California optometric laser associates

Cataract & Implant Co-Management

POLICY AND PROCEDURE MANUAL

California Optometric Laser Associates

Co-Management of Cataract and Implant Patients
Policy and Procedure Manual

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Introduction

Patients choosing co-management for their pre- and post-operative surgical care experience the benefits of continuity of care by their Primary Eye Care Provider (PECP) and convenience. This manual outlines the process for the co-management treatment of cataract and implant surgery patients. Together with some of California's most experienced cataract and implant surgeons, co-managing doctors of optometry can provide high quality care for cataract and implant patients, consistent with patient needs and desires.

The following guidelines comply with applicable state and federal statutes and regulations regarding co-management of patient care and referral arrangements.

1. The selection of an operating surgeon for patient referral will be based on providing the best potential outcome for the patient. Financial relationships between providers will not be a factor.
2. The patient's right to choose the method of post-operative care will be recognized and will be consistent with the best medical interest of the patient.
3. Co-management of post-operative care will be determined on a case-by-case basis and not prearranged. The patient will be advised prior to surgery of potential post-operative management options.
4. Co-managing doctors will be ODs or MDs licensed to practice in California.
5. The transfer of post-operative care will always be clinically appropriate and depend on the particular facts and circumstances of the surgical event.
6. Following surgery, transfer of care from the operating surgeon to a co-managing provider will occur when clinically appropriate at a mutually agreed upon time or circumstance, and such time will be clearly documented via correspondence and included in the patient's medical record. This information will be included in the referral letter from the ophthalmic surgeon to the co-managing provider at the time of transfer of care.
7. The operating surgeon and the co-managing provider will communicate during the post-operative period to assure the best possible outcome for the patient.
8. Compensation for care will be commensurate with the services provided. Cases involving care for Medicare beneficiaries will reflect the proper use of modifiers and other Medicare billing instructions.

Step-by-step instructions and co-management forms are provided in the following section of this manual.

Step-by-Step Process for Cataract Co-Management

1. ❑ The referring optometrist performs the following:
   a. ❑ Perform exam and identifies need for cataract surgery.
   b. ❑ Educate the patient regarding the process of cataract surgery and discuss fees.
   c. ❑ Discuss the typical co-management treatment plan and explain what care will be provided by the ophthalmic surgeon and the optometrist. Provide the patient with **Patient Handout** (page 11).
   d. ❑ Fax the **Pre-Op Examination and Consultation Request Form** (page 13) to the COLA MD's office.
   e. ❑ Have the patient sign the **Payment Authorization Form** (page 19) and the **Co-management Consent Form** (page 14) and fax the forms to both the MD's office and the COLA administrative offices.

2. ❑ The Patient Coordinator (PC) at the MD's office performs the following:
   a. ❑ Contact the patient and schedule an appointment for a consultation.
   b. ❑ Notify the referring optometrist of the date of the consultation appointment, or the reason the patient declined to book the appointment, if applicable.

3. ❑ The surgeon performs the following:
   a. ❑ Pre-op exam and pre-op testing
   b. ❑ Patient education and procedure selection
   c. ❑ Faxes **Surgeon Consults Results Form** (page 15) to the co-managing eye care provider, advising the date of surgery, patient findings and plans, and any other pre-op care instructions.
   d. ❑ Complete the **Transfer of Care Form** (page 16) (when deemed medically appropriate), which includes surgery information and findings from the previous post-operative visits and faxes the form to the co-managing PECP.

4. ❑ The co-managing PECP performs the following:
   a. ❑ Following each post-operative visit, fax **Cataract/Implant Post-Operative Form** (page 18). Usually at the one month visit, the PECP will perform the post-operative follow-up, refraction and prescribing glasses, if necessary.
   b. ❑ Bill third party payers for their portion of the post-operative treatment. Information regarding billing the PECP's portion of the co-managed care is provided on pages 14-16 of this manual.

5. ❑ Payment for upgraded IOLs or private pay services will be collected from the patient by the California Optometric Laser Associates and reimbursement will be made by COLA, inc. to the PECP for those services.

The MD's office will communicate with the referring provider via fax for any matter regarding their patients, including procedure outcomes and any follow-up visits seen by the surgeon.

Please contact the MD directly for any questions regarding individual patient care or complications.

For ordering necessary supplies, questions regarding payment or general questions about COLA co-management programs, please contact a COLA representatives at 510-895-9657.

We look forward to bringing together a partnership with our affiliated co-managing doctors in which cataract and implant patients can receive the best and most convenient available care.

Disclaimer: Every effort has been made to assure that all information contained in this manual is accurate, appropriate and current with the standards of care in the State of California. COLA takes no responsibility for the payment of individual insurance claims by Medicare or any other third party insurance. All medical care and advice is at the discretion of each MD's and OD's clinical judgment.

The volume of cataract surgeries will continue to increase as the population ages. So, we must stay educated in cataract surgery protocols and possible complications. A thorough pre-op exam and treatment of any existing problems may prevent complications from occurring after surgery. Though serious complications are rare, it is also important to know what post-op complications can occur and how you can manage them, and when it is time to refer the patient back to the surgeon.

PRE-OP EXAM

General Health

The first key to managing complications is to find ways to avoid them altogether or at least decrease their likelihood. This starts with astute observations during your pre-operative exam, and that starts with a general health history. Understanding the patient's overall health at the time of surgery can help chart the strategy of the procedure. It can also help predict and explain the prognosis and course of recovery.

Ask about systemic diseases that affect healing after cataract surgery, particularly **autoimmune and collagen vascular diseases such as rheumatoid arthritis, lupus and diabetes**. Patients with rheumatoid arthritis are at risk for abnormal healing. Examine the patient's hands for telltale signs. Arthritis or lupus may increase the inflammatory response after surgery, resulting in pronounced post-op inflammation, high intraocular pressure, cystoid macular edema or even a corneal melt near the incision.

If the history is positive for any of these diseases, you may have some options to help provide that patient with a normal post-op healing course. The surgeon could consider more inert intraocular lenses (IOLS) made of acrylic instead of silicone, which would reduce a potential source of inflammation. Be prepared for the need to increase the steroid dosing early in the post-op period to control the ensuing inflammatory response.

There are some concerns specific to diabetic patients: poor wound healing, and the risk exacerbating existing proliferative retinopathy and diabetic macular edema. **Diabetics** with poor blood sugar control may have a slower recovery following surgery. Some may benefit from delaying surgery until their diabetes is under control.

Anterior Segment Concerns

Examination of the eyelids prior to surgery should not be overlooked. The leading cause of endophthalmitis is the introduction of bacteria into the eye from the conjunctiva and ocular adnexa. It's important to diagnose and manage **blepharitis** and **meibomitis** prior to cataract surgery.

Also, look for other lid conditions such as **entropion, ectropion and lower lid laxity**. Improper apposition of the lower eyelid can contribute to an inadequate clearing of bacteria, which also increases the risk of endophthalmitis. You may want to refer these patients for an oculoplastic consult prior to cataract surgery.

Patients with **cranial nerve dysfunction** such as a seventh-nerve palsy, which results in an incomplete blink, are also at risk for corneal exposure problems and poor wound healing after cataract surgery. Lubricating ointments and a referral for surgical intervention may be indicated for these patients.

Pterygia, epithelial basement membrane dystrophy, Salzmann's nodular dystrophy or band keratopathy can prevent accurate measurements and limit vision. To accurately assess the cornea for proper IOL power calculations, crisp and regular mires on the keratometer or topographer are essential. Discuss this with the patient prior to surgery to help manage post-op visual expectations. These patients may benefit from corrective surgery prior to the cataract procedure, which would provide for better corneal measurements and improved corneal transparency.

Two additional corneal conditions to consider in counseling patients:

1. **Fuchs' dystrophy** • Patients with moderate to advanced Fuchs' are at risk of permanent corneal edema due to the strain that cataract surgery can put on already debilitated endothelial cells. Patients with significant Fuchs' dystrophy may benefit from a triple procedure, that is simultaneous cataract extraction, IOL implantation and corneal transplantation.
2. **Herpes simplex keratitis** • The Herpetic Eye Disease Study (HEDS) and other studies have shown that previous episodes of herpes simplex stromal keratitis are the single greatest contributing factor to subsequent bouts of recurrence. Trauma may also trigger recurrence. Because surgery involves some trauma to the eye, the surgeon may consider treating these patients prophylactically with oral antivirals before and after surgery. Cataract surgery may be contraindicated if an episode of HSV keratitis has occurred within the last 6-12 months.

Additional Pre-Op Concerns

Counsel patients with conditions that can result in weak zonular fibers, and in turn, increase the risk of a capsular rupture or tear. These include **Marfan's syndrome, Ehlers-Danlos syndrome, previous trauma and pseudoexfoliation**. Patients with a traumatic cataract secondary to an impact injury are at heightened risk of capsular rupture potential.

Pseudoexfoliation is the most common of these conditions. The surgeon will usually be prepared for potentially suturing the IOL in place or consider using a capsular tension ring, which might aid in centration of the IOL within the capsular bag.

Also perform a thorough dilated fundus examination to identify any pathology that may limit best visual acuity post-operatively or contribute to retinal tears or detachments following surgery. Consider referring patients with peripheral areas of weakness for prophylactic treatment prior to cataract surgery. Warn patients with a history of toxoplasmosis or histoplasmosis of the risk that the conditions could reactivate following cataract extraction.

Post-Op Visits

During these visits (see schedule, page 17), you need to assess the early stages of recovery and rule out any serious problems. Most complications after cataract surgery present early in the post-op period and will be resolved by the time the patient is released by the surgeon.

Review the post-op medication regimen that is prescribed, confirm compliance and clarify any questions the patient may have about his or her recovery. A post-op kit and instructions will have been provided to the patient.

Key Exam Areas

During your post-op exams, pay careful attention to these key areas:

Visual Acuity • It is not unusual for the patient to have reasonably good acuity immediately post-op. More mature cataracts, however can often result in a delayed return of acuity. This is due to corneal edema from the higher levels of phaco energy used during the procedure. (Corneal edema, in fact, is the most common cause of decreased vision on day one post-op.)

Given the variety of correction strategies available, including monovision corrections and multifocal IOLS, you should know what corrective strategy or targeted refraction the surgeon chose before you examine the patient.

The Incision • Carefully inspect the incision for any evidence of poor healing or a wound leak. Signs associated with this problem are a shallow anterior chamber, an IOP of less than 10mm Hg, and some degree of corneal edema. A Seidel's test with fluorescein can help you verify a wound leak.

Wound leaks are a serious issue. Not only do they delay visual recovery, but they put the patient at risk of intraocular infection or choroidal hemorrhaging due to the low IOP. Wound leaks require consultation with the surgeon. Significant wound leaks may require suturing for repair, while smaller leaks can usually be controlled by temporarily reducing the steroid medication and applying a bandage contact lens for a few days.

Corneal Integrity • Assessment of the cornea's overall status can help you anticipate when the patient will recover best visual acuity.

Stromal herpetic disciform keratitis can recur after cataract surgery. Cataract surgery may be contraindicated if an episode of HSV keratitis has occurred within the last 6-12 months.

Depending on the difficulty and length of the surgery, the cornea can respond with varying degrees of edema and endothelial folds. In an uncompromised cornea, swelling will limit vision early on, but this tends to dissipate within the first week post-op, resulting in improved acuity. Patients with compromised corneal endothelial cell function or Fuch's dystrophy can expect corneal edema to diminish more slowly, but they still tend to do well long-term.

Whenever you note significant corneal edema, be sure to consider IOP. A cloudy cornea with signs of microcystic edema is often a sign of elevated IOP following cataract surgery.

Though rare, corneal abrasions can develop immediately following cataract surgery. We can usually resolve this problem with a bandage contact lens for one or two days. Also we can temporarily decrease steroid usage to allow for improved epithelial migration; this can help the abrasion resolve more quickly.

Anterior Chamber Status • At day one the anterior chamber should appear well formed with moderate cellular reaction. A flat or shallow chamber may indicate a wound leak.

The cellular reaction can be more pronounced in difficult cases, but fibrin within the anterior chamber or the presence of hypopyon is never normal. A dense anterior chamber reaction with visual obscuration of the anterior segment anatomy indicates bacterial endophthalmitis, which requires immediate attention and culturing.

IOL Status Within the Capsular Bag • IOL decentration/dislocation is not common with uncomplicated surgery. Most IOL dilocations result from trauma, known zonular weakness or in association with a tear in the posterior capsule. Dislocations usually occur months to years after the original procedure.

Review any evidence of IOL dislocation with the surgeon. The surgeon may need to explant the IOL and then place it within the ciliary sulcus, or suture the implant in place.

Besides examining the implant location, carefully inspect the integrity of the capsular bag. Early wrinkles within the posterior capsule can cause minor visual distortion or streaking of lights. Fortunately, these tend to fade throughout the early post-operative period as the capsule shrinks.

In cases of posterior subcapsular cataracts, it is not uncommon to have early post-operative opacification of the posterior capsule in the first few weeks post-op. This is due to a higher degree of remaining lens epithelial cells that adhere to the posterior capsule after surgery. Patients with posterior capsule opacification can undergo Nd:YAG laser capsulotomy months after the initial cataract surgery. This is most likely needed one year post-op.

Keep in mind, however, that YAG procedures carry a short-term risk of an immediate IOP spike. You can usually control this with topical IOP-lowering agents in conjunction with a short course of topical steroids. Historically, alpha agonists have proven to work well with anterior laser surgery.

YAG laser capsulotomy also carries a long-term risk of retinal tear or detachment. So, it is important to perform a dilated fundus exam on these patients within a month after surgery. Several research studies are investigating different IOL designs and materials that will hopefully reduce the incidence of posterior capsule opacification.

Posterior capsule rupture has been cited in up to 4.1% of all cataract surgeries. Tears of the posterior capsule that occur during surgery require special care to prevent loss of lens fragments within the eye.

Evidence of free lens fragments post-operatively should be evaluated by the surgeon. These loose particles can lead to chronic inflammation and IOP elevation, and thus need to be dealt with carefully.

Intraocular Pressure • IOP spikes in the immediate post-op period occur in 5-14% of all cataract surgeries. Several studies have linked the viscoelastic substance used to fill the anterior chamber with the incidence of a 24-hour post-op pressure spike. Failure to completely aspirate and remove the protective viscoelastic substance at the end of the cataract procedure temporarily inhibits the normal aqueous outflow from the anterior chamber.

Patients who present with pressures higher than 30mm Hg may complain of a dull headache or pain in and around the eye. A steamy cornea that indicates diffuse microcystic edema typically manifests with pressures at or above this level. You may need to refer this patient back to the surgeon for an anterior chamber tap through the paracentesis to immediately reduce IOP.

If the anterior chamber tap is not an option, you can prescribe a topical pressure-lowering agent such as a beta-blocker, an alpha adrenergic agonist, or a carbonic anhydrase inhibitor – either alone or in combination – to reduce the pressure. (Of course, beta blockers are contraindicated in patients with a history of respiratory problems and may be contraindicated for those on similar therapy for high blood

pressure.) Once IOP is within normal limits, recheck the patient in 24-48 hours to rule out a rebound spike. Typically, IOP will have stabilized at the one-week visit, and it will be safe to discontinue the pressure-lowering drops.

Serious Complications

Some of the more serious though less frequent complications associated with cataract surgery include:

Endophthalmitis • This bacterial intraocular infection occurs in about 0.05-0.7% of cataract surgeries. The usual source of infection is the patient's own ocular surface, and most cultures are gram-positive organisms at work.

Although rare, endophthalmitis is the biggest emergency we face. Early diagnosis and treatment are critical. Without prompt treatment, the patient could lose an eye.

A patient with endophthalmitis presents with a red, photophobic eye, usually within a few days after surgery. One important symptom is the presence of unusual pain and blurred vision early in the post-op period. Upon slit-lamp examination there will be a marked anterior chamber reaction with possible fibrin and hypopyon.

Refer patients back to the surgeon immediately for intraocular culturing, intraocular antibiotics and possible vitrectomy.

Cystoid Macular Edema • CME often presents with unexplained decreased acuity within the first few weeks after surgery. At times, it can present nearly a month after surgery and persist for several months before it spontaneously resolves.

CME may be difficult to detect on fundus examination alone. Indeed, fluorescein angiography may be the only way to definitively diagnose the condition. Optical coherence tomography has shown that CME can develop in uncomplicated surgery.

Retinal Detachment • The likelihood of retinal detachment after uncomplicated cataract surgery is less than 1%. Complicated cases involving posterior capsule rupture and vitreous loss increase the likelihood of retinal problems after surgery. The incidence does rise in highly myopic eyes, necessitating detailed retinal examination and prophylactic treatment of lesions that could contribute to a retinal detachment.

The California Optometric Laser Associates and affiliated surgeons are committed to providing Continuing Education for the pre and post-operative management of surgical patients. We have provided an overview of treatment protocols in this manual, however, we encourage you to attend our Continuing Education seminars for discussions regarding these protocols. Please contact our surgeons any time if there is a question regarding pre and post-operative patient care.

Cataract Co-Management Billing For Medicare Patients

As per guidelines published by Medicare in 1992, specific components of major surgery were defined as the "global surgery package." The components they identified included pre-operative care, intraoperative services, post-operative care (90 days), and in-office care for any post-operative complications. In addition, the value of post-operative care for surgical procedures was standardized and post-operative care for ophthalmic surgery was valued at 20% of the global surgery package.

Medicare also published instructions to Medicare carriers on split billing of post-operative care, also known as post-operative co-management, within eye care. These instructions incorporated the following points, which are further defined in this section of our co-management manual:

1. Co-management requires a written transfer agreement between the surgeon and the receiving doctor(s).
2. Specific modifiers must be used on claims (54 – surgical care only; 55 – post-operative management only.)
3. The receiving doctor cannot bill for any part of the service included in the global period until he/she has provided at least one service.

Written Transfer Agreement

The transfer agreement between the surgeon and the co-managing doctor (optometrist) contains the surgeon's discharge instructions and the effective transfer date. According to current Medicare policy, the transfer date is "*determined by the date of the physician's transfer order*."

The responsibility for post-operative care may be transferred on or before the patient's appointment for the subsequent follow-up visit with the receiving doctor, who may submit a claim for services once he has seen the patient.

The split of post-operative care cannot be done or pre-arranged in advance of the surgery. Instead, a unique transfer agreement should be constructed for each patient. The essential elements of the Transfer Care Form from the surgeon to the optometrist should include the following (see Page 16)

Patient Name
Operative Eye
Nature of Operation
Date of Surgery
Clinical Findings
Discharge Instructions
Transfer Date

The optometrist should assume care of the patient on the following day. This form determines the "transfer date," as well as corresponding reimbursement for claims submitted. Because the surgeon cannot be certain the patient will actually keep the appointment with the optometrist, communication from the optometrist is necessary and is evidence that the optometrist actually saw the patient, and is in compliance with CMS's requirement that the optometrist "*has provided at least one service*."

Essential elements of the transfer agreement from the optometrist should include the following:

Patient Name
Operative Eye
Nature of Operation
Transfer Date
Results of First Post-Operative Visit

Both Doctors should retain copies of this documentation as part of the patient's permanent records. They may also serve as a useful attachment on claims, as necessary.

Modifiers for Claims Submission

Immediately following surgery, the surgeon can submit a claim for the surgical component of care using the appropriate CPT Code, i.e. 66984, and Modifier 54. This modifier is used to indicate the surgical event in a co-managed case. Medicare assigns 80% of the global fee to the intraoperative service.

Later the surgeon will submit a claim for his/her portion of the post-operative care. In order for this claim to be accurate, the surgeon needs to know the date the optometrist assumed responsibility for the remaining post-operative care (the transfer date noted above). This claim will be filed using the appropriate CPT Code, i.e. 66984, and Modifier 55, which indicates post-operative management only.

After the optometrist has seen the patient for post-operative care, he/she will submit a claim for the post-operative care provided, using the appropriate CPT Code, i.e. 66984, and Modifer 55. Again, in order for the claim to be accurate the optometrist must know the date he/she assumed responsibility for post-operative care (the transfer date).

Medicare uses chronology and number of days to calculate payment for care rendered by each doctor during the post-operative period (90 days). The fees submitted by the surgeon and optometrist will be different, depending on the number of days of post-operative care each one provided. An example of billing by the surgeon and optometrist follows.

Surgeon's Care		PECP (OD's) Care	
Date	**CPT Code**	**Date**	**CPT Code**
January 1:	66984-54	January 11-April 1:	66984-55
January 2-10	66984-55		
Reimbursement of care is valued at 20% of the global surgery fees. In this example, value of the post-op care is apportioned to the surgeon as follows:		Reimbursement of care is valued at 20% of the global surgery fees. In this example, value of the post-op care is apportioned to the PECP (OD) as follows:	
10/90th of 20% to the surgeon		80/90th of 20% to the optometrist	
(10 days)		(80 days)	

When submitting claims, many Medicare carriers instruct providers to write a comment in the body of the claim form, as follows:

Surgeon: "Assumed post-operative care on January 2, relinquished care on January 20."

Optometrist: "Assumed post-operative care on January 11, relinquished care on April 1."

Overlapping Post-Operative Co-Management

Many patients will have cataract surgery performed on the second eye shortly after their first surgery, in which case post-operative care may overlap temporarily. When these patients are co-managed, claims for each surgery are handled separately. The surgeon will file the second claim with Modifier 79, to indicate the second surgery is unrelated to the first (different eye). Both surgery claims will also be filed using Modifier 54, to indicate post-operative care is being co-managed. The post-op care claims will include both Modifiers 55 and 79 for the surgeon and the optometrist.

The chronology and windows of time on which payment is determined (as outlined above) are still relevant and the claims will be concurrent. The surgeon will determine if the transfer of care for the first surgery occurs before or after the second surgery.

If the transfer of care for the first surgery occurs before the second surgery, then two transfer of care letters or forms and transfer agreement letters must be prepared, established a unique transfer date for each surgery.

The comments provided herein relate to billing for cataract co-management for Medicare patients. Commercial carrier policies will vary. Should you have questions about a specific carrier's policy, we recommend you contact them directly. Also, if you have questions related to Medicare billing procedures, you can visit their website, www.cms.gov, or contact our office for assistance.

Patient Handout

Cataract Patient Co-Management Treatment Plan

This information is designed for patients who have been diagnosed as having cataracts and who intend to have cataract surgery. Any surgical procedure contains some element of risk in the post-operative period. For your health and safety, it is imperative that you receive proper follow-up care after your cataract surgery. This fact sheet will explain what follow-up care is, and who is qualified to perform it for you.

What is Follow-Up Care?

After your cataract surgery, you will have several appointments with an eye care professional. You should understand that complications may not necessarily occur during surgery, but may occur after the surgery had been performed. For this reason, it is imperative that you have appropriate care by a qualified eye care professional following our surgery. He or she will perform tests to measure your visual acuity and, ultimately, if necessary, fit you for eyeglasses. In addition, your doctor will ensure that any post-surgery complications are detected and treated. This series of visits is called your "follow-up care."

Who is Qualified to Provide Follow-up Care?

It is critical that your follow-up care be performed by a qualified eye care professional familiar with your case. Several different practitioners are qualified to provide this service. You should understand the roles that each may play in your recovery.

Your Surgeon • Your surgeon is a licensed ophthalmologist, a medical doctor who specializes in diseases of the eye and who will implant your lens. Your surgeon will always see you one day after surgery to ensure that your recovery is progressing normally. Your surgeon will also determine when you can be released from his or her care to return to your optometrist for further follow-up visit as well as post-operative glasses, if needed.

Your Optometrist • While you may request to receive your follow-up care from your surgeon, Doctors of Optometry are eye care professionals trained, licensed, and fully qualified to provide follow-up care once you are "released" by your surgeon. Most patients find it very convenient to return to their optometrist for post-operative care and services. Your optometrist is also the vision specialist who will examine and fit you for your glasses, if necessary, after recovery. Your optometrist will be in communication with your surgeon following each post-operative visit. If problems develop during the post-surgery follow-up period, your optometrist and your surgeon will communicate regarding your care until these have resolved.

Another Ophthalmologist • If you travel away from home to have surgery and wish to return home soon after surgery, or if you have any other personal reason for not receiving your follow-up care from your surgeon or optometrist, you may decide to see another ophthalmologist for your follow-up care. An ophthalmologist other than your surgeon can perform all of your follow-up care after your initial visit with your surgeon one day after surgery. You must, however, make arrangements with the ophthalmologist and notify your surgeon before having surgery. Your surgeon will only discharge you from his or her care if he or she has confidence in the professional who will supervise your recover.

Patient Treatment Plan, Cont.

Summary

We hope this summary has helped to explain some facts about the cataract surgical process. Your optometrist and surgeon will explain the improvements in your vision that you may enjoy after cataract surgery. If you have any questions or concerns, now is the time to raise them. You may contact your optometrist or your surgeon at any time, before or after surgery, to answer your questions.

Notes

Cataract/Implant Co-Management Pre-Op Exam & Consult Request

Use this form when referring your patient for surgery who desires to return to you for follow-up care during the 90 day global period.

Co-Managing PECP _____ Phone _____ Fax _____ UPIN#_____

Address _____

Office Contact _____ Email Adress _____

Surgeon _____

Patient Info

Name _____ D.O.B. _____ Date _____

Home Phone _____ Work _____ Cell _____

Clinical Info

Reason for Consultation: _____

Ocular History _____ Medical History_____

Examination VAsc OD _____ VAcc OD _____ Pupils (dim light) _____

OS _____ OS _____ Fields _____ EOM _____

Near Vision OD _____ OS _____

Keratometry OD _____ OS _____

Manifest Refraction OD _____ 20/

OS _____ 20/

IOP (Goldman/Non Con/Other) OD _____ OS _____

Slit Lamp Exam Dry Eye Testing - Method _____

OD _____ OD _____

OS _____ OS _____

Dilated Fundus Exam Topography OCT

OD _____ OD _____ OD _____

OS _____ OS _____ OS _____

Type of CLs _____ Time out of CLs _____

❑ Best corrected VA is 20/40 or less, even with glare testing
❑ Activities of daily living are impaired because of decreased vision
❑ Limitations of presbyopia discussed
❑ Presbyopia-correcting lenses discussed

Additional Comments _____

Fee Quoted _____

Fax completed form to MDs Office _____

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Co-Management Consent

To be completed by Co-Managing PECP or Surgeon – Please keep in Patient File

Patient Name: _____

Dr. _____ will be performing _____ on me.
NAME OF SURGERY

It is my desire to have my primary optometrist/ophthalmologist, Dr. _____
NAME OF PECP
perform my pre-operative and/or post-operative care.

I understand that a record of findings will be sent to my surgeon following each visit with my primary eye care provider and that my surgeon will be informed if I experience any complications related to my eye surgery. I understand that I may also contact my surgeon at any time after the surgery.

I understand that there are no additional fees associated with co-management and that the California Optometric Laser Associates will collect outstanding fees, if any, above those individually billed to insurance and forward the appropriate co-management fee to Dr. _____ for
NAME OF PECP
post-operative care.

Date _____

Signature _____

Witness _____

Please fax to MD and to COLA Administrative Office: 510.895.9680

Surgeon Consult Results Form

To be completed by Surgeon and faxed to Co-Manager

Surgeon Name _____ **Date** _____

Co-Managing PECP _____ Fax _____

Patient Name _____ D.O.B. _____ ❑ OD ❑ OS ❑ OU

Dear Doctor,

Thank you for referring this patient for cataract/implant evaluation. At this time:

- ❑ Attempts to contact this patient have been unsuccessful. Please contact our office so that we can verify patient contact information.
- ❑ This patient has scheduled an appointment for consultation. The date of the consultation is _____
- ❑ This patient has opted NOT to schedule a consultation for surgery at this time. The patient's stated reason is:

  _____

We have seen this patient for consultation. At this time:

- ❑ This patient has been scheduled for surgery. The date of surgery is _____. Please expect to receive a Transfer of Care form following surgery if co-management is indicated for this patient. A surgery report will be sent.
- ❑ This patient has NOT been scheduled for surgery. The reason that surgery has not been scheduled is:

  _____

Patient Billing *More than one item may be checked*

- ❑ This patient is a Medicare patient. Please bill Medicare directly for post-operative fees related to that portion of the surgery. If you are not a Medicare Provider, please contact our Co-Management Coordinator.
- ❑ This patient is NOT a Medicare patient or has supplementary insurance. A representative will contact you regarding billing arrangements indicated by this patient's plan.
- ❑ This patient is not covered by insurance. All services will be the responsibility of the patient.
- ❑ This patient has opted for additional non-covered procedures or lens upgrades.

Questions? Please contact the Co-Managment Coordinator at

_____

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Co-Management Transfer of Care Form

Surgeon Name _____ Phone _____ Fax _____

Patient Name _____ D.O.B. _____ Home Ph _____

Medicare # _____ Other Insurance _____

Date of Surgery _____ ❑ OD ❑ OS

Procedure/Lens _____

Diagnosis Code _____ CPT Code _____

Facility _____

Co-Managing Optometrist or Opththalmologist _____

Date Post-Op Care Began _____ Date Post-Op Care Ended _____

Post-Op Uncorrected VA: OD 20/_____ OS 20/_____

Post-Op Exam Findings _____

_____

Medications:

Post-Op visits to schedule for this patient:

❑_____ ❑ 30 Day ❑ 90 Day ❑ 6 Mo ❑ 1 Yr

Surgeon Signature _____ Date _____ *MD: Fax to co-managing OD*
I accept the Transfer of Care for the above-mentioned patient PECP Signature _____ Date _____ *Fax signed form back to MD*

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Sample Post-Operative Examination & Medication Schedule

Outlined below is a brief description of a typical cataract post-operative schedule. It is important that patient follow-up care be documented in written form, not only for medical, but for medical-legal considerations. **Fax a completed Post-Op Exam form to the MD's office following each patient visit.** Should you have any questions, do not hesitate to call the surgeon. Contact the surgeon immediately if any complication arises. Please note that Visit and Medication schedule may vary by surgeon and patient. Please consult with the surgeon for each patient.

Sample Patient:

Visit	Examination Description
Day 0	Patient undergoes surgery.
Day 1	Examination by Surgeon or Co-Managing PECP as predetermined.
Days 2-20	Patient remains under care of Surgeon. Patient may have no scheduled visits, but may see Surgeon as needed.
Days 21-90	PECP takes over care of first eye. Complete "Post-op Exam Form" and fax to surgeon following each visit.
Day 30	Examination by Co-Managing Doctor. Refraction and Evaluation of 2nd eye. 2nd eye referral to Surgeon if needed.
3 months, 6 months, 1 year	Multifocal or upgraded lens patients only: Examination and refraction by Co-Managing Doctor.

On *each exam*, the following observations need to be recorded on a post-op form and faxed to the surgeon's office:

- Vision, without correction and through a pinhole. Intermediate and near VA for presbyopia correcting IOL
- Consider Keratometric readings
- Slit lamp exam
- Intraocular pressure (call us if the IOP is above 25 mm Hg.)
- Refraction status w/visual acuity and near vision at 1 week, 1 month, and beyond for prebyopia correcting and toric IOLs
- Review post-operative medications and prescribe as appropriate

Cataract/Implant Post-Operative Form

Surgeon _____ Date _____

Patient's Name _____ ❑ OD ❑ OS ❑ OU

Surgery Date _____ Co-Managing Doctor _____

Follow-up Date _____ Had Surgery at (city) _____

Procedure ❑ Phakic IOL ❑ Toric ❑ Wavefront Analysis

❑ Accommodating ❑ Multifocal ❑ ICL ❑ Other _____

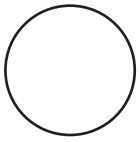
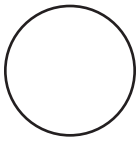
OD	❑ 1 Day	❑ 1 Week	❑ 1 Month	❑ 3 Months	❑ 6 Months
OS	❑ 1 Day	❑ 1 Week	❑ 1 Month	❑ 3 Months	❑ 6 Months
Other	OD _____		OS _____		

(Include slit lamp and dilated fundus as needed.) Current Meds _____

Subjective Findings _____

_____

_____

Assessment	OD	OS
VA sc	**D** 20/_____ **I** 20/ _____ Near _____	**D** 20/_____ **I** 20/ _____ Near _____
Refraction	_____ 20/_____	_____ 20/_____
Keratometry (auto/manual)	_____ / _____ @ _____	_____ / _____ @ _____
Lens	❑ Clear  Other _____ _____	❑ Clear  Other _____ _____
Intraocular Pressure *circle*: NCT / Goldman / Tonopen	_____ mm/Hg	_____ mm/Hg

Impression on presbyopia correction _____

Impression/comments _____

Plan _____

Next planned visit _____

Doctor's Agreement: I accept medical and legal responsibility for this patient's post-operative surgical care. I have explained this co-management arrangement with the patient and he/she understands that he/she may contact the surgeon at any time.

Doctor Signature _____

Please Fax Completed Form to Surgeon

COLA™
California optometric laser associates

COLA™ California optometric laser associates™

P.O. Box 1328
Santa Clara, CA 95052-1328
PH: 510-895-9657 Fax: 510-895-9680

PHAKIC IOL • REFRACTIVE IOL

Payment Authorization and Procedure Information

PATIENT INFORMATION

NAME (Last Name, First Name, Middle Initial)		DATE OF BIRTH (Month/Day/Year)	GENDER ❑ Female ❑ Male
ADDRESS (Street)		LAST FOUR DIGITS OF SSN	DOES PATIENT NEED A RECEIPT? ❑ Yes ❑ No
CITY		HOME PHONE ( )	
STATE	ZIP	WORK PHONE ( )	

SURGERY INFORMATION

SURGERY DATE (Month/Date/Year)	EYES ❑ OD ❑ OS ❑ OU	PROCEDURE
SURGERY CENTER		❑ Phakic IOL ❑ Toric ❑ Wavefront Analysis ❑ Presbyopia-correcting (accommodating, multifocal) ❑ Accommodating IOL (Crystalens, ReStor, ReZoom) ❑ Clear Lensectomy ❑ Other _____
PECP		This payment represents: ❑ Entire Global Fee ❑ Prof. Fee Only
SURGEON		Collection of Fee: ❑ OD ❑ Surgery Center

PAYMENT INFORMATION

TOTAL FEE	CREDIT/DEBIT CARDS	FINANCING
PROF. FEE ONLY	❑ VISA/MC $_____ ❑ AMEX $_____ ❑ Discover $_____ ❑ Other $_____	Please contact the COLA office at 510-895-9657
IOL ONLY	_____-_____-_____-_____ _____ Card Number Exp. Date	
CASH/CHECK ❑ Cash $_____ ❑ Check $_____ Payment must be received one week prior to surgery.	I understand that a hold will be placed on my account for the amount indicated above. The hold will be removed if the procedure is cancelled, or the surgeon elects to postpone surgery for medical reasons. _____ _____ Cardholder Signature Date Please note: Most banks place daily spending limits on debit cards. Please check with your bank before your procedure.	

COMMENTS

_____

_____

I have elected to have refractive correction surgery at a surgery center contracting with the COLA Medical Corporation. I request that my pre-operative and follow-up care be done by my primary eye care provider (PECP). I agree to have refractive surgery done by the Surgeon contracting with COLA Medical Corporation whose name is listed above. I understand that the Surgeon and my PECP are independent practitioners who cooperate for the purpose of providing continuity of patient care. Both doctors and the facility will receive separate payment for their services.

I understand that the basic intraocular lens procedure is paid for by Medicare and each doctor and the facility will bill Medicare independently. However, certain services related to the premium intraocular lens I will receive are not covered by Medicare,

I understand that COLA will coordinate payment for the non-Medicare covered services. I choose to make one Global Fee payment as listed above to COLA with the understanding that it will distribute payment to my Surgeon, my PECP and the facility as specified under the COLA Medical Corporation contracts.

Patient Signature _____ **Date** _____

Form Completed By	Date Mail/Fax

Faxed to COLA 510-895-9680: Date_____ Initials _____ **Copy to Patient:** Date_____ Initials _____