

ROP Conditions of Coverage

The components of care discussed in this summary (and reflected on the application) are required for coverage for ROP care. OMIC has created toolkits known as the ROP Safety Net, which can aid you in meeting these requirements. However, we recognize that individual institutions and health care systems have a variety of processes that may not be identical to those in the Safety Net. Insureds should utilize components of the Safety Net that work in their institution, as well as any additional safety mechanisms necessary to ensure that they meet the conditions for coverage. This document summarizes the conditions of coverage that appear in the ROP application; see that application for a complete discussion of the requirements. They do not appear here in the same order as in the application. Instead, they follow the process of care: tracking, exam, follow-up, and treatment.

Maintenance of clinical competency

Insured ophthalmologists must take and pass the FocusROP course once every five years. OMIC pays the registration fee and offers a risk management premium discount. To enroll, please contact Risk Management Coordinator Linda Nakamura at lnakamura@omic.com or 800-562-6642, extension 652.

Tracking of ROP care

- The physician's office and the hospital must maintain a system that tracks each infant. Tracking begins at the time of the first exam (whether in the hospital or office), and is concluded only when one of the following conditions is met:
 - 1) The child has met the conclusion-of-acute-phase-ROP screening criteria
 - 2) The child has been treated and followed up appropriately through the necessary post treatment course.
 - 3) You have formally transferred care to another ophthalmologist.
- The infant must be tracked by at least one person in the hospital and at least one person in the ophthalmologist's office. (It is possible that these might be the same person in some practices). We call these trackers the ROP coordinators; H-ROPC refers to the person in the hospital and O-ROPC the one in the office/outpatient setting. The physician must be personally involved in and oversee the tracking process. The ROPCs must be familiar with the most recent AAP/AAO/AAPOS Policy Statement (PS)¹ and use it to review the appropriateness of follow-up intervals.
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- The H-ROPC tracks ROP appointments in the hospital and contacts the O-ROPC to schedule the first outpatient appointment. The O-ROPC tracks ROP appointments in the hospital, and schedules, tracks, and follows up on ROP appointments in the office.
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- The tracking system must be:

- Updated every time the baby is evaluated or treated.
- Reviewed jointly by the HROPC and the OROPC from the time of the infant's last imaging exam through the first outpatient exam to coordinate transfer of point of care
- Evaluated by the appropriate ROPC at least once a week while infants are being actively screened to ensure that all follow-up exams are scheduled and performed. After transition of care has been made from hospital to outpatient, it is only necessary for the O-ROPC to monitor once the infant is an outpatient.

ROP exam requirements

• An ROP consult note must be placed in the infant's chart at the time of each exam. Use ICROP (International Classification of Retinopathy, Third Edition)² to classify, diagram, and record the retinal findings.

• The ophthalmologist, neonatologist, or ROPC should provide a letter to the parent or legal guardian after each examination reviewing results and recommendations for the timing of the next evaluation.

o **The infant must not be discharged from the hospital without an out-patient appointment being made.**

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• **Screening exams must continue until one of the following conditions has been met:**

- 1) Both eyes have met the conclusion-of-acute-phase-ROP screening criteria
- 2) A treating ophthalmologist has verified that all treatment and follow-up examinations have been completed
- 3) Care has been formally transferred to another ophthalmologist

When care is transferred, the referring ophthalmologist must conduct and document a transfer-of-care discussion with the next ophthalmologist when referring or transferring care of any infant who has active disease, the potential of developing active disease in the future, or the possibility of persistent avascular retina which may require treatment. The transferring ophthalmologist should convey the level of urgency of the referral, ensure that the receiving ophthalmologist has copies of/access to the records of prior examinations, and confirm that the ophthalmologist has agreed to take over care in the appropriate time frame.

Follow up ROP care after discharge

• When you indicate the follow-up interval in the hospital or office medical record, **give both the interval and approximate date (e.g., in two weeks, on approximately 7/14/22).** The follow-up period must be consistent with the AAO/AAPO/AAP guidelines, and must not exceed 3 weeks if there is any active disease.

Schedule the next outpatient appointment before the parent or legal guardian leave the office.

- Review outpatient appointments within 24 hours of the date they are scheduled.
- The O-ROPC must notify the ophthalmologist immediately of any change in ROP appointments, including no-shows and cancelled or rescheduled appointments. All follow-up efforts must be clearly documented in the medical record.

Transfer of care for Treatment and Post-treatment follow-up

If the screening ophthalmologist does not treat ROP, the following guidelines are necessary for transfer to a treating ophthalmologist.

- 1) The hospital at which the ophthalmologist does the screening must have access to a treating ophthalmologist who can provide treatment for ROP within 72 hours, within 24-36 hours if Aggressive ROP is present, or be able to arrange transfer to another hospital with access to such an ophthalmologist.
- 2) The referring ophthalmologist must notify the neonatologist and/or H-ROPC when transfer for treatment is needed, specify a recommended time frame for treatment, and document the recommendation.
- 3) The ophthalmologist must write an order for an urgent consultation with a treating ophthalmologist, indicating that treatment must take place no later than 72 hours, or 24-36 hours if aggressive ROP is present.
- 4) The referring ophthalmologist must conduct and document a transfer-of-care discussion with the treating ophthalmologist.

If an infant is treated for acute phase ROP with anti-VEGF medication, the following post-treatment care guidelines must be followed:

- 1) Follow infants closely until at least 65 weeks PMA. At 65 weeks PMA, screening may end if one of these endpoints has been reached:
 - *Both retinas are fully vascularized
 - *There is no active ROP and vascularization is in close proximity to the ora serrata for 360° in both eyes
 - *The avascular retina has been successfully treated with laser and there is no active ROP
 - * The infant has a DNR order

Use of Telemedicine for ROP

Telemedicine uses remote digital fundus imaging (RDFI) instead of a binocular indirect ophthalmoscopy (BIO) exam to evaluate an infant's ROP status. **Coverage for remote screening of ROP using telemedicine instead of an in vivo exam is not covered by the standard OMIC policy.**

However, your OMIC policy does cover review of images as part of the documentation of the ROP exam, or to provide a second opinion by reviewing photos taken in conjunction with another ophthalmologist's BIO exam. If you will at any time use photos to replace a live exam, you must apply separately for remote ROP coverage.

When selecting infants to participate in ROP telemedicine screening, it is important to inform the parents or guardians of their long-term responsibilities. To be eligible to participate in telemedicine, parents or legal guardians must sign an agreement and consent to bring the child to all scheduled outpatient appointments. The parent or legal guardian must be notified that Child Protective Services (CPS) or the local equivalent agency will be contacted if they do not bring the infant as requested. In addition, the ophthalmologist must have a written protocol on how and when to contact CPS for cases of non-adherence to follow-up recommendations.

Infants screened using telemedicine only must have a BIO exam either for continued outpatient follow-up, or to confirm that they have met end-of screening criteria. A live BIO exam must take place at one of several time points:

1. Prior to discharge from the NICU or
2. In the outpatient setting within 72 hours of discharge from the hospital or
3. In the outpatient setting within 1 week of the most recent imaging, if the most recent image was interpreted as PAR.

UNDERWRITING ASSISTANCE

Contact your underwriter for any questions about coverage. [Find my underwriter on OMIC's webpage](#) can give you the name, email address, and phone number of the underwriting contact for your state.

RISK MANAGEMENT ASSISTANCE

OMIC policyholders may obtain confidential risk management help by contacting OMIC's Risk Management Hotline at 800.562-6642, option 4, or by emailing us at riskmanagement@omic.com

Fierson WM, American Academy of Pediatrics (AAP) Section on Ophthalmology, American Academy of Ophthalmology, American Association for Pediatric Ophthalmology and Strabismus, American Association of Certified Orthoptists. Screening Examination of Premature Infants for Retinopathy of Prematurity. [Policy Statement.] Pediatrics. 2018;142(6):e20183061.

Available at:

<http://pediatrics.aappublications.org/content/142/6/e20183061> (Accessed: 3/16/22)

Chang MF, Quinn GE, Fielder AR, Wu WC, Zhao P, Zin A, et al. International Classification of Retinopathy of Prematurity, Third Edition. Ophthalmology. 2021;128(10):E51-E68.