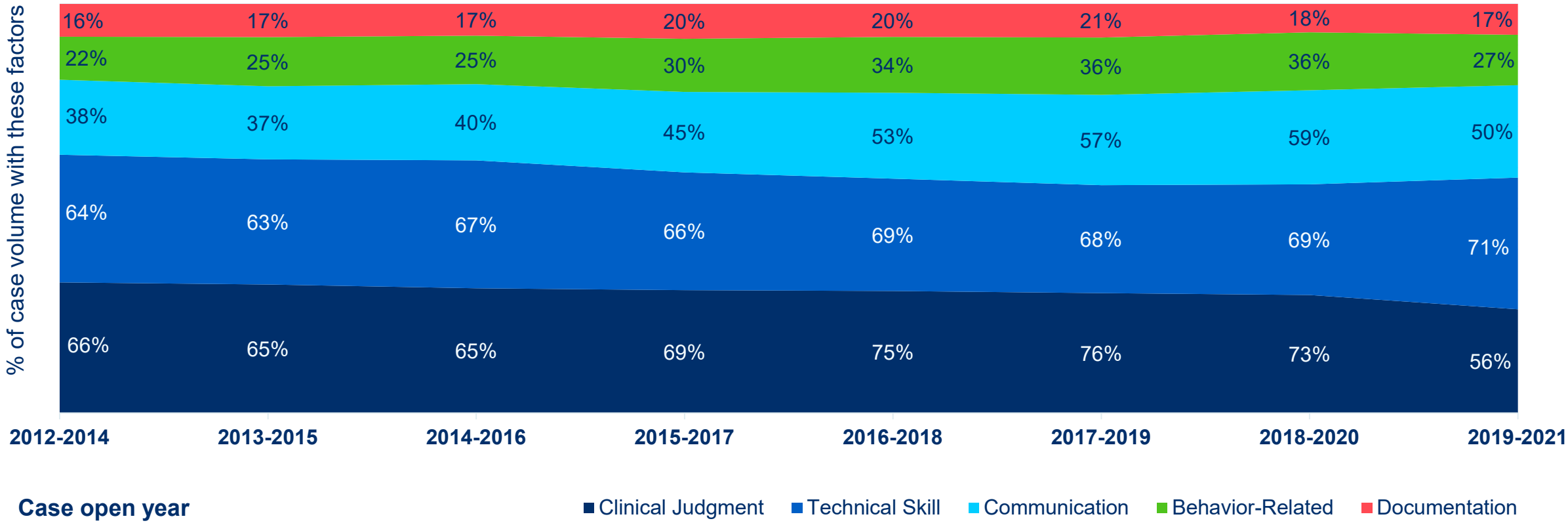
Administrative	Factors related to medical records (other than documentation), reporting, staff, ethics, policy/protocols, regulatory
Behavior-related	Factors related to patient nonadherence to treatment or behavior that offsets care; also provider behavior including breach of confidentiality or sexual misconduct
Clinical environment	Factors related to workflow, physical conditions and “off-hours” conditions (weekends/holidays/nights)
Clinical judgment	Factors related to patient assessment, selection and management of therapy, patient monitoring, failure/delay in obtaining a consult, failure to ensure patient safety (falls, burns, etc), choice of practice setting, failure to question/follow an order, practice beyond scope
Clinical systems	Factors related to coordination of care, failure/delay in ordering test, reporting findings, follow-up systems, patient identification, specimen handling, nosocomial infections
Communication	Factors related to communication among providers, between patient/family and providers, via electronic communication (texting, email, etc), and telehealth/tele-radiology
Documentation	Factors related to mechanics, insufficiency, content
Supervision	Factors related to supervision of nursing, house staff, advanced practice clinicians
Technical skill	Factors related to improper use of equipment, medication errors, retained foreign bodies, technical performance of procedures

Most Common Contributing Factor Categories by Allegation



MedPro Group + MLMIC cases opened 2012-2021, Ophthalmology as responsible service (N=703); More than one factor per case, therefore totals >100%

Distribution of Top Five Factor Categories Over Time



While the distribution of these top (most common) factors across rolling three-year timeframes is relatively consistent, take note of even slight increases over time as indicators of emerging risk issues.

MedPro Group + MLMIC cases opened 2012-2021, Ophthalmology as responsible service (N=703); More than one factor per case, therefore totals >100%

Focus on Most Common Drivers of Clinical and Financial Severity

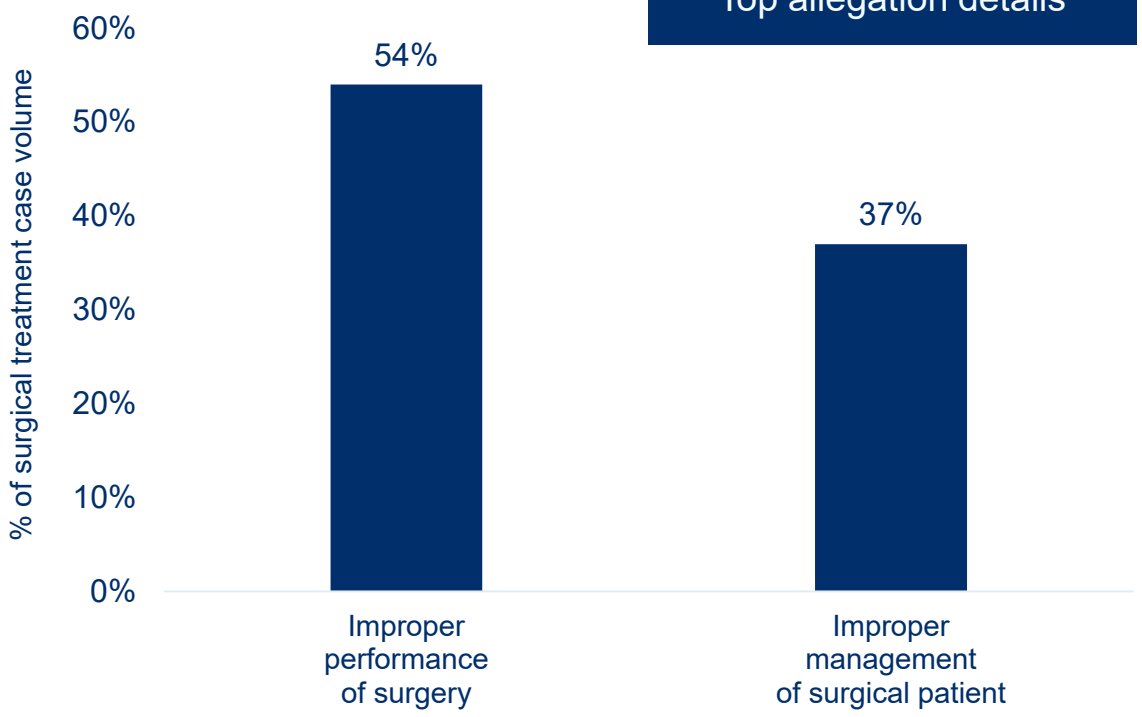
Factors associated with high clinical severity outcomes	**(TS) recognition/management of known complications (40%)**	**% of high severity case volume**
	(CJ) selection/management of most appropriate surgical procedure (33%)	
	(CJ) failure to appreciate/reconcile signs/symptoms/test results (25%)	
	(CJ) failure/delay in obtaining consult/referral (19%)	
	(TS) poor procedural technique (12%)	
Factors associated with the costliest indemnity payments	**(CJ) failure/delay in ordering diagnostic test (34%)**	**% more expensive than the average indemnity payment***
	(AD) Inadequate staff training/education (24%)	
	(DO) insufficient/lack of documentation related to clinical findings (19%)	
	(CJ) failure to appreciate/reconcile signs/symptoms/test results (18%)	
	(CJ) failure/delay in obtaining consult/referral (14%)	

Technical skill factors, including the management of known complications and poor procedural technique, clinical judgment factors related to diagnostic decision-making, inadequate staff training, and insufficient documentation which can lead to a more difficult defense of subsequent medical malpractice actions, are key drivers of both clinical and financial Ophthalmology case severity.

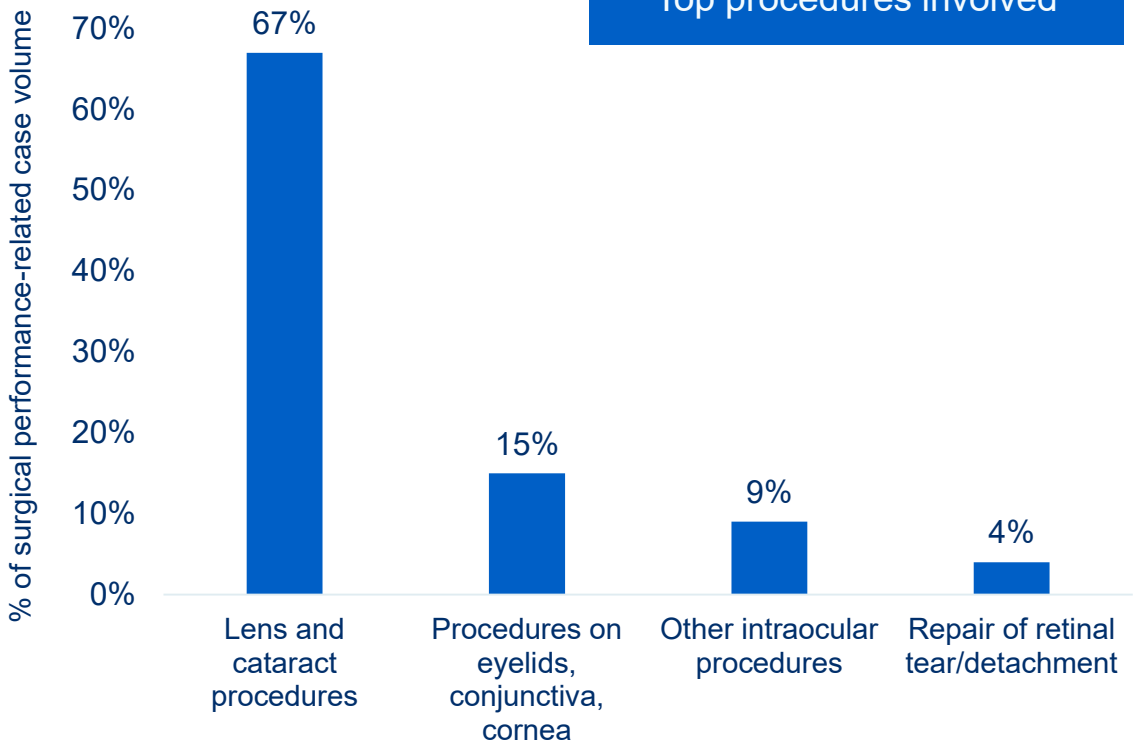
AD: administrative; BR: behavior-related; CE: clinical environment; CJ: clinical judgment; CO: communication; CS: clinical systems; DO: documentation; SU: supervision; TS: technical skill
MedPro Group + MLMIC cases opened 2012-2021, Ophthalmology as responsible service (N=703); More than one factor per case, therefore totals >100%; *limited to factors associated with >/= 15 cases

Focus on Surgical Treatment Allegations

Top allegation details



Top procedures involved

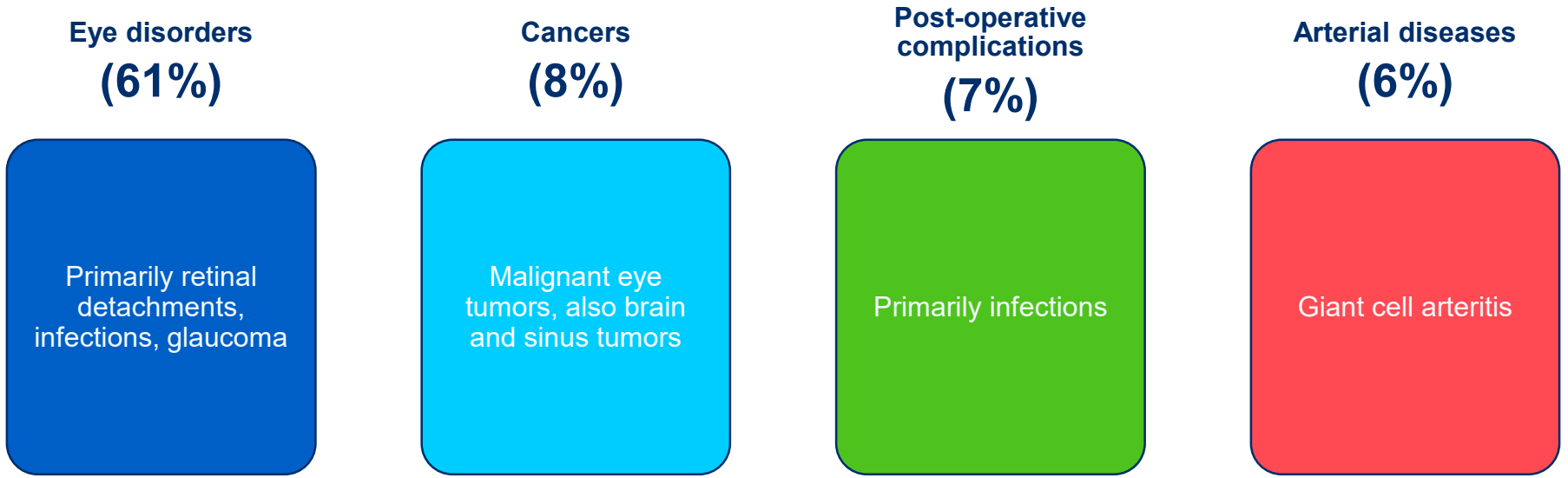


Cases involving the management of surgical patients, including pre-, intra-, and post-operatively, are often related to the surgeon's response to developing complications. While complications of procedures may have been the result of procedural error, the failure to timely recognize and/or monitor/manage the issue prevents the opportunity for early mitigation of the risk of serious adverse outcome.

MedPro Group + MLMIC cases opened 2012-2021, Ophthalmology as responsible service (N=703)

Focus on Diagnosis-Related Allegations

Diagnosis-related allegations encompass wrong diagnoses, failures/delays, and misdiagnoses. See below for the top diagnoses* noted in these cases.



MedPro Group + MLMIC cases opened 2012-2021, Ophthalmology as responsible service (N=703); *as a percentage of all diagnosis-related allegations

Focus on Diagnosis-Related Allegations

Diagnosis-related allegations encompass wrong diagnoses, failures/delays, and misdiagnoses. Note the key opportunities to reduce diagnostic errors along the diagnostic process of care* below.

Phase 1

Initial diagnostic assessment

89%
of cases

- Patient notes problem & seeks care
- History & physical
- Patient assessed, symptoms evaluated
- Differential diagnosis established
- Diagnostic testing ordered

Phase 2

Testing and results processing

7%
of cases

- Performance of diagnostic tests
- Interpretation of diagnostic test results
- Test results transmitted to/received by ordering provider

Phase 3

Follow-up and coordination

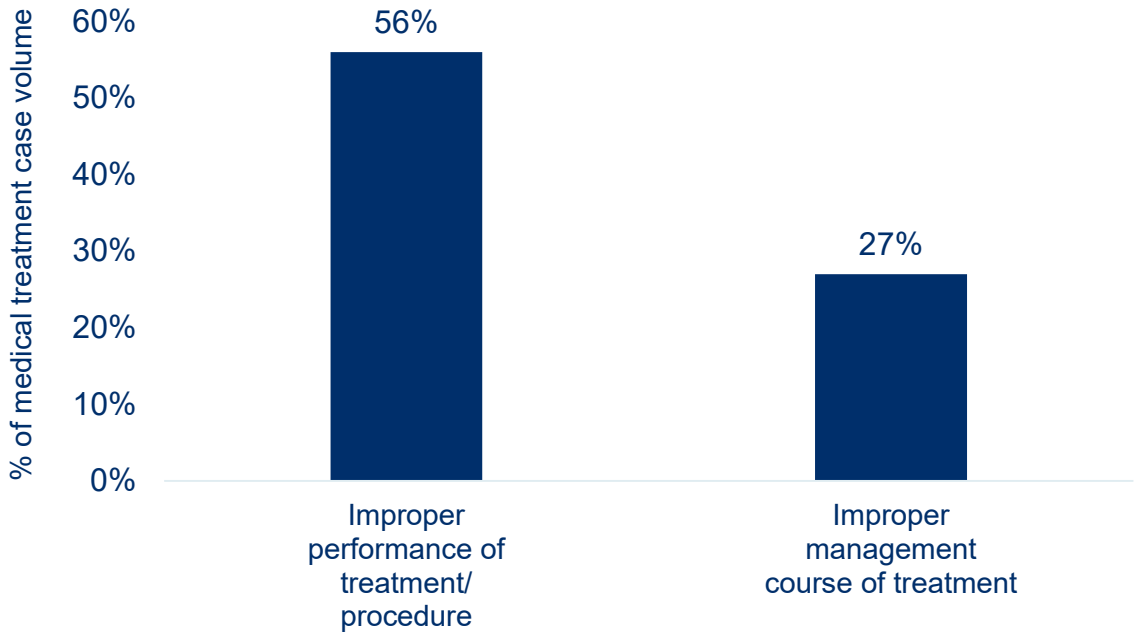
61%
of cases

- Physician follows-up with patient
- Referrals/Consults
- Patient information communicated among care team
- Patient compliance with follow-up plan

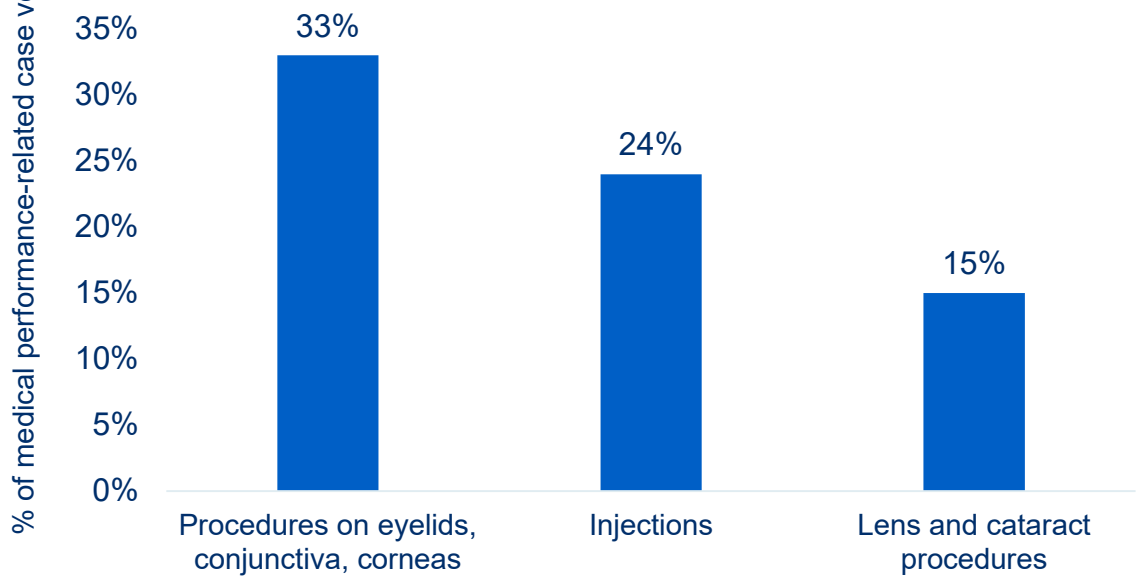
MedPro Group + MLMIC cases opened 2012-2021, Ophthalmology as responsible service (N=703); *each step reflects a combination of contributing factors; diagnostic process of care algorithm courtesy of Candello, a division of CRICO Strategies

Focus on Medical Treatment Allegations

Top allegation details



Top procedures involved



Procedural performance cases can be impacted by delayed recognition of complications, while management cases most often reflect issues with selection of the most appropriate course of treatment for the patient, and appreciating and reconciling symptoms and test results.

MedPro Group + MLMIC cases opened 2012-2021, Ophthalmology as responsible service (N=703)

Contributorily Responsible

Although this analysis is focused on cases reflecting Ophthalmology as the primarily responsible service, another 74 cases identify Ophthalmology as contributorily responsible. The primary services in these cases are varied, reflecting the myriad of providers who care for patients along the healthcare continuum. The most common primary services, and a comparison of top allegation categories, are shown below.

Anesthesiology 32%

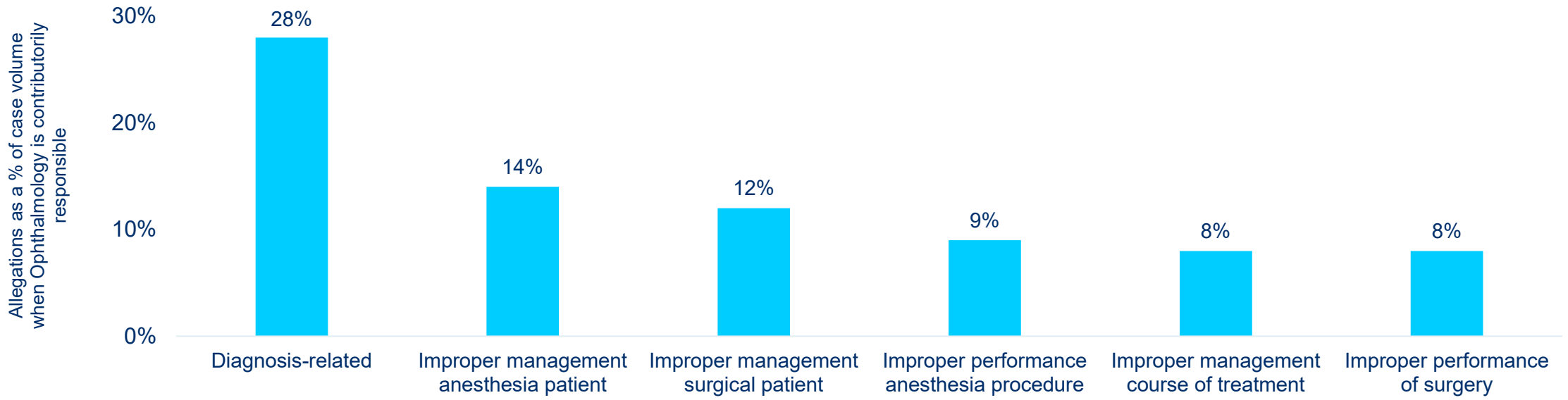
Nursing staff 9%

Emergency medicine 7%

Family medicine 5%

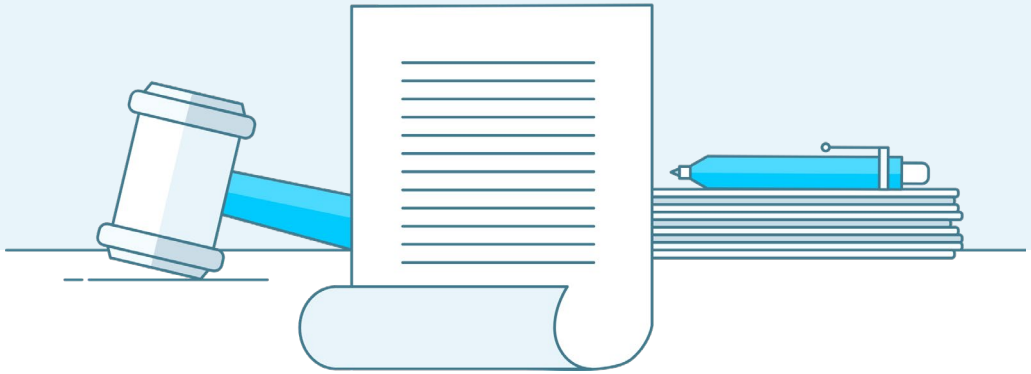
Optometry 5%

Radiology 5%



MedPro Group + MLMIC cases opened 2012-2021, Ophthalmology as contributorily responsible (N=74)

Case Examples



The following stories are reflective of the allegations and contributing risk factors which drive cases brought against Ophthalmologists.

We're relaying these true stories as lessons to build understanding of the challenges that you face in day-to-day practice. Learning from these events, we trust that you will take the necessary steps to either reinforce or implement best practices, as outlined in the section focused on risk mitigation strategies.

Case Examples

SETTLED

$415,000

CONTRIBUTING FACTORS

Behavior-related

Patient seeking other provider due to dissatisfaction with care

Documentation

Inconsistent documentation (between ophthalmology and anesthesiology)

Technical skill

Occurrence of known complication, and poor technique

IMPROPER PERFORMANCE OF CATARACT SURGERY RESULTING IN DECREASED VISION

A 67 year-old male, status post-iridectomy, was scheduled to undergo left cataract surgery. Co-morbidities included sleep apnea. Surgical plan was for monitored anesthesia care administered by anesthesia care team, and anesthetic eye drop administered by the ophthalmologist.

Immediately after incision, the iris prolapsed out of the surgical wound. After several unsuccessful attempts to replace the iris in the capsule, a bimanual vitrectomy was done. An anterior intraocular lens was then placed due to the complications encountered. The procedure took one hour (had been expected to take approximately 10 minutes), and the patient was discharged to home the same day.

When seen for his post-operative visits, it was noted that visual acuity in the patient's left eye was 20/400. He then elected to continue care with a different ophthalmologist. When seen for an initial evaluation by the second ophthalmologist, visual acuity in the left eye was 20/200. **The patient stated he could see shadows and reported that it felt like he had something in his eye. He was referred to a retinal specialist** and seen same day. Impression was a retained cortex and prolapsed iris.

The patient subsequently underwent repositioning of the lens and subtotal removal of a prolapsed vitreous and pupilloplasty. Some scar tissue was identified; it was opined this could impeding vision. He later underwent a corneal transplant. **His best corrected vision in left eye postoperatively was limited to counting fingers**.

Of note, the original ophthalmologist dictated his operative note two days after surgery, and appeared to attempt to point fingers at the anesthesia care team; he noted there was an issue with the patient developing posterior pressure in the head due to positioning and that he had difficulty breathing in the desired position due to a history of sleep apnea. The ophthalmologist further noted that several times during the procedure he needed to pause so anesthesia could manipulate the patient's chin or breathing status. The anesthesia record did not indicate any issues with instability.

Case Examples

SETTLED

$1.0M

CONTRIBUTING FACTORS

Behavior-related

Patient seeking other provider due to dissatisfaction with care

Clinical judgment

Narrow diagnostic focus (assuming previous/chronic diagnosis to be true)

Failure to appreciate/reconcile relevant sign/symptom/test results

Inadequate response to repeated patient concerns/symptoms

FAILURE TO DIAGNOSE CLOSED ANGLE GLAUCOMA AND ASSOCIATED DELAY IN SURGICAL INTERVENTION

A 48 year-old female was **diagnosed with chronic open-angle glaucoma** and presented to an ophthalmologist who specialized in medical treatment of glaucoma. **Her medical history was significant for psoriatic arthritis** diagnosed at the age of 15 for which she had been treated with chemotherapy, steroid and biologic medications.

During the first one year of glaucoma treatment, she was noted to have ongoing elevated intraocular pressures. These were documented, and eye drop medications were adjusted. **After a year, the patient reported light sensitivity, and expressed concern about vision loss**. The ophthalmologist diagnosed uveitis in the right eye secondary to psoriatic arthritis. MRI of brain was unremarkable.

Seven months later, the ophthalmologist noted deterioration in the patient's visual fields, but believed appearance of optic nerve refuted abnormal visual field test result. He continued conservative management of glaucoma over the course of multiple visits.

At the final office visit with this ophthalmologist, the patient noted persistent visual field loss and decrease in visual acuity. **The patient then sought a second opinion from another glaucoma specialist who agreed that the patient may have subclinical uveitis related to psoriatic arthritis**. Trabeculectomies were performed to decrease elevated intraocular pressures. However, extensive damage to the optic nerve, particularly impacting the right eye, had already been sustained, and resulted in **profound vision loss in both eyes with advancement of glaucoma**. The patient's work-life expectancy will be cut short due to the severity of progressing ocular disease.

Expert review was critical of the ophthalmologist's failure to diagnose closed angle glaucoma, and delay in surgical intervention to decrease patient's intraocular pressures resulting in vision loss. Expert review was also critical about length of time between exams.

Risk Mitigation Strategies

- **Ongoing evaluation of procedural skills and competency with equipment is critically important.**
- **Conduct a thorough assessment of the patient pre-operatively.**
  - Ensure that all testing and specialty evaluations are available for review prior to induction; in an ambulatory setting, these details might not always be as readily available as in the inpatient setting.
  - Maintain a consistent post-procedure assessment process.
  - Update and review medical and family history at every visit to ensure the best decision-making.
  - Maintain problem lists.
- **Communicate with each other.**
  - Focus on care coordination if other specialties are involved, including next steps and determining who is responsible for the patient.
  - Elicit a comprehensive patient history and conduct a thorough informed consent with the patient.
  - Give thorough and clear patient instructions.
- **Engage patients as active participants in their care.**
  - Consider the patient's health literacy and other comprehension barriers.
  - Recognize that patient satisfaction with treatment outcomes can be influenced by a thorough informed consent and education process.
- **Document.**
  - The operative record is critically important for detailing the pre-operative patient assessment, intra-operative steps, and post-operative sequence of events. Discrepancies or gaps in the details/timing make it much more difficult to build a supportive framework for defense against potential malpractice cases.

MedPro Group & MLMIC Data

MedPro and MLMIC are partnered with Candello, a national medical malpractice data collaborative and division of CRICO, the medical malpractice insurer for the Harvard-affiliated medical institutions.

Derived from the essence of the word candela, a unit of luminous intensity that emits a clear direction, Candello's best-in-class taxonomy, data, and tools provide unique insights into the clinical and financial risks that lead to harm and loss.

Using Candello's sophisticated coding taxonomy to code claims data, MedPro and MLMIC are better able to highlight the critical intersection between quality and patient safety and provide insights into minimizing losses and improving outcomes.

Leveraging our extensive claims data, we help our insureds stay aware of risk trends by specialty and across a variety of practice settings. Data analyses examine allegations and contributing factors, including human factors and healthcare system flaws that result in patient harm. Insight gained from claims data analyses also allows us to develop targeted programs and tools to help our insureds minimize risk.