



# Doctors Direct Insurance

AN ILLINOIS INSURANCE COMPANY CREATED FOR AND BY ILLINOIS PHYSICIANS



Autumn 2011 | [www.doctorsdirectinsurance.com](http://www.doctorsdirectinsurance.com)

## LETTER FROM THE TREASURER

*Stanley J. Fronczak, MD, JD, FACS, FAANS  
West Suburban Neurological Associates, S.C.  
Treasurer, Doctors Direct Insurance*

Dear Physicians,

*Among my duties as the treasurer of Doctors Direct Insurance is the timely review of the company's financial statements. Every quarter, DDI files a report with the Illinois Insurance Department as a part of the ongoing regulation.*

*The second quarter of 2011 was DDI's best quarter in its five-year history, with net income setting a quarterly record. Investment income continues to be strong, helping us to keep rates at a stable and affordable level. All of these positive indicators imply we should be successful in our first attempt to obtain a favorable rating from A.M. Best in early 2012. As a new company, we have to be in business for five years before we can apply for a rating.*

*Many Illinois physicians have caught wind of the "DDI difference" and are telling us that they plan to make the switch to DDI when their current coverage expires. New business continues to flow into the company, having met our underwriting standards.*

*Insurance is nothing more than a means by which people finance risk. For physicians, especially those of us with hospital privileges, the purchase of liability coverage is a practical necessity. However, I am certain that many of us would buy the coverage even if there were no hospital requirement. We are not willing to "go it alone" in the face of a potential devastating loss and instead choose to pool our risk with other*

*Letter continues on page 3*

## REDUCE YOUR AUDIT RISK WITH THE 2011 OIG WORK PLAN

*By Karen Zupko*

Have you considered implementing the Office of the Inspector General's (OIG) 2011 Work Plan in your practice? The plan will highlight areas in your practice you need to inspect now, likely saving you audit hassles, legal fees and paybacks later.

One of our recent clients, a solo surgeon, received a \$900,000 demand letter representing five years of erroneous coding after a Recovery Area Contractor review. The surgeon was incredulous and wondered why insurance companies paid his practice for five years, instead of notifying him about the coding errors. The surgeon learned the hard way that just because an insurance company paid you, doesn't mean it can't ask for the money back. Don't let this situation happen to you. Give this article to your office manager and put follow-up on your iPhone or other device now.

### Evaluation and Management Services Coding

In 2009, Medicare paid out \$25 billion for Evaluation and Management Services (E & M) visits. In 2011, Medicare is paying more attention and unlikely to pay out as much. You need to know how your code utilization compares to other surgeons in your specialty in the state. You can easily profile yourself by using our E & M Analyzer™, which is available on our website or through the AAOS Code X. The Analyzer has the most recent Medicare data for E & M payments in an Excel format. You simply load your CPT frequency data, and colorful graphs appear comparing and contrasting your code usage with your colleagues. While your profile doesn't have to exactly match those of other doctors, you need to be sure your documentation is perfect where you differ. It's only \$150 to profile up to a group of eight orthopaedic surgeons. And, you can reuse the data after your coding education.

*Article continues on page 2*

## FEATURES

### Reduce Your Risk

Implementing the Office of the Inspector General's (OIG) 2011 Work Plan could save your practice unwanted fees and hassles.

1

### Evidence-Based Practice

The Obama Administration recently ear-marked \$1.1 billion in economic stimulus funding for research concerning effective treatment approaches.

3

### Claims in the News

Plaintiff's estate receives \$150,000 after he dies of an embolism following his release from the hospital.

4

## FOLLOW US



### 10.7.2011

ILMGMA Chicago Area Payor Update, Oak Brook

### 10.11.2011

Rock Island County Medical Society Meeting, East Moline

### 10.12.2011

DuPage County Medical Society Meeting, Oak Brook

### 11.12.2011

Midwest Anesthesiology Conference, Chicago



## MEET THE TEAM

Doctors Direct Insurance

### KENNETH LUDWIG

President & Chief Executive Officer

Mr. Ludwig has had a long career in the medical malpractice industry. Prior to joining DDI, Mr. Ludwig served as the president and chief executive officer of OMSNIC, the specialty risk retention group for oral and maxillofacial surgeons.

### C. TRAVIS WATTS

Vice President of Sales & Marketing

Mr. Watts joined DDI after several years as a national medical malpractice insurance broker with Arthur J. Gallagher. Mr. Watts concentrated on business development in Illinois and Texas but had clients in nine states. Prior to Gallagher, Mr. Watts was the Sales Manager for CARE Risk Retention Group, a medical malpractice insurance company that sold insurance in 15 states.

### EDWARD PFISTER

Vice President of Claims

Mr. Pfister was the founding and former Managing Partner at the Nyhan, Pfister, Bambrick, Kinzie & Lowry law firm from 1991 to 2006. Previously he was a partner at the Pope, Ballard law firm. Mr. Pfister has more than 29 years of litigation experience involving orthopedic and neurological injuries and 15 years of management experience. Mr. Pfister obtained a bachelor's degree from Florida State University, Tallahassee, Florida and a jurist doctorate degree from DePaul University School of Law, Chicago, Illinois.

### NANNETTE SANTIAGO

Office Assistant

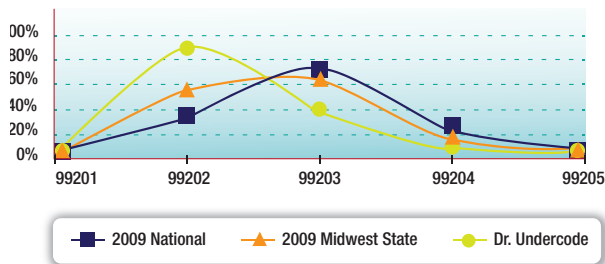
### CHABLIS TIPTON

Accountant

# REDUCE YOUR AUDIT RISK WITH THE 2011 OIG WORK PLAN

Article from page 1

ESTABLISHED PATIENT



**Recommendation:** Learn where you are different than the bell-shaped curve and why.

Identify possible over- and under-coding. Notify partners who don't take care with their coding that all refunds will come from their production and that they will not be paid.

## EMR Note Cloning

Medicare contractors have noted an increased frequency of medical records with identical documentation across services. One of the most frequent noted errors concerns the cloning of the History of the Present Illness. For instance, a recovering alcoholic for six months was dismayed to see that current physician notes still reported the consumption of "6 or 7 beverages a day." Consultants point out that automation makes it easy to make these errors; they never would have occurred when physicians used handwritten or dictated notes.

**Recommendation:** Audit successive visit notes for several patients to verify that the HPI is uniquely updated and not simply carried forward. Make sure that the individual nuances of handwritten or dictated charts have not been obliterated by automation.

## Check your compliance plan

Every surgical practice should have a Small Practice Compliance Plan that correlates with the criteria laid out by the OIG. Many of the recommendations simply require that your practice has good business principles in place. Monitoring coding patterns among partners and making sure that your staff members are educated annually on current coding rules are good business practices. Ignorance is not only dangerous, but expensive. Refunds are another high-risk area. Failing to make timely refunds to patients and plans deflates your true accounts receivable.

**Recommendation:** Initiate a compliance plan, if none is in place. If you already have a plan, verify that it's functional. Make sure someone is updating the activity log regularly. ■

*Karen Zupko & Associates specializes in advising surgeons about the business side of their practice. They provide coding education and auditing for practices across the country, from solo surgeons to academic departments and publicly traded entities. Contact Colleen Gallagher, (312) 642-5616, to discuss the scope and cost of services.*

# WHAT WE HEAR

I strongly recommend Doctors Direct Insurance to my colleagues. Compared to the other insurance companies I have dealt with in the past, Doctors Direct clearly offered the most competitive rates with a personalized approach. If you prefer doing business with smaller companies that care about their customers as individuals, you would be remiss to not at least inquire about what this fine company can offer you.

Brian M. Braithwaite, MD | Chicago Plastic Surgeon

# EVIDENCE-BASED PRACTICE VS. PRACTICE-BASED EVIDENCE

By Chris E. Stout, PsyD

Pay-for-performance, which links physician payment to patient outcomes, is one of several payment programs gaining momentum across the country. The Obama Administration recently ear-marked \$1.1 billion in economic stimulus funding for research on the effectiveness of comparable treatment approaches. Congress is working to mandate that all Medicare payments be tied to “quality metrics.”

We need to exercise caution in ensuring logic and science are in synchrony with payment before jumping on the bandwagon—a task that is not as easy or obvious as it sounds. Take, for example, some evidence-based medicine facts from our clinical colleagues:

- **Cough remedies do no better than a placebo for children or adults.**
- **Angioplasties and stents do not prevent subsequent heart attacks in 95 percent of patients receiving these procedures.**
- **Only 3 percent of patients undergoing coronary bypass operations have prolonged life as a result.**

What is particularly interesting is that Medicare and healthcare insurers pay for these procedures.

Commonly-accepted antibiotic treatments also are under question. While antibiotics for ear, bronchial and sinus infections may offer relief from symptoms, the frequent use of these medications allows antibiotic-resistant strains to develop. And these infections have been found to mitigate on their own after a few days.

## Accepted treatments may no longer be the best

States experimenting with quality metrics have noticed that some randomized clinical trials are contradicting the expert consensus guidelines that had been the basis of the quality metrics. An analysis of Medicare pay-for-performance for hip and knee replacement at 260 hospitals in 38 states, published in the March/April 2009 issue of *Health Affairs*, showed that conforming to or deviating from expert quality metrics had no relationship to the actual complications or clinical outcomes of the patients.

It is difficult enough for physicians to keep up with the literature, even within narrow sub-specialties, let alone broader scientific findings. But today, we also need to follow what has been recommended by the scientific literature. John Ioannidis, a Stanford University epidemiologist, published an article in the *Journal of the American Medical Association* that looked at the 49 most-cited clinical research studies in three major medical journals. Forty-five of these studies reported positive results, suggesting that the intervention being tested was effective. Because most of these studies were randomized controlled trials—the “gold standard” of medical evidence—they tended to have a significant impact on clinical practice, and led to the spread of treatments such as hormone replacement therapy for menopausal women and daily low-dose aspirin to prevent heart

*Letter from page 1*

*physicians. We pay a premium, a relatively small amount in relation to the coverage limits, to meet our needs for the coming year.*

*You may wonder what happens to your malpractice premium once you pay it. You can be assured that medical malpractice carriers follow very stringent accounting and regulatory rules in the conduct of their business. Carriers must account for all funds, undergo an independent audit annually, and file a report of the auditor's findings. They must set premium rates and maintain loss reserves according to actuarially sound principles. They must undergo an annual certification of the loss reserves by a qualified actuary. In addition, the state insurance department conducts an in-depth examination of all carriers once every three years.*

*We at DDI are in full compliance with all rules and regulations.*

*The one area in which DDI does not face regulatory restrictions is in the high level of service we provide to our policyholders. We don't need regulations to realize the value of excellent customer service.*

*I have been in practice for 31 years and know first-hand the pressures we all face when it comes to reimbursements and other burdens. In the past, lack of service from my malpractice carrier often became just another headache that I endured as a practicing physician. One of the reasons I became associated with DDI—and invested in the company—was to ensure that my malpractice insurance would not be just another nuisance in a busy physician's practice.*

*I hope that DDI has eliminated a nuisance in your practice and that you're enjoying the “DDI Difference” with your choice of malpractice carrier that takes the time to assess your specific risk, prices your coverage appropriately and takes all the right steps to defend you if a claim should occur.*

*Sincerely,*



Stanley J. Fronczak, MD, JD, FACS, FAANS  
West Suburban Neurological Associates, S.C.  
Treasurer, Doctors Direct Insurance



Scan with your smartphone to learn about the DDI Difference

Article from page 3

attacks and strokes. Nevertheless, Ioannidis found that of the 34 claims that had been subject to replication, 41 percent had either been directly contradicted or had their effect sizes significantly downgraded. Ioannidis went on to examine the published literature concerning the presumed roles genes play in the risk of developing a certain disease. His research of 432 claims found that only one was consistently replicable.

## Realistic Approaches for Keeping Up-to-date

People, illnesses, injuries and biology all change over time. While medicine and clinical work are science-based, they are not static or

perfect. Thus our repository of clinical science and knowledge also must be dynamic and ever-changing so that it can truly inform our practice.

At ATI Physical Therapy, we are developing a robust electronic medical record complete with outcome tools. We are now adding real-time evidence-based practice consultation options, if a clinician needs to rapidly see what the current literature is recommending, as well as a video demonstration. After we collect outcome data on each treatment episode, we can then circle back to see how well the literature fared with the various patients in our practice. This is how we will harvest our practice-based evidence, giving us a feedback loop that will shape our learning and perpetually inform our subsequent practice. ■

# CLAIMS IN THE NEWS

## PLAINTIFF'S ESTATE RECEIVES AWARD AFTER BACK PAIN PATIENT DIES OF EMBOLISM FOLLOWING RELEASE FROM HOSPITAL



Tried: April 27 – May 4, 2011  
Verdict: \$150,000

(\$75,000 for each of the deceased plaintiff's two children)  
Verdict is subject to a setoff of \$45,000 hospital settlement prior to the first trial

On November 3, 2001, the plaintiff was admitted to the hospital for severe back pain after lifting 50-pound boxes at work. The plaintiff was morbidly obese, at 275 pounds and 5 feet 9 inches tall. His family physician requested a consultation with the defendant orthopaedic surgeon.

Suspecting a herniated disc which would require surgery, an orthopaedic surgeon in the defendant's practice ordered an MRI and pelvic traction. However, a previous CT scan showed no evidence of a herniated disc, and neither did the MRI. So the defendant ruled out surgery and ordered a myelogram.

By November 10, the plaintiff was having less pain and was able to move 80 feet using a walker. The defendant's partner recommended he be discharged from the hospital the following day, with the approval of his family physician.

During the next few days, the plaintiff's mobility was restricted due to his pain. On November 17, he was walking down the stairs of his home when he developed shortness of breath. He was rushed to the hospital, where he died that same day of a massive pulmonary embolism.

The plaintiff was survived by his wife and three children. His two minor children (ages 16 and 17 at the time of his death) were the beneficiaries of his estate.

The estate contended that the defendant should have ordered a deep vein thrombosis prophylaxis via either anticoagulants or compression boots due to the plaintiff's risk factors of obesity and immobility. The defense maintained that the plaintiff was not so immobile to require DVT prophylaxis, his obesity was not a major risk factor, and all his symptoms were consistent with his back injury. Since he was being considered for surgery and a myelogram, he could not take anticoagulants.

The case was originally tried in 2007 and resulted in a not guilty verdict against the family physician and the defendant's partner, and a \$500,000 verdict against the defendant and his orthopaedic practice.

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*This is not an actual DDI claim, but that of another company. It was reprinted with permission of the Jury Verdict Reporter, a Division of the Law Bulletin Publishing Co.*