



Doctors Direct Insurance

AN ILLINOIS INSURANCE COMPANY CREATED FOR AND BY ILLINOIS PHYSICIANS



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LETTER FROM THE BOARD

Sandra Drewes, MD, Anesthesiologist

Dear Physicians,

As a Board member of Doctors Direct (DDI) Insurance, I'm involved in the oversight of all the affairs of the company. I was involved in creating the initial concept and defining the principles of operation of DDI, and have been a director since the company commenced operations nearly five years ago. In that span of time, there have been a lot of changes in the Company. The Board members have witnessed significant growth and advancement toward our business goals, but we remain dedicated to our initial precept that our physicians deserve high quality medical malpractice coverage at a reasonable cost, based on their individual loss history, not the bottom line of the corporation.

I was trained and practiced as an anesthesiologist in Illinois for over 35 years. In my specialty, precision has always been an absolute necessity. In a similar way, I have found that, in the highly-regulated world of medical malpractice insurance, there is need for careful attention to detail. This begins with our relationships with the DDI policyholders. Everything we do is geared toward making the doctor's experience with our Company as effortless as possible. From the qualification for and issuance of policies to the handling of claims, we are determined to meet a very high standard of customer service.

At the outset of Doctors Direct, we issued a mandate that all doctors would be treated with respect and afforded superior service. That is one of the reasons why we chose a "direct approach" for the Company. By eliminating mid-level groups of contacts, i.e., the agents, we are able to put together the doctors and the decision-makers in our operation.

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EMPLOYEE EMBEZZLEMENT: IT CAN HAPPEN TO YOU

By Cheyenne Brinson, MBA, CPA & Karen Zupko

Physicians are easy targets for employee theft. A recent MGMA survey revealed that 83 percent of practices have experienced from \$250 - \$250,000 in employee theft. Undoubtedly, it has happened to a colleague or even yourself.

Employees who embezzle do not wear a T-shirt to work that says "I steal from you."

Fortunately, there are steps you can take to protect you and your practice from employee theft.

Perform Background and Credit Checks

Know who you are hiring before you make an offer. According to national recruiting data, nearly 30 percent of applicants provide false, inaccurate, misleading or incomplete information.

Plan to spend \$50-\$100 per applicant. Don't think it's worth it? A background check would have prevented a Chicago practice from losing more than \$250,000 from embezzlement. The employee had previously been convicted of embezzlement- a background check would have revealed this. Trusted Employees provides this service at a reasonable fee. (www.trustedemployees.com/index.php)

Physicians Sign Checks

The person who opens the mail should not post payments or write checks. Too often, the same person posts all charges, payments, adjustments and refunds; prepares the bank deposit slip; and does the month-end close.

Segregation of Duties

One of the best internal controls is to limit check signing authority to physician owners. It protects the practice and protects the honest employee. Proper back up must accompany the check. Additionally, physicians need to review the bank statement for any unauthorized transactions.

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A satisfied customer, Dr. Mash of M & M Orthopaedics, has this to say about our product: "Our practice, with six locations across different hospitals and 28 physicians, is a complicated one when it comes to after-hours paging. Overnight, AlertMD has changed our risk management documentation, created great physician satisfaction and saved us money on top of it all."

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EMPLOYEE EMBEZZLEMENT: IT CAN HAPPEN TO YOU

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Computerized Receipts

The person who collects the co-pay is the appropriate person to post it into the practice management system and issue a computerized receipt to the patient. Hand-written receipts compromise internal controls.

Perform a Formal Daily Close

Balance payments collected at check-in to the practice management system. Every month, balance payments recorded in the practice management system to the accounting software (e.g. QuickBooks, Peachtree, etc.)

To summarize:

- When performing the daily close, a staff member who does not post the payments should count the money and then run an adding machine tape. Then compare the practice management system journal to the money on hand.
- Compare the bank receipt to the adding machine tapes to ensure staff deposited the correct amount.
- Compare actual deposits in the checking account (and accounting system) to practice management system reports at the end of the month. The two totals should match, except for deposits in transit.

Use the Encounter Form Reconciliation Tool

Account for all scheduled visits and walk-ins at the end of the day by using the practice management system's encounter form reconciliation tool. Account for surgeries in the same manner. Not only is this an increased internal control, it will stop revenue leaks from un-billed visits and surgeries.

Watch Write-offs

Closely monitor adjustments and write-offs. Select 10 Explanation of Benefits (EOBs) to check if adjustments were properly categorized. Unscrupulous employees will cover up their embezzlement by writing off a patient's balance to contractual allowance.

Prohibit Credit Card Refunds

Electronic Funds Transfer (EFT) is direct deposit of your insurance checks. Electronic Remittance Advice (ERA) is auto-posting of the EOB. Use of EFT and ERA eliminates staff from handling insurance payments, makes funds available more quickly and saves time in posting payments.

Utilize EFT and ERA

If a patient needs a refund, issue a check signed by a physician. Monitor the credit card daily reports to ensure no refunds are made. Making refunds to one's own credit card or friend's credit card is a common fraud scheme.

Use RDC or lock box

Remote deposit capture (RDC) is a scanner that converts paper checks to direct deposits. Scanning checks upon receipt reduces risk and saves time since there is not a deposit slip to complete or a bank run to make. Use of a lock box serves as an elevated audit control, eliminating the possibility that staff could embezzle mailed checks.

These internal controls can significantly reduce the opportunities for employee embezzlement. As an extra protection, speak to your insurance broker about employee dishonesty coverage.

WHAT WE HEAR

With all the changes in the health care environment, our group needed to look for a stable, long-term alternative to the medmal carrier we used previously. It was refreshing to go directly to the carrier and save the broker fees, which you can do with a strategic partner like Doctors Direct. Doctors Direct set us up with a comprehensive yet affordable plan. We saved significantly from our previous carrier.

Dave Kanzler, CEO, Hinsdale Orthopaedics Associates

TAKE YOUR SEAT AT THE HEALTHCARE POLICY TABLE

By Laura Ann Miller

Declining reimbursement rates from Medicare coupled with the prospect of more patients covered by the healthcare reform's individual mandate is enough to raise the hair on the back of any physician's neck. But for most medical professionals, the real threat comes from newly-formed groups such as the Independent Payment Advisory Board (IPAB) and the Patient-Centered Outcomes Research Institute (PCORI).

Most medical professionals prefer to rely upon their expertise and collaboration with their patients to make treatment decisions, instead of on government committees that cite selective evidence-based medicine to determine appropriate treatment pathways. IPAB was formed to examine the literature and advise on which procedures Medicare will cover. PCORI conducts evidence-based research and makes recommendations based on the results.

Other key issues facing physicians include the sustainable growth rate, lack of tort reform, meaningful use requirements and accountable care organizations. No medical provider wants to be left behind in these issues, yet many fail to engage in the discussion about how to build a new healthcare system.

Professional groups with time and money to spend on interactions with their legislators have the most influence. Something as little as a donation to your specialty political action committee (PAC) or a phone call to your Congress member's office could have some impact on the decisions made every day on Capital Hill. However, the real results come from surgeons who dedicate large sums of energy and capital toward advocacy efforts. Here are the different tactics specialty groups are using:

American Gastroenterological Association

AGA facilitates interaction between its members and their legislators through an online advocacy system and the Congressional Advocates Program (CAP). Gastroenterologists who participate in CAP have the opportunity to meet their representatives in Washington, DC. AGA has a PAC that works to obtain reasonable Medicare reimbursement rates and encourages liability reforms and increased federal funding for biomedical research. The organization also updates the "AGA Washington Insider Blog," which contains information about new policies and advocacy efforts.

American Academy of Orthopaedic Surgeons

AAOS supports "The Orthopaedic PAC," which recently sponsored the second annual Specialty Physician Candidate Workshop, aimed to educate and elect candidates who advance physician issues. AAOS hosted the inaugural Orthopaedic Quality Institute in Washington, DC, this past October to provide a forum for clinicians, payors, healthcare purchasers, consumer advocates and government officials to meet and discuss musculoskeletal care. The organization also supports Research Capitol Hill Days which allows patients and orthopedic surgeons meet with U.S. Senators and Representatives to promote additional funding for orthopedic research. Finally, AAOS holds the National Orthopaedic Leadership Conference where orthopedic surgeon meet in Washington, DC, to advocate for important issues.

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The policyholders of DDI have access to all levels of the Board and management essentially on a 24/7 basis. This availability makes a tremendous difference in the way you are treated. It is one reason why so many Illinois physicians are making the switch to DDI when their current coverage expires. Our underwriting standards are stringent, but many high-quality physicians are moving to DDI.

No service aspect at DDI is more important than claims. DDI's panel of attorneys teamed with our outstanding claims department and physician advisors ensures that a claim against you will be handled promptly and professionally. We take every matter seriously, and work to bring claims to disposition in a careful manner, always respecting the doctor's prerogative in terms of your consent to settle a case. We are proud of the record we have established in defending claims, and we pledge to the physician community in Illinois to maintain our strong defense posture. After all, when claims are successfully defended, all practicing physicians benefit, not just the insureds of Doctors Direct.

The greatest achievement of DDI is our enhanced customer service due to our direct approach that results in lower costs. In other words, Doctors Direct brings a simplified and cost-effective way of providing medical malpractice insurance, and that simplified methodology makes for superior service to the doctor. You can rest assured that we pass those cost savings on to our doctors. Our rates are consistently 10-15% lower than the competition, not because we have underpriced anything, but because our direct approach produces the savings.

Along with all of the Board members and senior management staff, I would be happy to speak with you about any of these issues. As I said, doctors have access to all levels of the Board and management, and we would welcome the opportunity to visit with you.

Sincerely,

Sandra Drewes

Sandra Drewes, MD
Member, Board of Directors
Doctors Direct Insurance

WHY DDI?

Medical malpractice insurance is a specialized business that requires exceptional management and oversight. During its formative years, Doctors Direct has assembled a quality team that gives us professional management of the highest quality.

As a physician-owned insurer, Doctors Direct understands intimately the needs and challenges that physicians face. That's why we take the time to individually assess every practice we insure. By evaluating each doctor's unique risk profile, not only based on a classification table, but on the treatment each doctor offers, Doctors Direct is able to zero in on a more precise and fair rate for you.

DDI was founded to overturn the conventional wisdom by allowing Illinois Physicians the ability to work directly with their insurance company free of intermediaries. Illinois' quality physicians deserve competitively priced coverage and the consistency, reliability, and stability of a direct market for Illinois malpractice insurance.

By removing the intermediary, the insurance purchasing process at Doctors Direct is streamlined and benefits you in THREE simple ways:

Applying Direct Saves Time-
We don't require you to fill out a lengthy application

Buying Direct Saves Money-
You are not paying a broker commission

Communicating Direct Gets Correct Answers Quickly, THE FIRST TIME- Talk to the decision makers, not the middle man.

Visit our new website to learn more about the DIRECT approach at DDI
www.doctorsdirectinsurance.com

TO TREAT OR NOT TO TREAT FOLLOW THE RULES WHEN YOU DECIDE AGAINST BECOMING A PATIENT'S HEALTHCARE PROVIDER

By Victoria J. Sterling, JD

There are very few circumstances in which a doctor is required to treat a patient merely because that person presents himself or herself for examination. As a physician, you may freely choose who you wish to treat. You may make your decision after completing an initial examination, and determining a presumptive diagnosis and the extent of possible treatment.

You can refuse to treat for any reason: lack of expertise, a demand for what you believe to be substandard care, an inner sense that the personal relationship between you and the patient will not be easy or pleasant, or if the patient simply acknowledges that he or she can't pay for services

There are some caveats:

- Use good judgment in phrasing a refusal to treat someone who is protected under the Americans with Disabilities Act. Even if you lack the expertise to treat the patient, such refusal to an HIV-positive patient may lead to charges of discrimination.
- Read the fine print in your managed care contract. Some contracts require that any and all patients under that plan will be treated.
- If you believe the patient's condition requires prompt treatment, don't merely make an off-hand suggestion that the patient seek further care. Casual advice to simply "See specialist 'X'" is not often taken seriously, especially when the patient surmises future care will be either painful or expensive.

If you decide not to treat, the patient deserves an explanation of the situation or a referral to a practitioner who might treat. The following risk management suggestions will benefit both you and the patient in this situation:

- Walk the patient to your receptionist, who will call the appropriate specialist, hand the patient the phone to set up an appointment, and then confirm that an appointment is made. Offer copies of your exam records and any pertinent radiographs for the patient to take to that visit. Have staff chart that appointment, then use your tickler file to call on that date to check if the patient complied. If not, staff should call the patient to follow up.

- If a patient does not follow your direction, send an explanatory letter as you would for a patient who has refused care. Send the letter via both regular and certified return receipt requested mail.

- Chart the visit Include an explanation of your reason for referral, as well as warnings of the consequences that could occur if the condition is not treated. It is important that records protect you from a patient who doesn't follow your guidance, then returns in a year or two to allege that you were the cause of the bad outcome. This is especially true for lesions requiring biopsy.

One significant caveat: If the patient being referred is in pain and you are concerned that he/she is suffering while awaiting care by your consultant, think twice about prescribing pain medication. If you prescribe medication (or offer office samples) you have treated the patient and a doctor/patient relationship now exists. The same applies to any prescription, including antibiotics.

Once a doctor/patient relationship has been established, you have a duty to treat that patient until the relationship is properly terminated.

Visit DDI's website at www.doctorsdirectinsurance.com for tips on withdrawing an existing patient from your care.

FEATURED VENDOR

Pipeline Medical is the purchasing agent for 65+ medical entities executing ambulatory surgical procedures on premise. By aggregating the purchasing power of allied practices, Pipeline Medical captures substantial cost-savings in a wide range of disposable surgical and pharmaceutical supplies from leading distributors (e.g., Cardinal, MMS, Medline). The company also manages the entire purchasing process for clients including billing, order fulfillment, and product research matters.

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EPIDURAL STEROID INJECTIONS: MINIMALLY INVASIVE, MAXIMALLY DANGEROUS

By Scott E. Glaser, MD, DABIPP www.painchicago.com

The number of transforaminal epidural steroid injections given by pain management doctors, physiatrists, interventional radiologists and surgeons to treat spinal and radicular pain has escalated dramatically in the past 10 years. The primary reasons for this increase include: increased efficacy compared to interlaminar epidural steroid injection; increased training of doctors to do this procedure; and a burgeoning demand for safer, more effective and minimally invasive treatment of spinal pain.

Unfortunately, there also has been an increase in complications from these injections, such as spinal cord damage, paralysis and even death. As knowledge regarding the anatomy of the foramen and the blood supply to the spinal cord has increased, it has become clear that most of these complications are related to interruption of blood supply to the cord.

The original proponents of these injections — primarily Way Yin, MD; Nikolai Bogduk, MD; and Charlie Aprill, MD; from the International Spinal Intervention Society —taught that doctors should inject patients in the “safe triangle” to avoid the nerve root. They continue to promote this approach and defend it in the literature and in court.

The “safe triangle” is a location of the foramen in the anterior and superior aspect directly underneath the pedicle. Its proponents describe it as being at the 6 o’clock position on the pedicle and striking the posterior vertebra as an endpoint.

As this procedure grew in popularity, disturbing reports of paraplegia began to circulate at meetings and eventually found their way in to the literature. Unfortunately, one of those affected patients was mine, a 67- year-old female who was paralyzed in 2001 following a spinal cord infarct secondary to a left T12-L1 transforaminal epidural steroid injection. Prior to her case, there were no reports in the literature of this complication.

In 2005 I co-wrote a case report about this complication, following a malpractice trial and research into the complication’s cause. Since my article was published, I have been asked to review seven other cases of transforaminal epidural steroid injections resulting in spinal cord damage or paraplegia. In addition, there are now 19 cases of this complication detailed in literature. All of these cases involved placement of the needle in the “safe triangle.”

Following my procedure’s complication, my research to identify the causative factors led me, my co-authors (Frank Falco, MD and Rinoo Shah, MD) and others to the conclusion that these complications would be unavoidable until we abandoned the safe triangle technique. Our reasoning is based on simple anatomic facts regarding the blood supply to the anterior spinal cord.

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North American Spine Society

NASS established the National Association of Spine Specialists as its advocacy arm in 1999 to work with lawmakers on public policy that has an impact on spine surgeons and specialists. NASS has a Washington, DC, office, which serves as home base for spine surgeons when they visit Capitol Hill. NASS facilitates meetings between spine surgeons and key officials, arranges testimony at hearings and hosts candidate fund-raisers. In addition, NASS has funded several physician-champion candidates through its SpinePAC. In 2009, SpinePAC received more than \$120,000 and made contributions to both Democrats and Republicans.

American Academy of Ophthalmology

AAO provides several resources for its members to stay up-to-date on advocacy efforts, including advocacy pod casts and the “AAO Eye on Advocacy” blog. The organization joins with others to fight decisions contrary to physician advancement, such as the proposed optometric surgery regulations in Kentucky. AAO has its own PAC, OPHTPAC, and encourages physicians to join the state societies and fight local battles, in addition to national struggles over appropriate healthcare legislation.

American Society of Interventional Pain Management

ASIPP has influence on Capitol Hill through its Interventional Pain Physician-PAC. The organization has also developed and supported the National All Schedules Prescription Electronic Reporting bill, which was designed to protect patients and physicians from controlled substance abuse. While the group is relatively young, it has an impressive list of accomplishments under its belt, and provides representation from around the country.

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Scan with your smartphone to learn about the DDI Difference

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The majority of the blood supply to the anterior spinal cord in the thoracic and lumbar spine is from a watershed artery, the artery of Adamkiewicz or arteria radicularis magna. This artery usually is found traversing a foramen in the upper lumbar or lower thoracic spine on the left. However, in anatomic and radiologic studies, this artery has been shown to be present in all of the foramina in the thoracic and lumbar spine on the left and right. In other words, prior to any transforaminal procedure on any patient, it is impossible to predict with absolute certainty whether or not the artery will be in the foramen in which doctors are placing the needle.

However, the studies also confirm that the artery's course within the foramen is minimally variable. The artery travels around the waist of the vertebra and enters the foramen while becoming invested with the nerve root in the superior and anterior aspect of the foramen. In other words, doctors can avoid the artery altogether, no matter which foramen it is in, by avoiding the "safe triangle".

Although the exact mechanism of injury is unknown, the sharp bevel of a spinal needle and the artery in the foramen are very similar in size. It is likely that the injection is severing or severely damaging the artery, and that there are intimal flaps and possibly embolic events. Attempts to avoid this complication by relying on techniques to detect intravascular injection (dye injection, digital subtraction imaging) are doomed to failure.

The only foolproof method to avoid paraplegia is to avoid the placement of the needle in the "unsafe triangle," as Dr. Shah and I have renamed it.

Doctors can continue to perform transforaminal epidural steroid injections, which are remarkably efficacious and invaluable in the treatment of spinal pain and radiculopathies, as long as they avoid the "unsafe triangle." The most logical location for placing the needle, from a safety and efficacy standpoint, is below the nerve directly posterior to the disc.


I and many others have used this technique in tens of thousands of patients with success for years. In my opinion, my results are now even better as I am targeting the disc/nerve interface, delivering active medication as close to the site of pathology as possible. Most importantly, however, this approach completely avoids any interaction of the needle with the artery and therefore should reduce and possibly eliminate the incidence of paraplegia secondary to spinal cord ischemia.

CLAIMS IN THE NEWS

JURY FINDS FOR PLAINTIFF IN SINUS SURGERY GONE WRONG

Tried: March 7-11, 2011

Verdict: \$880,000

 (\$830,000 to the plaintiff—\$280,000 for medical expenses, \$200,000 for past pain and suffering, \$75,000 for future pain and suffering, \$250,000 for loss of normal life, \$25,000 for disfigurement—and \$50,000 to the plaintiff's wife for loss of consortium)

The plaintiff, a 66-year-old man, underwent a maxillofacial CT scan in January of 2009, which indicated sinus disease on the right side of his nose. He saw an ear, nose and throat specialist (ENT), who was employed by the defendant medical group, later that month for an evaluation. The ENT scheduled surgery for the plaintiff, but failed to perform a biopsy of any of the sinus tissue prior to the procedure.

The ENT performed an endoscopic sinus surgery on the plaintiff in March of 2009. He found polyps on the right side of the sinus, not on the left, but he still cleaned out the ethmoid sinus cavity on the left. During the procedure, he negligently punched a hole through the left sinus into the intracranial cavity.

The plaintiff's attorney stated that the surgery on the left side of the sinus was unnecessary. In addition, post-operative pathology performed on a polyp found on the right side of the sinus found it was actually an inverted papilloma.

The plaintiff's attorney maintained that the surgeon should have performed a different surgery to remove it.

The attorney for the defense countered that the sinus was punctured on the right side, and it may have occurred at the time of the surgery, or following the surgery when the plaintiff sneezed.

The sinus perforation resulted in a cerebrospinal fluid leak and pneumocephalus (air within the cranial cavity), requiring surgery the day following the first surgery. In the second surgery, a neurosurgeon drilled bilateral burr holes in the plaintiff's skull in an attempt to release the trapped air. The plaintiff then underwent a third surgery—a bifrontal craniotomy and skull base defect repair with a pericranial flap.

The plaintiff has losses in his sense of smell and taste, suffers from mild memory deficits, has surgical scarring and more than \$300,000 in medical bills.

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