Insured Colleague

APPLIED MEDICO-LEGAL SOLUTIONS RISK RETENTION GROUP, INC.

February 2009 • Volume 004

AMS RRG President's Message

By Richard B. Welch

As we enter 2009, it is impossible not to reflect on the economy as it relates to AMS RRG. As an AMS RRG partner, you know that our organization is focused on reducing risk for physicians. But our conservative approach is also central to our overall strategy, and in light of the collapse of AIG and other financial institutions, we want to reassure you of the strength of our company's financial position. Following are just some of the ways we are working to preserve your investment in AMS RRG.

- ***Adherence to robust underwriting policies.***
  We remain focused on maintaining the underwriting philosophy that has been central to our success: to assess and write appropriate risks and preserve our capital surplus position.

- ***A rating.***
  In June, Demotech awarded AMS a Financial Stability Rating® ("FSR") of A, Exceptional following an intense, four-month review process.

- ***New investment manager.***
  At the end of the second quarter, we took an important step to secure our financial picture by changing our investment manager to Brown Brothers Harriman (BBH). BBH is the oldest and largest partnership bank ($43 billion in assets) and has managed physician insurance assets for over 30 years. Committed to developing customized investment solutions, BBH will continue our focus on capital preservation and conservative growth.

- ***Managed premium growth.***
  AMS RRG recently moved into six new territories and is now registered to do business in 35 states. As of the end of 2008, we were just above $23 million in premium, landing us a spot among the nation's top 25 risk retention groups as ranked by *Risk Retention Reporter.*

In today's unsettled economic conditions, we expect you to closely analyze your liability insurer and want you to understand the sound financial principles that guide our organization's

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AMS RRG Launches 2009 Risk Mitigation Initiatives

Based on growing shareholder interest, we'll enhance our risk mitigation services by adding some new services to our proven staples. Our objectives include:

- Holding four quarterly conference calls on different specialty practice areas
- Conducting site visits to specified practices
- Offering risk consultations with our Specialty Medical Directors
- Providing timely risk mitigation articles in our four newsletters
- Offering self-audit questionnaires for hospital and non-hospital based practices to help them assess risk
- Providing specialty-specific risk mitigation tools on our website

To learn more about any of these new offerings, contact Susan Martin at 1-866-520-6896.

ACEP Guidelines

By Steven Shapiro, MD
AMS RRG Chief Medical Officer

One of the founding principles of the Insured Colleagues Program™ is to help physicians understand the guidelines put forth by the national societies that affect their discipline of practice. While the American College of Emergency Physicians (ACEP) evaluates quality of care issues that affect primarily Emergency Medicine physicians, their guidelines, as well as those of all societies, impact many specialties. Shown below is a summary of some of these guidelines.

It is important to note that the clinical findings and strength of these recommendations are not listed in this article, but are readily available on the ACEP website. Moreover, these recommendations *are not intended to set standards of care* or represent the only diagnostic and management options that a physician should consider. The ACEP, as well as the Insured Colleagues Program™, recognize the importance of the individual physician's clinical judgment. These guidelines help define those strategies for which medical literature exists to provide support for answers to the crucial questions addressed.

I. Acute headache:

1) Does a response to therapy predict the etiology of an acute headache?

   a. "Pain response to therapy should not be used as the sole diagnostic indicator of the underlying etiology of an acute headache."

2) Which patients with headache require neuroimaging in the ED?

   a. Those with "new abnormal findings in a neurologic examination (including focal deficit, altered mental status, altered cognitive function)."
   b. Those "patients presenting with new sudden-onset severe headache."
   c. "HIV-positive patients with a new type of headache should be considered for an emergent neuroimaging study."
   d. While clinical evidence is lacking for those patients who are older than 50 years and presenting with a new type of headache but with a normal neurologic examination, the ACEP recommendation is that these patients be "considered for an urgent neuroimaging study."
   e. "Emergent studies are those essential for a timely decision regarding potentially life-threatening or severely disabling entities."
   f. Urgent studies are those that are arranged prior to discharge from the ED (scan appointment is included in the disposition) or performed prior to disposition when follow-up cannot be assured.

3) Does lumbar puncture need to be routinely performed on ED patients being worked up for nontraumatic subarachnoid hemorrhage whose noncontrast brain CT scans are interpreted as normal?

   a. Patients presenting to the ED with sudden-onset, severe headache and a negative noncontrast head CT scan result should have a lumbar puncture performed to rule out subarachnoid hemorrhage.

4) In which adult patients with a complaint of headache can a lumbar puncture be safely performed without a neuroimaging study?

   a. It is recommended that those patients exhibiting signs of increased intracranial pressure, i.e. papilledema, absent venous pulsations on fundoscopic examination, altered mental status, focal neurologic deficits, signs of meningeal irritation, etc. should undergo a neuroimaging study before having a lumbar puncture.

5) Is there a need for further emergent diagnostic imaging in the patient with sudden-onset, severe headache who has negative findings in both CT and lumbar puncture?

   a. Those patients with negative findings on a head CT, normal opening pressure, and negative findings in CSF analysis do not need emergent angiography and can be discharged from the ED with follow-up recommended.

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State Board Investigations/Administrative Claims – Protecting Your License

By Susan Martin, R.N., J.D.

Physicians work extremely hard for much of their lives, attending medical school, internships and residency programs, all in an effort to achieve tangible evidence of their determination and success: the license to practice medicine. The license is a precious commodity and physicians should take all necessary steps to safeguard and protect it from restriction and/or revocation.

Any complaint from the state board is a serious and a potential threat to licensure status. Since many state board investigations are subject to open record (or published on state board websites), it is imperative that physicians get competent legal advice when responding to a board investigation.

AMS RRG's approach to these actions is unique. Most professional liability carriers or risk retention groups do not provide coverage for state board investigations and/or administrative actions, or they require the physician to retain his own counsel and request reimbursement for the fees from the carrier (or its designee) – a cumbersome process for the physician and one that also lacks a guarantee. At AMS RRG, we are guided by the following policy language:

"If you become subject to a state of federal regulatory investigation, we will pay the costs of *defending* the investigation up to but not exceeding Twenty-Five Thousand Dollars ($25,000) for any one such investigation and Seventy-Five Thousand Dollars ($75,000) in the aggregate for the policy period. We will not pay these costs unless:

a. the investigation is of a civil and not a criminal nature;

b. the investigation is the outcome of an injury or damage resulting from a medical incident covered under this policy; and

c. you have informed us of the investigation promptly after you receive notice of it and we receive your notice of the investigation during the policy period.

As outlined above, if the complaint is of criminal nature, AMS RRG will not cover it. If a physician has sexual relations with a patient, and the patient or family files a complaint, it is not a "medical incident" and would not be covered because sexual misconduct is excluded. But in most cases, the coverage applies because the complaint is more straightforward, such as a standard of care concern.

To ensure coverage, however, the complaint must be reported to AMS RRG **promptly** during the policy period, meaning within 30 days of receipt of the letter from the state board or administrative agency. Once the complaint is received, physicians also have a duty to respond according to their state's specific requirements and timeframes. For example, in Texas, the state board ("TMB") requires a written response to the complaint within 14 days of the date on the letter. If a physician is out of town or does not get the letter until after the date to respond, the board will consider it "untimely" and open up a formal investigation file. The TMB does not grant **any** extensions on the first letter of complaint. Many other states have the same or similar requirements.

AMS RRG will usually assist in the answer to the complaint or response to the formal investigation, if contacted immediately. Upon request for a meeting, hearing, or any other proceeding, AMS RRG will assign legal counsel for the physician. We retain very competent, knowledgeable attorneys who have expertise in managing administrative law claims and know how to get in front of the state medical board. Many of our defense panel counsel also handle both medical malpractice litigation as well as state administrative complaints or investigations.

AMS RRG stands ready to fully support our insureds through these often intrusive board investigations. We want our physicians to consider us a true partner who will work closely to provide timely, expert advice and assistance; all we ask is that insureds treat all complaints as seriously as we do.

If you have any questions about our claims management process, please contact Susan Martin, Esq. at (866) 520-6896 or Steve Shapiro, MD at (954) 332-2423.

Key Team Members Added to Maintain Top Service

Best Practices Insurance Services, LLC recently hired two professionals to maintain its high level of service to AMS RRG: Patricia ("Trish") Tornillo and Norma Hill.

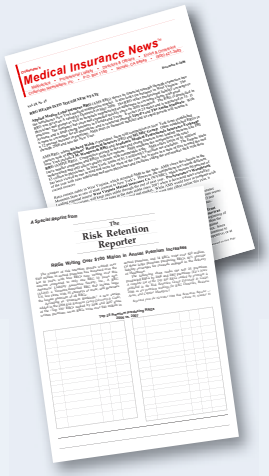
An attorney with extensive experience in the field, Trish joined our Texas operation's medical claims/litigation management team, where she assists Susan Martin, our EVP of Litigation/Loss Control. Most recently, Trish ran her own TPA specializing in medical liability claims adjudication for self-insured programs. Previously, she worked with Western Litigation Services where she was responsible for several clients, including a large ED group in Orlando, Florida.

With her banking background, excellent attention to details and responsive nature, we brought Norma in to join our Pennington, New Jersey, operational team as Billing and Accounting Specialist. She will now be the primary contact for billing and accounting matters, enabling underwriter Chris Edge to spend more time on our insureds.

AMS RRG Now Registered in Pennsylvania

In November, AMS RRG received approval to do business in Pennsylvania, completing our strategic expansion into the Northeast region. By broadening our network of insureds, the addition of the state will enable us to enhance our service to area groups and ensure we continue to deliver the most competitive pricing.

News Bites



AMS-RRG's expansion into the New York market was featured in the December 8, 2008, issue of *Crittenden's Medical Insurance News.*

The company was also listed among the nation's top 25 risk retention groups, ranked by gross written premium, in the November 2008 issue of *Risk Retention Reporter.*

Technology Officer Promoted to Meet Evolving Needs

As we continue our rapid growth, we recognize the increasing need for disciplined processes to control access to our organization's information and maximize its usefulness. To assist us in our transformation to a more information-centric organization, Best Practices Insurance Services, LLC recently promoted Ramy Reddy to the role of Vice President of Information Services.

Ramy has been a valuable member of our team since joining the organization in 2005. During his tenure, Ramy led our efforts to select and implement our enterprise technology system, Sirius, and brought his attention to detail to meet our dynamic needs for internal process development and external stakeholder reporting.

"It didn't take long for us to realize Ramy's critical contribution to the management of our information, and we're pleased to expand his title to Vice President of Information Services to reflect his ever-growing role in this important area of our organization," said Richard Welch, President of AMS RRG.

ACEP Guidelines

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II. Critical issues in the evaluation and management of adult patients with non-ST-segment elevation Acute Coronary Syndromes.

Clearly, patients presenting to the emergency department with chest pain and other symptoms suggestive of acute coronary syndromes are among the most common reasons patients go to the ED. The differential diagnosis for these symptoms range from the benign, including chest wall strain, bronchitis, indigestion, etc. to the life-threatening, including Acute Myocardial Infarction (AMI), pulmonary embolism, and aortic dissection, among others. These patients account for a significant percentage of the medico-legal risk a physician will face both in the Emergency Department as well as the outpatient setting.

The ACEP, as well as multiple other societies, including the American College of Cardiology, have devised guidelines to help physicians in their evaluation and treatment of patients presenting with these symptoms. We recommend that all physicians avail themselves of these sources of peer reviewed information to help them better understand the national guidelines affecting their provision of care. Below is a brief summary of ACEP guidelines designed primarily to help physicians reduce their medico-legal risk when evaluating patients presenting with chest pain. This discussion is designed to help evaluate those patients who present to the ED with chest pain syndromes that are not typical of an Acute Myocardial Infarction at initial evaluation.

1) Serial EKGs are recommended during the ED evaluation of patients in whom the initial EKG is nondiagnostic for injury and who have symptoms consistent with ongoing or recurrent ischemia. Studies suggest that 30 to 60 minutes after baseline may be a reasonable time interval for repeat EKG.

2) Do not utilize cardiac serum marker tests to exclude non-AMI acute coronary syndromes such as unstable angina.

3) There have been multiple strategies developed and criteria issued by the World Health Organization and Joint European Society of Cardiology (ESC) in combination with the American College of Cardiology to evaluate patients for the presence of an acute myocardial infarction. Ultimately, from a medico-legal standpoint, cardiac enzymes need to be measured. Symptom onset is not always clear and if the first set of enzymes is negative, a second set should be considered. Typically, this second set should be performed 90 to 120 minutes after the first set for those patients presenting less than 8 hours after symptom onset.

4) Ultimately, it is the decision of the Emergency Medicine physician to determine whether cardiology is consulted, the patient is admitted, or the patient is discharged. When there is any remaining concern, it is safer to involve cardiology, admit the patient (even if this requires using observation status), and to continue the serial workup of these patients pending further physician involvement.

5) Please review the ACEP website as well as the website for the American College of Cardiology for further information regarding the evaluation and management of these patients.

Lastly, I want to again emphasize the wealth of peer reviewed information available online. Below are the links to some of the national society websites available to physicians:

- **www.acep.org**
  American College of Emergency Physicians
  (available online)

- **www.acc.org**
  American College of Cardiology
  (available online)

- **www.aaos.org**
  American Academy of Orthopaedic Surgeons
  (available online)

- **www.facs.org**
  American College of Surgeons
  (information is available for purchase here)

- **www.acponline.org**
  American College of Physicians
  (available online)

AMS RRG President's Message

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strategy and growth. Our premium goal for 2009 is $30 million. To reach that milestone, we will continue the strategies that have served us well since our inception: underwriting discipline, proactive clinical risk management, aggressive claims management, and capital growth/preservation. We'll also continue to enhance our infrastructure to support our growth and to provide the exceptional level of service that our members expect.

Upcoming Conferences and Meetings

AMS-RRG will be at the following events:

Arizona Society of Anesthesiologists
February 13-16 in Scottsdale, AZ

PLUS Medical Professional Liability Symposium
March 24-25 in Chicago, IL

American Association of Orthopaedic Executives (BONES)
May 3-6 in Austin, TX

Next Physician Call

- **March 3, 2009**
  3:00 pm EST
  Emergency Medicine

401 East Las Olas Blvd.
Suite 1400
Fort Lauderdale, FL 33301