

Academy Notebook

NEWS • TIPS • RESOURCES

WHAT'S HAPPENING

■ Major Gift Establishes Pediatric Ophthalmology Education Center

The Academy recently received a \$1 million donation from the Knights Templar Eye Foundation (KTEF). The charitable contribution, one of the largest in the Academy's history, will be used to establish the KTEF Pediatric Ophthalmology Education Center on the Ophthalmic News and Education (ONE) Network.

The first of its kind, this virtual skills transfer center will give ophthalmologists worldwide access to a surgical simulation library and other clinical resources to help prevent pediatric blindness. The KTEF Center will aggregate and organize related content into what will become the Academy's primary online educational resource for pediatric ophthalmology.

This resource will support the lifelong learning needs of pediatric ophthalmologists and the on-demand learning needs of comprehensive ophthalmologists. It will offer expert-level information on both innovative and time-tested approaches for managing pediatric ophthalmic disease.

"This is an extraordinary gift for ophthalmology. It will allow the Academy to aggregate in one location the best in pediatric ophthalmology educational resources. Most important, it will be on-demand—from any device

that can access the Web. Reviewing images, surgical videos, and pediatric-specific drug doses will be possible for any ONE user around the world. I have no doubt that it will truly impact the care of individual children. The Knights Templar Eye Foundation is a tremendous partner for our profession and our patients," said David W. Parke II, MD, Academy executive vice president/CEO.

Incorporated in 1956, KTEF is a charity sponsored by the Grand Encampment of Knights Templar, a fraternal organization. Their mission is "to improve vision through research, education, and supporting access to care." The KTEF has been a key supporter of EyeCare America and the Foundation of the American Academy of Ophthalmology (FAAO) for the last 19 years. Their generous contributions, totaling more than \$4.4 million, have enabled EyeCare America to provide sight-saving services to the medically underserved across the United States. Since its inception, the KTEF has spent more than \$140 million on research, patient care, and education, and has provided more than \$23 million in grants for researchers working in the fields of pediatric ophthalmology and ophthalmic genetics.

"We are pleased to support the Pediatric Ophthalmology Education Center within the ONE Network, as it



KNIGHTS TEMPLAR EYE FOUNDATION DONATION. KTEF President David D. Goodwin also serves on the FA AO Advisory Board. The KTEF Center on the ONE Network will become the primary online resource for pediatric ophthalmology.

provides a real opportunity to make a difference and improve the outcomes in eye care for children worldwide. We are proud to expand our relationship with the Academy and contribute to the advancement of ophthalmic education through this innovative new resource," said KTEF President David D. Goodwin, who also serves on the FA AO Advisory Board.

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MEDICARE PAYMENT DATA: The Academy
steps in to provide clarification.

FOR THE RECORD

■ Annual Business Meeting

Notice is hereby given that the Annual Business Meeting of the American Academy of Ophthalmology will be held Sunday, Oct. 19, in North Hall B of the McCormick Place Convention Center in Chicago, 10-10:30 a.m.

■ Board Nominees

In accordance with Academy bylaws, notice is hereby given of the following nominations for elected positions on the 2015 board. These nominations were made by the Academy Board of Trustees in June. If elected, the following individuals will begin their terms on Jan. 1, 2015.

President-Elect:

William L. Rich, MD



NOMINATED FOR OFFICE. *If elected, Dr. Rich will be next year's president-elect.*

Senior Secretary for Advocacy:

Daniel J. Briceland, MD

Trustee-at-Large:

Andrew M. Prince, MD

■ Board Appointments

The Board of Trustees is the policy-making body of the Academy. The charge of the Board of Trustees is to manage and direct the business affairs of the Academy in furtherance of its mission and strategic goals. For more information, visit www.aao.org/bot.

During the June Board of Trustees meeting, the following individuals were appointed to the Board of Trustees and will begin their new terms on Jan. 1, 2015.

Public Trustee:

Humphrey J.F. Taylor (Mr. Taylor has served as public trustee

for seven terms and has been reappointed for an eighth term beginning Jan. 1.)

International Trustee-at-Large:

Jan-Tjeerd H.N. de Faber, MD

■ Procedures for Nomination by Petition

On Jan. 1, 2015, three Board of Trustees positions will become vacant. Elections to fill those positions will take place by mail ballot after the Oct. 19, 2014, Annual Business Meeting.

To nominate a candidate by petition, submit a written petition to the Academy executive vice president/CEO no later than Aug. 20. The petition must be signed by at least 50 voting Academy members and fellows.

To suggest a nominee for the 2016 board, watch for the call for nominations that will be published in the January *EyeNet Magazine*.

To read the rules in full, visit www.aao.org/bylaws and see Article V.

TAKE NOTICE

Train Your Team

The Academy's new website for ophthalmic technicians, assistants, and nurses provides resources to help your team deliver high-quality care. The site links to the following:

- Ophthalmic technician training
- Free tools and practice guidelines, including *Introducing Ophthalmology: A Primer for Office Staff*
- Patient education, practice management, and coding
- Career opportunities

Learn more at www.aao.org/techresources.

■ Ask the Ethicist: Informed Consent—Resident Involvement in Care

Q: I am a third-year resident at a teaching hospital. Many of our patients do not understand that there is significant resident involvement in their clinical and surgical care. How much information about the exact role of the resident needs to be discussed with the patient? Usually, we say that the attending physi-

cian is operating and we will be assisting "as an extra set of hands," even if we will be doing the entire procedure (with oversight). If we were explicitly honest with patients, it is unlikely that we would be able to do any primary surgeries. What are other options?

A: An honest response to patient inquiries about resident involvement in their care is essential in building a trusting relationship. The following guidelines apply regardless of your level of training or experience.

- Determine how much the patient would like to know when you are considering the extent of your disclosure.
- Explain that the complication rate for resident performance reflects that of the resident's mentor and not that of the resident.
- Select appropriate patients. For example, a patient who needs a lot of extra attention or who has a complicated ophthalmic history or coexisting conditions may not be the best choice for a first surgery.

In *OMIC Digest*, Paul Weber, JD, OMIC vice president of risk management, states the following:

It is the attending physician's duty to inform patients if a resident will be responsible for any part of their care. Patients should never be misled about who participates in their care. Hospitals and universities that employ residents should include language in their general consent form about the role of residents in the patient's care and treatment. The same disclosure applies to the informed consent process if a resident provides surgical assistance to a physician's private practice patients. "Ghost surgery," in which the physician allows another doctor to perform the surgery unbeknownst to the patient, has attracted unfavorable press.

A contingency plan must be in place to handle situations in which a patient refuses to have a resident participate in his or her care. The physician who uses a resident despite the expressed wishes of a patient does so at his or her own risk and may be sued for battery [making physical contact where there is no consent] even if there is no negligence.¹

¹ Weber P. *OMIC Digest*, Spring 2002, www.omic.com/resident-supervision.

ACADEMY STORE

■ Newly Updated: The Ultimate Ophthalmic Study Guide

The Practicing Ophthalmologists Learning System, 2014-2016, is the Academy's online review program. It contains 4,000 self-assessment questions and 1,400 study outlines; more than 600 of these study outlines were recently reviewed for currency and revised accordingly. Use the self-assessment questions to build custom exams. Further, each question is linked to a corresponding study outline. This program is ideal for practicing ophthalmologists preparing for MOC exams.

Learn more at www.aao.org/learningsystem.

■ ICD-10's Delay Shouldn't Postpone Your Preparation

Take advantage of the extra time you have before the Oct. 1, 2015, launch of ICD-10 and ensure that you and your staff are fully prepared to use the new code set. Use the Academy's ICD-10 collection (book, workbook, and online course) to stay ahead of the curve. These ophthalmology-specific ICD-10 solutions break down the new coding rules, help you practice dual coding, and show you how to revise your superbills.

To purchase, visit www.aao.org/store and enter "ICD-10" in the keyword search field.

MEMBERS AT LARGE

■ AOS: New Leadership

On May 17, Richard P. Mills, MD, MPH, *EyeNet* Chief Medical Editor, was elected President of the American Ophthalmological Society (AOS), the oldest specialty society in American medicine, founded in 1864.

Dr. Mills said, "What the AOS is about is advancing the science and art of ophthalmology. We address essential issues in medicine through symposia at our annual meeting, many of which are published in the peer-reviewed literature."

D.C. REPORT: Release of Medicare Payment Data

In April—for the first time in history—the Centers for Medicare & Medicaid Services (CMS) released extensive individual Medicare physician pay data. Ophthalmologists topped the list of doctors who received the largest payments, but the initial news reports failed to provide a proper context for the data, leading to confusion and incomplete information. The Academy responded with a quick and concentrated effort to educate the public and news media about what the information really meant.

Assisting members. The Academy provided talking points for members to use in meetings with lawmakers on Capitol Hill during Congressional Advocacy Day in Washington, D.C. The talking points focused on the high volume of Medicare patients seen by ophthalmologists and the high cost of FDA-approved drugs used to treat several chronic retinal diseases. The Academy also responded to reporter requests for interviews to interpret the data.

In addition, the Academy offered general talking points to members for use during interviews with their local news media or when they are questioned about the reports by patients or other individuals. In some cases, these questions might focus on a member's own Medicare payment information. The Academy therefore encourages members to check their information in the Medicare database (instructions below).

Preventing future misunderstandings. CMS indicated that updated physician payment data will be released annually, so the Academy is taking steps now to prevent potential misinterpretations. The Academy is pressing CMS to (at a minimum) separate Part B in-office drug payments from payments for physician services, as those drug payments are essentially passed on to the pharmaceutical company. In some cases, drug costs account for as much as 85 percent of the Medicare payments to the ophthalmologist.

A meeting with CMS. In a session hosted by the AMA, the Academy and other organizations met with CMS to express concerns about the data release. Specifically, the Academy asked CMS to provide clarifying language to accompany the released data, as it could easily be misinterpreted and the number of services provided overstated. In response to this request, the CMS overview now tells readers that the data are not intended to indicate the quality of care provided and are not risk-adjusted to account for differences in underlying severity of disease of patient populations. Because of this meeting, CMS also added limitations in the methodology document to include points that specifically impact ophthalmic data.

- Medicare payments for a given service/setting can vary based on a number of factors including modifiers, geography, and other services performed during the same visit. For example, modifiers (which are two-character designators that signal a change in how the code for the procedure or service should be applied) may be included on the claim line when the service intensity was increased or decreased, or when an additional physician administered services. These modifiers may impact allowed amounts and payments.
- Allowed amounts and payments vary geographically because Medicare makes adjustments for most services based on an area's cost of living.
- Allowed amounts and payments can also be adjusted when a physician renders multiple services to a beneficiary on the same day, which is referred to as a multiple procedure payment reduction.

To check your information, visit www.cms.gov. Select the tab labeled "Research, Statistics, Data, & Systems"; then, under Statistics, Trends, & Reports, click "Medicare Provider Utilization and Payment Data" and "Medicare Provider Utilization and Payment Data: Physician and Other Supplier."

See also the May 2014 *Current Perspective*, "When 'Transparency' Isn't!"