Cataract Co-Management Manual

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INTRODUCTION

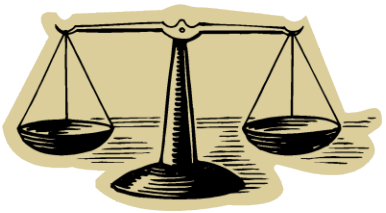
The co-management model of primary care eye doctors working with secondary and tertiary care ophthalmologists has been successful in Hawaii. This joint arrangement provides patients with the alternative of having post-operative care provided by their own eye care professional with whom they have a longstanding relationship, and may be more accessible, especially on the neighbor islands.

Ongoing and clear communication between doctors is essential for ethical and safe co-management for cataract and refractive surgery patients. This manual is intended to serve as a guide for co-management of cataract patients. It includes a brief description of the pre-operative evaluation, our current surgical technique and post-operative findings.

Fortunately, most cataract surgeries result in safe, rapid visual rehabilitation. However, there is the possibility of vision threatening complications. The ability to recognize abnormal from normal post-operative findings is paramount to ensure a successful post-operative result.

PRE-OPERATIVE EXAM

Cataracts are a leading cause of reduction of vision, particularly in the aging population. A careful dilated eye exam is needed to determine the nature of the cataract and to ensure that the cataract is the only cause of visual loss. Macular disease is common in this older population and its presence may reduce the visual benefit from cataract surgery. Questions to consider before proceeding with surgery: Is the patient having problems doing the things he or she needs or likes to do? What is the predicted outcome? What is the condition of the other eye? What is their medical status? Do the benefits outweigh the risks?



The chief criterion for proceeding with surgery is *interference with lifestyle.*

This subjective guideline may mean different recommendations for different patients. For example, a patient with nuclear sclerotic cataracts and 20/80 distance best vision who experiences no visual difficulties in their daily activities and does not drive may not be a candidate for surgery at this time. An accountant with 20/25 distance vision and posterior subcapsular cataracts may be very affected, as he or she could be experiencing difficulty with their predominantly near tasks and demonstrate a significant reduction in vision with glare testing. In every case a decision should be made based on the individual patient's needs and desires.

SCHEDULING

When you call to refer a patient a cataract evaluation, please let us know if you are interested in co-management. There are two forms that must be completed to appropriately bill for co-management: ***Cataract Referral Record*** and ***Patient Consent for Co-management***. It is important for the patient to understand that you will participate in their post-operative care and to have them sign the patient consent form for co-management. Not all local insurance companies recognize co-management, but we will gladly check on the patient's insurance.

We will always try to schedule a cataract evaluation as soon as we can when you call but if you need the patient to be seen sooner, just let the receptionist know their time frame, and we will do our best to accommodate their schedule.

We will coordinate with your patient to schedule the surgery, either in person if it is urgent case, or via phone to minimize office time. Upon leaving our office, the patient is given a packet with general surgery information, more detailed consent forms tailored to patients surgical plan are sent via mail or email.

After surgery, our team will see the patient on the one-day post-operative visit. We will fax the result of the exam to you so that you will have it on subsequent patient visits. Please fax post-operative forms back to us and always give us a call if you have any questions.

NEIGHBOR ISLAND CO-MANAGEMENT

Dr. Jenkins and Dr. Peterson work with neighbor island doctors for refractive and cataract surgery co-management. If a patient chooses to have cataract surgery on Oahu, we will be glad to help with the arrangements.

Neighbor island patients may have their cataract evaluation the day before surgery and undergo surgery the next day, followed by their one-day post-operative visit on the third day. This schedule requires a two-night stay on Oahu.

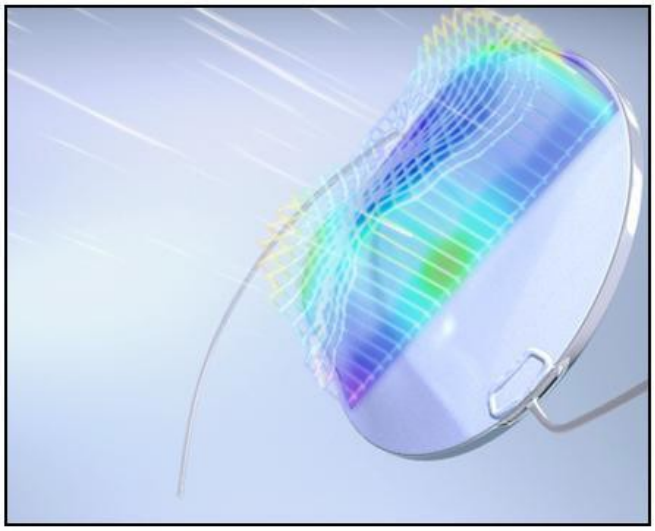
We require that the patient arrange for a surgical clearance from their primary care physician before arrival on Oahu.

For scheduling neighbor island patients, please call our office and speak with one of our surgery coordinators.

INTRAOCULAR LENS (IOL) OPTIONS FOR CATARACT PATIENTS

When a cataract is removed, it is replaced with an artificial intraocular lens (IOL). There are a variety of IOLs that can be used in cataract surgery. Each has their own set of advantages and disadvantages. The FDA approval process for IOLs is among the most rigorous in the world.

Fixed Focus Monofocal IOLs are used in the majority of cataract procedures. These lenses have a fixed focal point, and may be set for distance or near vision. This requires detailed discussion with the patient on what their refractive goal will be. These lenses have the advantage of excellent quality distance or near vision under a variety of lighting conditions. For patients willing to use reading glasses for near tasks, these IOLs are an excellent choice. Millions of lenses of this variety have been used for decades with an excellent safety record. Recent refinements in the optical quality of these lenses have allowed an even higher quality of vision than previously achieved. Using innovative wavefront lens technology, aspheric IOLs can improve contrast so one can see well even in low-light situations such as night driving. Some IOLs are available with special materials used to block potentially harmful blue light. Fixed focus monofocal IOLs are usually covered by most insurance companies, along with the expense of the surgery.



Toric Monofocal IOLs are a great refractive surgical option for patients with high corneal cylinder. Although limbal relaxing incision (LRI) procedures can be effective for mild to moderate corneal astigmatism correction (-0.75 to -1.25 diopters of cylinder), there is no better surgical choice for those with higher corneal cylinder (≥ -1.25 diopters) than a toric monofocal IOL like Alcon's AcrySof Toric. The toric IOL has been approved to correct over 4 diopters of astigmatism. The criterion for selection of these patients is that their refractive astigmatism is corneal based, not lenticular (i.e. refracted cylinder is similar to keratometry or topography cylinder). As this is considered a refractive option, insurance policies will not cover both the toric IOL and LRI, so there will be an out of pocket expense for your patients.

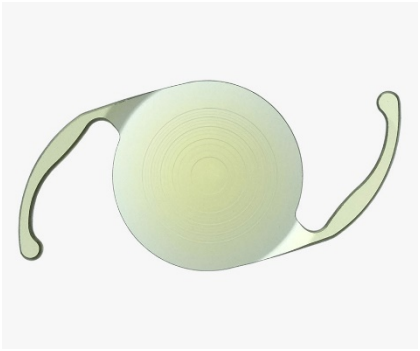
Model	Cylinder Power and Recommended Correction Range

	IOL Plane	Corneal Plane*	Range
SN6AT3	**1.50**	**1.03**	**+.75 - +1.50**
SN6AT4	**2.25**	**1.50**	**+1.50 - +2.00**
SN6AT5	**3.00**	**2.06**	**+2.00 - +2.50**
SN6AT6	**3.75**	**2.57**	**+2.50 - +3.00**
SN6AT7	**4.50**	**3.08**	**+3.00 - +4.00**
SN6AT8	**5.25**	**3.60**	**+4.00 - +4.50**
SN6AT9	**6.00**	**4.11**	**+4.50 on**

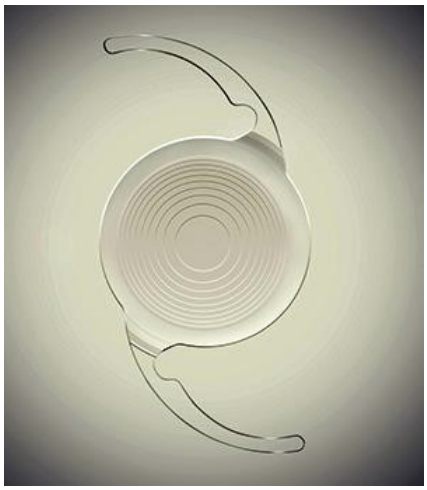
AcrySof Toric

Multifocal IOLs enable patients to achieve good distance and near vision without glasses. Excellent results have been achieved by FDA approved lenses of this type. The Vivity, Pantopix and the Symfony are among the most popular multifocal IOLs. These IOLs use a patented diffractive optical design to divide light into multiple focal zones so that near and distance objects can both be seen without glasses. Multifocal IOLs have a slightly greater tendency to cause halos at night than other IOLs, so those who drive a great deal at night may wish to consider a different IOL. Patients should also be aware of the possibility that a mild pair of reading glasses may be required for fine print or long-term reading. Multifocal IOLs are also available to correct astigmatism, greatly expanding the patients who are candidates for these lenses.

Vivity IOL



PanOptix IOL

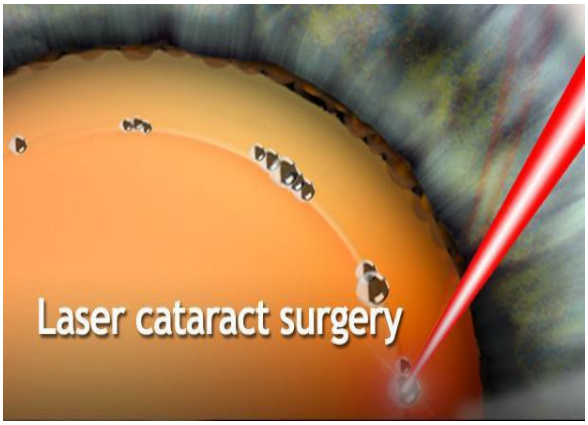


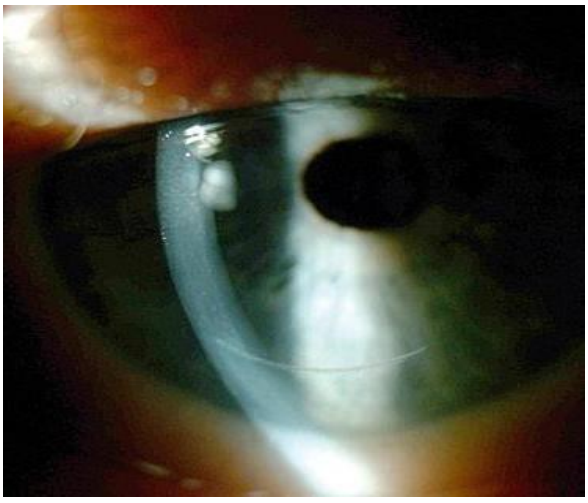
Symfony IOL

Toric IOLs and Multifocal IOLs are high technology lenses that require additional measurements and preoperative counseling. The cost of these services as well as the cost of the IOL *is* ***NOT payable by insurance*** (though the cost of the cataract surgery is typically payable by insurance companies).

ORA (Optiwave Refractive Analysis) SYSTEM OPTIPLUS uses a wavefront analyzer in the operating room that can assist the surgeon in determining the ideal power and position of the implanted IOL. Surgical Suites is the only facility in Hawaii that has this system. This unique technology can further enhance the accuracy of the surgical outcome. We may recommend the use of OptiPlus in patients who decide to have Toric or premium IOLs, as well as those who have had previous LASIK, PRK, AK or RK procedures. This technology is **NOT covered by insurance** but is included in the premium package if the patient elects to have their corneal astigmatism reduced (with or without a toric IOL) or chooses a multifocal IOL.

Laser-Assisted Cataract Surgery (LenSx)

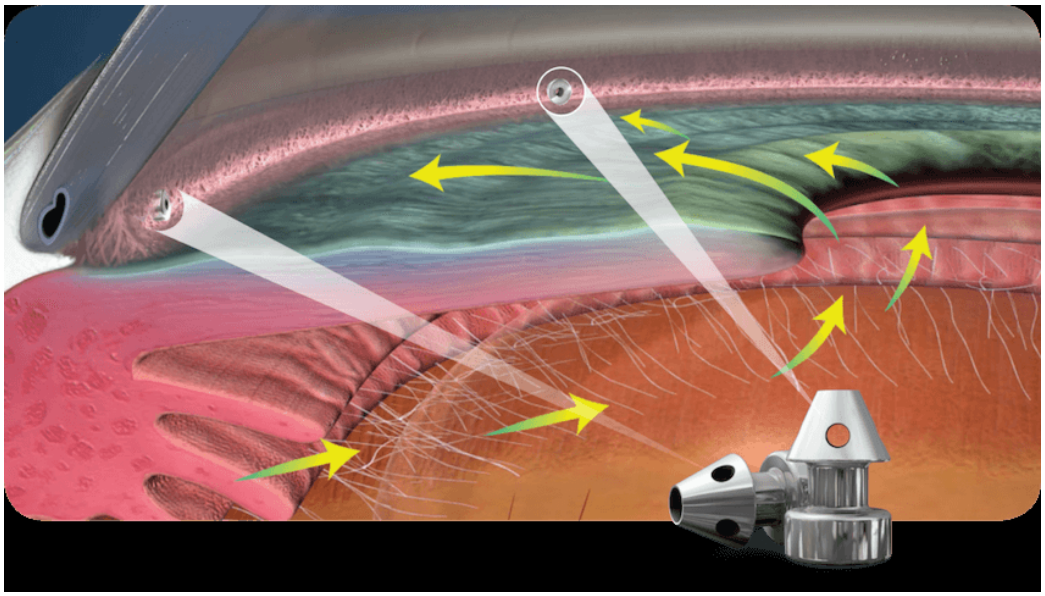




LENSX is a femtosecond laser that assists during cataract surgery. This technology further improves the predictability, safety, and visual outcome of refractive cataract surgery. The laser is used to make the corneal incisions, limbal relaxing incisions, anterior capsulotomy, and dissection of the cataract prior to ultrasound. Laser-assisted cataract surgery can decrease anterior chamber inflammation post-operatively and potentially lessen surgically induced endothelial cell damage. This technology is **NOT covered by insurance** but is included in the premium package if the patient elects to have their corneal astigmatism reduced (with or without a toric IOL) or chooses a multifocal IOL. The patient may not be a candidate if their pupils do not dilate well or if suction cannot be attained during the procedure.

Cataract Surgery for Patients with Glaucoma

For patients with glaucoma, cataract surgery is an excellent opportunity for additional IOP lowering by combining cataract extraction with a minimally invasive glaucoma surgery (MIGS). We currently offer both the iStent, Micropulse Laser and the Omni Surgical System. These procedures add only minutes to the overall operating time, and provide a sustained IOP lowering effect, allowing patients to minimize their dependence on glaucoma drops. MIGS may be used in patients undergoing both standard and premium IOL implantation.



SURGICAL TECHNIQUE

Our current technique is a “clear-cornea” technique and typically stitches are not needed for wound closure. An incision approximately 2.5 mm is made either superiorly or temporally at, or just inside the limbus, extending about 2 mm into the cornea. The architecture of this incision makes it self-sealing. One or two 1 mm incisions also are made. The eye is filled with a viscoelastic substance to help maintain the anterior chamber. An anterior capsulotomy (a rounded continuous tear) is performed. This is called “capsulorhexis.” The nucleus of the cataract is loosened with saline and then removed with an ultrasound phacoemulsification instrument. The remainder of the cataract is then removed with aspiration.

An empty capsular “bag” remains. Unless there has been a tear in this bag during surgery, a foldable lens implant is placed in the bag. This lens may be made of silicone or acrylic. Insertion is made with a special inserter through the original 3 mm incision with the assistance of viscoelastic. The viscoelastic is then removed because it can be a cause of high intraocular pressure post-operatively. It is at this time that MIGS is performed, if indicated. The anterior chamber is inflated with saline at the end of surgery, which causes the wound to seal.

Topical anesthesia is typically used for this technique. On rare occasions, a patient may need additional anesthesia such as a retrobulbar injection. A small amount of intravenous sedative (a Valium-type drug) is given for relaxation. An anesthesiologist monitors the patient’s vital signs. The patient is asked to fixate on the microscope light and usually will not experience any pain but may feel some pressure. If the patient experiences any undue discomfort, an additional intraocular anesthetic may be injected into the eye. Patients frequently say they see “a light show” (no extra charge!) and are amazed when the procedure is completed in 10 to 20 minutes.

POST-OPERATIVE CARE AND COMPLICATIONS

IMMEDIATE POSTOPERATIVE PERIOD – The patient generally walks out of the operating room with some assistance, and is given some refreshments – coffee, juice, and toast. Usually a patch is not needed (though some patients may be patched) and the patient is given instructions. The patient is discharged when vital signs are stable: typically about a half hour after surgery, or a total of one and a half to two hours from arrival. At this point, the patient can see out of the operated eye but because it is still dilated, images may be blurry.

The patient is not allowed to drive the day of surgery. Post--operative eye drops are reviewed. These may include:

-topical antibiotic
-topical NSAID
-topical steroid

Currently we're using a special formulation that is a compound of all three medications above. The combination eye drop is our preferred therapy that we have found aids in compliance and ease of use. All patients will receive an additional intracameral injection DexMoxi, unless contraindicated by allergy.

The patient will be asked to wear a shield at night for 1 week, avoid water in the eye, and avoid vigorous exercise and exertion for the week. The patient can expect some mild discomfort as well as a foreign body sensation.

If the patient has some pain, we recommend they take what they would ordinarily take for pain. We also recommend the use of lubricants if a gritty sensation is felt. If severe pain or loss of vision is experienced, they need to call us as soon as possible.

ONE-DAY POST-OPERATIVE EXAM (at Jenkins Eye Care)

The patient may drive to this appointment if they feel comfortable. Vision may be variable and the patient will be instructed to continue their eye drops as instructed.

If the IOP is noted to be elevated, an anti-hypertensive medication will be given. The result of this exam will be faxed to you to ensure you have this information for the one-week exam.
For patients undergoing concomitant MIGS, the IOP is often quite low after surgery, and glaucoma drops are typically held.

ONE WEEK POST-OPERATIVE EXAM – (at the co-managing doctor's office)

Subjective

Typically the patient will say that their vision has improved. He or she may continue to complain of photophobia and of a foreign body sensation. Complaints of severe pain or visual loss anytime in the early post-operative course should alert the doctor to the possibility of endophthalmitis, which needs to be treated immediately.

Vision

Vision is checked to ensure it is not out of proportion with physical findings. A manifest refraction at this time will help provide feedback to our office on the accuracy of our measurements. If the best-corrected vision is decreased, this should be documented and explained. Possible reasons for reduction in best-corrected vision include persistent corneal edema, macular edema and epiretinal membrane.

Tension

IOP at this point should be in the normal range. If the patient is on anti-hypertensives that were started at the first post-op visit, and the IOP is within normal limits, the medication may be discontinued. If the patient has been on glaucoma medications in the past, he or she should continue throughout the post-operative period. If the IOP is <7, the wound integrity needs to be evaluated. Instilling 2% flourescein eye for a Seidel test is the best way to check for wound leaks. Wound leaks at the one-week post-operative visit are extremely rare. If the IOP is elevated and no other abnormalities found, the patient may be a steroid responder. In this case consider switching the patient to Lotemax and/or adding an ocular IOP-lowering medication may be needed for the duration of steroid use.

Lids

Ptosis – Some amount of ptosis is occasionally seen. This may be due to post-operative inflammation or may be a side effect of the steroids. In either case, it is usually self-limited and the patient should be reassured that the ptosis will resolve. If a 1-2 mm ptosis persists beyond three months and the patient is off medications, it should be considered permanent. This is thought to be a result of the lid speculum used intraoperatively for lid retraction, which can cause levator dehiscence. Surgery may be indicated if it interferes with the patient's superior visual field.

Ecchymosis– Bruising will usually only occur in patients who have had a retrobulbar injection and will resolve in two to four weeks.

Conjunctiva

Hyperemia or injection of the conjunctiva is variable and is related to the amount of inflammation seen. At one week there typically is only trace to +1 injection seen. If there is still some inflammation, prolonged steroid use may be indicated.

Subconjunctival hemorrhage may be seen occasionally. The patient needs to be reassured that this will clear in several weeks.

Cornea

Epithelium – Patients often complain of a foreign body sensation and usually this is due to some epithelial irregularity around the wound. Addition lubrication in the form of artificial tears and lubrication gels or ointment at night may help. At this point the wound should be watertight, and the patient may resume water activities.

Stroma – The most common corneal finding is edema. This may vary from none to moderate. It may be only around the wound but also may take the form of endothelial folds. If these folds are central they will affect vision. Keeping the IOP as low as possible and adding Muro 128 ointment to the post-operative regimen usually helps. Fortunately, most cornea edema is self-limited and resolves during the first six weeks post-operatively.

Anterior chamber

Cell and flare are seen in all patients immediately after surgery as a result of traumatic uveitis. At the one-week visit, some persistent cell and flare may be detected. Hypopyon, or severe inflammation, is unusual and endophthalmitis should be a concern in that case. REFER THE PATIENT BACK TO US ASAP. Cortical fragments may rarely be seen in the anterior chamber or even the posterior pole. The patient may experience floaters. These symptoms may be

associated with increased IOP or inflammation but they generally resolve in weeks. The increased inflammation and IOP can be controlled medically. Nuclear fragments are waxier in appearance compared with the cotton-like cortical fragments. Larger nuclear fragments are responsible for persistent inflammation and further surgical management may be indicated. *Please call us if you suspect this.*

Iris

Damage to the iris may occur during phacoemulsification. Ordinarily, it is only of cosmetic concern. The pupil should be round unless it has been traumatized.

IOL

The IOL should be well centered. Minor decentrations are generally of no visual significance but may cause edge glare at night. If the IOL placement is abnormal, please contact the surgeon, especially in cases of pupillary capture.

Posterior Capsule

This should be clear. There may be some residual capsule opacification in cases of severe posterior sub-capsular (PSC) cataracts. This eventually may require a YAG laser capsulotomy. Late posterior capsular opacification (PCO) occurs in about 30% of patients and requires a capsulotomy if visually significant. If the capsule was ruptured at the time of surgery, a central capsule may not be present. In most such cases a posterior chamber lens can still be inserted but is instead positioned in the sulcus rather than the capsular bag. In these cases, there may be increased and prolonged inflammation requiring modification of the post-op drug regimen.

Vitreous and Fundus

The vitreous should be clear. However, if a patient complains of floaters look for a posterior vitreous detachment, retained cortical or nuclear remnants, or a vitreous/retinal hemorrhage. If a patient complains of floaters or flashing lights anytime during the post-operative period, a dilated fundus examination with careful attention to the peripheral retina is warranted. On occasion, a patient will describe a flashing sensation immediately after surgery, which is characterized as a “shimmering” or “fluttering” feeling. This is probably due to an optical effect from the implant and should not persist beyond the first post-operative week. If it does last longer, a dilated exam should be repeated.

Medications and Activities

Medication use may vary depending on the individual and type of surgery performed. Common schedule for the compounded drop is TID x 3 days prior to surgery, continue for 1 week post op, then taper to BID x 1 week and QD x 2 weeks then stop.

If the patient has persistent inflammation, it may be appropriate to continue the steroid/combo drop for another few weeks. If, however, the eye is very white and quiet, the combo drop can be discontinued around 1 month. Artificial tears still may be used for intermittent foreign-body sensation. At this point, the patient usually can resume all normal activities. The timing of the next visit is determined by how the patient is doing. If his or her eye is quiet and healing well, he or she may be seen in three to four weeks. If the patient has high pressure or unusual inflammation he or she may need to be seen sooner.

ONE-MONTH POST-OPERATIVE EXAM – (at the co-managing doctor's office)

The purpose of this visit is to perform a thorough examination to detect any persistent problems. If good visual acuity is not attainable at this point, the etiology should be determined. Possible causes include cystoid macular edema (Irvine-Gass Syndrome), posterior capsular opacification (PCO), corneal abnormalities and/or age-related macular degeneration.

Perform a manifest refraction. Vision should be correctable to near 20/20 if there is no significant macular pathology. Lids, conjunctiva, cornea, AC, IOL, posterior capsule and the fundus should be normal. The anterior chamber reaction should have disappeared by now. Evaluate the posterior capsule well - striae or early fibrosis may be the a cause of reduced vision. A careful dilated fundus examination is appropriate at this point. A dilated fundus exam is needed sometime during the first month after surgery. It should also be performed anytime the patient is complaining of symptoms of flashes and floaters or severely decreased vision that cannot be explained. If the patient is not having surgery on the other eye in the near future, then a prescription for glasses may be dispensed. If there is any concern at this visit or any visit regarding the healing process, please give us a call.

THREE TO SIX MONTH POST-OPERATIVE VISITS - (at the co-managing doctor's office)

The timing for this visit should be determined on a case-by-case basis. Again, a full eye exam should be performed with special attention to the posterior capsule and posterior pole. Once again, any reduction in visual acuity needs to be explained. Twenty to thirty percent of patients will develop posterior capsule opacification, and may need a YAG laser capsulotomy within a year of surgery. If the capsule is opacifying but not yet causing vision loss, a return visit within a few months is indicated.

YEARLY EXAMS - (at the co-managing doctor's office)

Once a patient is stable following a successful cataract extraction, a thorough yearly eye exam is needed. Pseudophakic eyes have a higher incidence of certain problems such as retinal detachment, macular edema, and diabetic retinopathy. Therefore, you should continue to see your post-cataract surgery patients on a yearly basis.

Note: *Diabetic patients should be seen more frequently as cataract surgery can trigger and/or exacerbate retinopathy.*

CONCLUSION

Cataract surgery is an extremely successful procedure and complications are rare. Early recognition and treatment of problems are essential. Communication between the surgeon and co-managing doctor's office is paramount for providing the best care. The co-managing doctor following the patient should be available at all times to answer the patient's questions and to see the patient on an emergency basis. The team at Jenkins Eye care will be available at all times for consultation.

Please let us know if you have any questions regarding a patient's postoperative course. We look forward to working with you.

Billing Co-Management Care
(HMSA, Medicare, Medicaid Only)

For patients with Medicare, HMSA and/or Medicaid, the following are suggested guidelines for billing cataract co-management services.

- Basic coverage requirement for the co-management of a patient: the surgeon must initiate the notification to the insurance carriers listed above by using the modifier -54 with the surgery claim (not after the procedure). E.g. 66984-54RT.

- Using form 1500, the co-manager must submit a claim to Medicare, HMSA or Medicaid with the same CPT surgery code (66984), modifier (55), right (RT) or left eye (LT) and the date of surgery as the date of service. E.g. 66984-55RT.

- For Medicare: The exact number of days of care provided to the patient must be identified.

- The beginning date of co-management care is immediately following the date of transfer on the corresponding letter from surgeon to co-managing doctor.

- If the surgeon sees the patient at 1 day or 1 week, and then turns the patient over to the co-manager for the remainder of the 90-day post-operative period, the co-manager can submit the claim showing only care from the date the patient was first transferred, not the first day of the postoperative period *Ex. Patient sees Jenkins Eye Care for 1 day post op and is released to co-manager's care as of that day, Co-Managing doctor is able to file for post-operative care from Day 2 through Day 90.*

- There must be documentation in the surgeon's charting that the patient has requested to return to his or her local optometrist/ophthalmologist for the remainder of the post-operative care. *signed co-manage consent form received by surgeon PRIOR TO SURGERY!

- Only the surgeon can make the decision as to when it is MEDICALLY APPROPRIATE for the patient to be released to the care of the co-manager. This decision cannot be made prior to surgery.

- The receiving doctor should hold off with billing for any part of the service until after the patient is seen.

- If 2nd eye is done within the post op period of the 1st eye, you need to add modifier 79 in addition to modifiers 55 and RT/LT.

Filling in Health Insurance Claim Form 1500

Box 1-13: Complete as usual (patient information)

Box 14: Enter the date of surgery

Box 17: Enter surgeon's name (ex: Tyrie Lee Jenkins, MD)

Box 17b: Surgeon's NPI number (ex. Ty's is 1316903610)

Box 19: **For Medicare**: Dates of the post-op period starting with the day after transfer of care date indicated by surgeon (communicated via letter from surgeon).
Example: ***"Comanaged post op care: # of days (the day after the date of transfer according to surgeon) to (90 days from surgery date)."***
For Private plans like HMSA, HMOs, UHA, HMA, etc:
Example: ***"20% Postoperative Care Fee: 80% Surgeon Fee"*** as they recognize only the % of care split between the surgeon and the co-managing physician/OD.

Box 21: Diagnosis code(s). Enter the most significant diagnosis in #1 and it should be the main reason for the surgery. Ex: Nuclear sclerosis is 366.16

Box 24A: Date of surgery

Box 24B: Place of service is "24" which stands for the surgery center

Box 24 D: CPT code for cataract surgery is "66984"
Modifiers are "55" for co-management, "RT" for right eye or "LT" for left eye, and "79" if it is the 2nd eye within post op period (90 days) of the first eye.

Box 24E: Diagnosis Pointer corresponds with box 21 which indicates the number of diagnosis codes listed. "1" if just one diagnosis code, or "1,2" if two codes are listed, etc.

Box 24F: Enter the total amount you would like to bill for the all the post-op visits. This is what you determine your office charge is. Ex. "$500.00"

Box 24G: The total number of units should be 1. There is a 90 day global period.

Box 24J: NPI # of co-managing physician/optometrist.

Box 25 -33: Complete as usual.

Actions >

SAMPLE COMANAGED CATARACT BILLING
FOR RELEASE OF CARE AFTER 1 DAY
POST OP WITH SURGEON.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [X] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 01 SEX M [ ] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): PO BOX 12345

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: HONOLULU STATE: HI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 96818 TELEPHONE (Include Area Code): (808) 123 4567

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary **to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment** below.

SIGNED: SIGNATURE ON FILE DATE: 01 08 13

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize **payment of medical benefits to the undersigned physician or supplier for** services described below.

SIGNED: SIGNATURE OF FILE

14. DATE OF CURRENT: MM DD YY: 01 01 14 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: TYRIE JENKINS, MD

17a:

17b. NPI: 1316903610

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE: COMANAGED POSTOP CARE: 89 DAYS 01/03/14 TO 04/02/2014

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 366.16
2. 366.14
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 DA TE OF SU RG RY		24		66984	55 RT	1,2	500 00	1		NPI	YOUR NPI #
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 123456789 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 500 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

JANE SMITH MD 010913

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION:

ALOHA EYE CENTER
12345 ALOHA STREET
HONOLULU, HI 96818

a. 8888888888 b.

33. BILLING PROVIDER INFO & PH #: (808) 123 4567

JANE SMITH OD LLC
PO BOX 9999
HONOLULU HI 96818

a. 0987654321 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Premium Lens Fees

This fee is to be determined & collected by your office in addition to insurance co-payments for standard cataract surgery

Type of Premium Service/Lens	Estimated Fee To Jenkins Eye Care	Estimated Fee for IOL to Surgical Suites	Fee to Co-Managing Doctor
Astigmatism Correction by LenSx only	$2000 + tax	$0	$0 if LenSx only
TORIC IOL	$1350 + tax	$550	estimated $150-$350
Vivity PanOptix Symfony IOL	$2150 + tax	$1050	estimated $150-$350

Premium lens fees paid include some or all of the following:

- **Refraction to determine refractive error**
- **IOL master/immersion ultrasound to determine IOL power**
- **Corneal mapping/topography – including Pentacam**
- **Corneal Keratometry**
- **ITrace visual analysis**
- **Corneal endothelial cell count**
- **Pachymetry**
- **Marking of the axis of astigmatism on the eye at the outset of surgery**
- **LenSx laser refractive cataract surgery to assist in corneal incisions, precise capsulorhexis softening of the cataract and placement of incisions to treat astigmatism**
- **Wavefront aberration testing intraoperatively to determine lens power and placement (Optiplus)**
- **IOL exchange in extraordinary cases**
- **LASIK or PRK to refine any residual refractive error *(if necessary)***

With the premium lens care fees being non-covered by insurance companies, we highly recommend acquiring an ABN for these services. At Jenkins Eye Care, we educate each patient on the estimate of fees, so they know what to expect, including a portion of the premium lens fee to be paid to your office. We thoroughly educate the patient that these premium lens fees are in addition to the standard portion of surgery copayment.

FINANCING OPTIONS

Several financing options are available for your patient should they choose to use them. We use Care Credit and Alphaeon Credit. Approval takes only seconds, making these procedures more affordable for our patients. Applications can be filled out online or in our office.

JENKINS EYE CARE

615 Piikoi St., # 205, Honolulu, HI 96814 Ph: 808-591-9911 ♦ Fax: 808-591-9909 ♦ Toll Free: 855-522-2020

CATARACT REFERRAL RECORD

Date _____ *Patient's Name* _____ *DOB*

Referred By _____ *Address* _____

Address _____ *City, State, Zip* _____

Phone _____ *Home Phone* _____ *Work Phone*

Reason(s) for Referral: _____

Pertinent Symptoms, History: _____

_____

Results of Examination:

Rx: OD _____ BCVA_____

OS _____ BCVA _____

Tonometry /_____(method) Time: OD_____OS _____

Pupil Sizes (bright/dim illum): OD_____mm/_____mm OS_____mm/_____mm

Other Pertinent Results of Examination: _____

_____

Procedures Requested:_____

_____

_____ **Co-manage?** Yes / No

Referring Doctor's Signature (if Yes, have patient sign co-management consent)

JENKINS EYE CARE
Tyrie Jenkins, MD Jeffrey Peterson, MD, PhD Nicole Chang, OD Katherine Lynch, OD, FAAO
615 Piikoi Street Suite 205, Honolulu, Hawaii 96814 Ph: 808-591-9911 Fax: 808-591-9909

CONSENT FOR CO-MANAGEMENT AFTER EYE SURGERY

Patient Name:_____

Patient Confirmation:

Dr. Tyrie Jenkins / Dr. Jeffrey Peterson will be performing my CATARACT surgery.
It is my desire to have my eye doctor, Dr. _____, perform my cataract post-operative follow-up care. I have discussed this postoperative selection with Dr. Tyrie Jenkins / Dr. Jeffrey Peterson and Dr._____.

I understand that my eye doctor will contact Jenkins Eye Care immediately if I experience any complications related to my eye surgery. I also understand that I may also contact Jenkins Eye Care at any time after the surgery.

Patient:_____Date: _____

Witness:_____Date: _____

Eye Doctor Confirmation:

I agree to provide CATARACT post-operative care on_____. I will see the patient after surgery when Dr. Tyrie Jenkins/Dr. Jeffrey Peterson releases the patient to my care. I also agree to provide progress reports to Jenkins Eye Care during my portion of the postoperative period and will notify Jenkins Eye Care, immediately should complications arise.

Optometrist:_____Date: _____

JENKINS EYE CARE
Tyrie Jenkins, MD Jeffrey Peterson, MD, PhD Nicole Chang, OD Katherine Lynch, OD, FAAO
615 Piikoi Street Suite 205, Honolulu, Hawaii 96814 Ph: 808-591-9911 Fax: 808-591-9909

PRE-OPERATIVE CHECKLIST

Before Surgery:

- Have your primary care physician complete a medical clearance exam within 30 days prior to surgery.
- Return signed and initialed consent forms to Jenkins Eye Care prior to surgery.
- You will be given an eye drop medication to use three times per day in the surgical eye - **begin the drop three days before surgery** and continue to use as directed.
- Continue all prescribed eye drops until otherwise directed (ex. glaucoma, dry eye, allergy, etc.).
- Fasting:
  - If your surgery is before noon: NO food or drink (including water) after midnight the night before surgery.
  - If your surgery is after noon: NO food after midnight the night before surgery. Non-dairy liquids are allowed up until 6 hours before your scheduled surgery (ex: juice, broth, black coffee, water, or non-dairy smoothie).
- Arrange for transportation on the day of surgery. You will not be able to drive. Your driver must be available for pick up within 10 minutes of discharge. You may resume driving the day after surgery.

Day of Surgery:

- Medications:
  - the morning of surgery ONLY take medications prescribed for your heart or high blood pressure.
  - All other medications you take in the morning (for diabetes, cholesterol, etc.) can be taken immediately after surgery.
- Bring a photo ID, insurance cards, and completed surgery center forms (including a medication list).
- You may shower but avoid getting water in your eye for one week after surgery.

The Week Following Surgery:

- Use the provided eye shield at bedtime for one week after surgery.
- Continue to use the eye drops 3 times per day in the surgical eye.
- Do not use eye makeup.
- Avoid strenuous activity, heavy lifting, and bending from the waist. After two weeks you may resume normal activity, including underwater sports.

POST-OPERATIVE CATARACT EXAM

*Patient Name:*_____ *Date:*_____

*Co-Managing Doctor:*_____

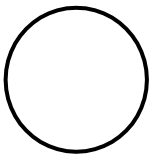
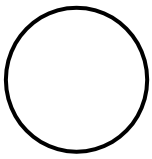
Operative Eye: OD OS OU *Date of Surgery:* _____

Post-Op Exam: 1 Day 1 week 1 Month 3Months 6 Months Other: _____

Procedural Goal: *OD:*_____ *OS:*_____ *Patient Satisfaction:* Low 1 2 3 4 5 High

*Chief Complaint:*_____

*Current Medications:*_____

Cataract	*OD*	*OS*
UCVA	20/____	20/____
Manifest Refraction (*required at 1-week and 1-month post-ops)	_____ / - _____ x _____ 20/____	_____ / - _____ x _____ 20/____
IOP	mmHg	mmHg
Wound	Intact_____Separation	Intact_____Separation
Cornea	Clear_____ Edema_____ 	Clear_____ Edema_____ 
Anterior Chamber	0 +1 +2 +3 +4 Cell/Flare	0 +1 +2 +3 +4 Cell/Flare
IOL Status	Centered_____Decentered_____	Centered_____Decentered_____
Post Capsule	Clear_____Hazy_____Wrinkled_____	Clear_____Hazy_____Wrinkled_____

Plan:

*Next Visit:*_____ *Doctor's Signature:*_____

Please fax this completed form to Jenkins Eye Care
Fax: ***808-591-9909*** *Mail:* ***615 Piikoi Street, Suite 205, Honolulu, HI 96814***