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Non-ambulatory vision service

Abstract
Non-ambulatory vision service

Degree Type
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NON-AMBULATORY VISION SERVICE

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Submitted in partial fulfillment for the
Doctor of Optometry Degree
May 7, 1986

By

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INTRODUCTION

Beck, Ettinger, and Jackson, writings on gerontology and geriatrics education, state that medical and dental practitioners are reluctant to treat elderly patients. Some reasons for this reluctance include:

- Negative attitude towards the elderly, generated by a cultural bias against old age.
- A general lack of knowledge and experience in treating elderly patients.
- A lack of experience in treating patients outside the office setting.
- A lack of financial incentive partly due to the additional time needed to treat elderly or nonconventional patients.

Perhaps, education is the best way to increase awareness of elderly needs through continuing education offered by State Optometric Associations for the practitioner and through better geriatric curriculum models for the students. Some say student experience with elderly persons tends to reinforce fears about disability and mortality. The more such fears are suppressed, the greater likelihood of dismissing the needs of the aged patient. These patients do not go away or dissappear, they are real. The American obsession with youth is giving way to a growing awareness for the elderly, due largely to the fact that the "young" are becoming rapidly outnumbered by the "old". This "graying of America" has created a greater need for vision care of the elderly person.

The vision care of the elderly requires different knowledge and altered behavior from that needed to care for young or middle aged adults. A health care professional with some understanding of the social, economic, physical, and emotional aspects of aging, is more able to prevent exacerbations of illness, to achieve patient compliance with treatment programs and to interact better with patient and family in a more meaningful way. In addition, the optometrist must understand the important differences

between the "functional elderly" and the "non-functional" or infirmed elderly to be better able to improve the vision of both groups.

Population Trends

Aging is an inevitable and irreversible process starting at birth. It is important to have accurate predictions about the older population in the coming decades in order to anticipate health, socioeconomic and vision service needs for these potential patients. Since optometry is one of the major providers of vision care, population trends must be understood by optometrists and other health planners to meet the needs of specific populations.

The elderly population is growing rapidly. In 1900, people age 60 and older numbered less than five million, representing only one of every sixteen Americans. Today, the elderly have the fastest rate of increase of any age group. Their net increase is nearly 820 persons per day.[2] Currently they number about 39 million or 1 of every 6 americans.[1]

In the next 40 years, the 60 and over age group are projected to represent 25% of the U.S. population. Furthermore, the older population is in itself getting older.[1, 2] In the age group 75 and over, there is a projected increase from 1985 of 8.5 million to over 14.7 million, an increase of 58% by the year 2000.[3]

The elderly 65 years + comprise 87% of the residents in nursing homes.[3] The National Institute on Aging (N.I.A.) reported that between 1964 and 1977 the number of residents in U.S. nursing homes grew from 554,000 to 1.4 million.[3] It is predicted this number will quadruple by 1990.[3] By the year 2000, an elderly person of age 65 can be expected to live, on the average, another 21.8 years.[3] These can be very critical years in which optometry can make a large contribution to the quality of life for the elderly person.

Vision Care

In recent studies on vision care for the elderly, it was found that out of nine nursing homes in Washington County, Oregon, none (0%) had a full time staff optometrist; and that only three out the nine (33%) had a part time staff optometrist.[4] It was also shown that 40% of the patients screened have not had an optometric

examination in the past three years or longer,[5,2] with another 6% never having seen an eye doctor before.[5] Further more, a study of 154 licensed South Dakota nursing homes, with a bed capacity of 6,615 residence, were screened by the Association for the Blind and the Lions' Sight and Service Foundation. The purpose of the vision screening was to determine whether these persons are receiving adequate visual care. A pass/fail criteria was set in reference to 20/70 acuity and presence of pathology. Of the 4,383 screened , 1,651 failed and were found in need of vision care. Many of the nursing home staff were unaware of the need for vision care and the improvement possible with proper eye care. It is optometry's responsibilty to educate the nursing home staff of the importance for proper visual care and how to identify those who need intervention. Only 10% of the total population had received any type of visual care in the past year. The national average for the 65+ age group is 21.5%.[9] In one instance, a patient's visual acuity was improved from 20/300 to 20/40 with conventional lenses alone. The paper makes mention of two reasons for poor eye care.

- Difficulty in getting to the doctor's office
- Lack of education by the nursing home staff and the patient's family in the area of vision care

These surveys show strong evidence that our present health care system must change to meet the vision care of the elderly.

The N.I.A. estimates the number of people with limitations in their activities for health reasons reached 30.2 million in 1976.[3] Cardiovascular, diabetes, hypertension and visual impairments are the leading contributors to this increase in disabilty.[3] In addtion to chronic illness, vision impairments are a serious problem among the elderly. In one national health survey from July 1963 to June 1965, 9% of people 65 and over reported severe visual impairment that limited their activity.[6] In this survey, vision impairments ranked fourth after heart conditions, arthritis, and orthopedic impairments.

As we age, our sensory system declines and receptors require more energy to reach threshold. Often the consequence of this reduced sensory input causes more

conscious awareness of our behavior. Older people frequently monitor their body movements visually to assure adequate placement, where previously their movements were automatic, requiring less attention. These subtle changes predispose an individual to accidents. Thus, even a partial loss of sight can create a profound effect upon the elderly person attempting to remain active in the mainstream of today's society. It has been shown that accidents are the fifth leading cause of death in the elderly population.[7] Of special interest to optometrists is the fact that at least one-third of these accidents occur due to faulty visual perception and improper environmental conditions.[2]

A partial gain in sight as well can have an enormous effect on the elderly behavior and health. The optometrist working with the elderly population should be aware of common age related changes that occur. The following is a list of some of the normal physiological changes seen in the elderly.

- Intelligence: slight if any loss of intelligence with age.
- Learning: the elderly retain their ability to learn, however it takes a little longer.
- Memory: some decline in recall memory.
- Thinking: poor at forming concepts, making generalizations and making logical inferences.
- Problem solving: difficulty with multi-stimuli presentations and more trouble remembering this information. Loss of focused attention.
- Creativity: quantity may diminish, but quality stays intact.

The following is a list of normal and pathological ophthalmological changes that occur in the elderly population:

I. <u>Adnexa and Lids:</u>

- Senile Enophthalmos
- Xanthelasma
- Sebaceous cyst
- Commedone
- Senile keratosis
- Dermatochalasis

- Acne Rosacea
- Senile involutional ptosis
- Lentigo (pigmentation)
- Seborrheic dermatitis
- Senile involutional ectropian
- Senile involutional entropian
- Lagophthalmos
- Neoplasms: basal cell carcinoma, actinic keratosis, squamous cell carcinoma, Hutchinson's Freckle.
- Angular conjunctivitis

II. Conjunctiva

- Pinguecula
- Pterygium
- Low grade bacterial infection
- Lithiasis (concretions)
- Infected socket from a prosthetic eye

III. Sclera

- Senile hyaline plaque
- Scleromalacia

IV. Cornea

- Decreased sensitivity
- Corneal curvature changes towards against the rule astigmatism
- Arcus senelis
- White limbal girdle of Vogt
- Guttata
- Farinata
- Hudson-stahli line
- Dellen
- Loss of luster

- Keratic precipitate
- Cell number count decreases

V. Paralytic Strabismus

- Three main causes: 1. Diabetes mellitis 2. Basal artery insufficiency 3. Giant cell arteritis

VI. Anterior Chamber

- Depth of Anterior chamber decreases
- Aqueous, slight decrease in production
- IOP, slight increase
- Palisade of vogt

VII. Pupil/Iris

- Senile miosis
- Increase in depth of focus
- Iris atrophy
- For pupil diameter less than 2.5mm diffraction becomes a problem and blur circle diameter tends to increase, leading to a decrease in VA

VIII. Crystalline Lens

- Loss of accommodation
- Increase in thickness of the anterior and posterior cortex
- Lens capsule and elasticity decreases
- Initial increase in index of refraction and power
- Lens substance yellows, leading to an increase in light absorption-greatest at the violet end of the spectrum
- Some high molecular Wt. protein tends to accumulate, and can tend to scatter light reducing retinal contrast and act as a veiling glare
- The accumulative effect of miosis and lens thickness reduces the amount of light reaching the retina. This reduces visual performance especially under poor light conditions
- Cataracts: nuclear, cortical, posterior subcapsular

IX. Vitreous

- Liquification and shrinks after fifth decade
- Muscae volitantes

X. Refraction Status

- Relative increase in hypermetropia approximately .25^{D} per decade after age 35

XI. Retina

- Parapapillary atrophy
- Senile macular degeneration
- Senile macular hole
- Retinal detachments
- Venous retinopathy; central venous occlusion, branch occlusion
- Amarosis fugax

XII. Temoral Arteritis

XIII. Diabetic Retiopathy

XIV. Temporal Resolution

- Difficulty separating serial visual events both centrally and peripheral

XV. Variability and Individual Differences

- Both of these become greater with increasing age
- Variability in visual performance between individuals increases with age for virtually all tasks.

XVI. Visual Acuity [8]

- Hirsch found age range of 40-44, 93.5% achieved 20/20, while the age group 70-74 only 41.9% achieved 20/20.

The major causes for the decrease in VA for the 75-84 age group:

Cataract..46%

SMD...28%

Glaucoma......................................7.2%

Retinal Path..................................7.0%

Other & Unexplained....................12%

XVII. Stereopsis

- Very little change with age as long as VA remains good

XVIII. Visual Fields

- Visual fields in normal aging individuals decreases, but no more than what is expected from the effects of miosis and decrease in retinal luminance

XIX. Color Vision

- There is a shortening at the violet end of the spectrum
- Difficulty discriminating blues from blue-greens and purple from pinks

XX. Versions

- Monocular pursuits become slower, so that the number of saccades increases when following a moving object

XXI. Vergences

- Distance phoria becomes more eso
- Near phoria becomes more exo

XXII. Fusion Vergence[8]

- Positive fusional reserve decreases, but negative fusional reserve stays about the same (Sheedy and Saladin)

XXIII. Contrast Sensitivity

- With sine wave bars there is a loss of intermediate and high frequencies with age, peak sensitivity shifts to lower frequencies

Many of these conditions which result in decreased or difficult visual performance cannot be avoided or corrected, but they can easily be explained to the elderly patient. We as optometrists should be certain that the patient understands the cause of his/her symptoms and should be advised as to ways and means of improving visual performance. For example, using more light and/or changing incandescent for fluorescent light. But most important of all, is an understanding and empathetic optometrist, who will ultimately be an aged viewer of the world's beauty.

WHERE TO IMPLEMENT NON-AMBULATORY SERVICES

The practioner can implement a non ambulatory vision service in the following instituions:

- Skilled nursing facilities.
- Nursing homes or convalescent homes
- Hospices and private homes
- Retirement homes
- Rehabilitations centers
- Prison institutions

WHEN

The optometrist can fill void time in a new or part time practice to supplement income as a vision consultant to homes for the elderly.

REWARDS

Non-ambulatory vision service provides the practitioner an additional, obligatory way to serve society. Perhaps the greatest reward of all is witnessing an improvement in the quality of life, as the elderly rediscover or discover for the first time the rewards of improved vision. Research in behavioral science shows that if patients can recover a degree of independence and a sense of control then they can gain not only increased alertness and involvement, but also improvements in general health.[3]

EVALUATION

A desire to provide out-of-office vision care involves a stepwise plan such that frustration is kept to a minimum. Failure to plan will almost certainly cause discontent with portable eye services. Determine if the rewards of providing this kind of service are great enough to offset the extra effort which goes into every phase of portable services. Keep in mind that the developmentally disabled, emotionally distraught, hyperactive, senile or incapacitated individual will become your average patient type. Most of them will be institutionalized and under the control of nurses, administrators,

physicians and family members, some or all of whom must be dealt with in order to provide any vision services. Realistically, a thorough evaluation of the implications are in order before you consider a "nursing home practice".

There are several factors working in your favor with mobile vision services. Your patients will probably feel more at ease in their familiar surroundings which can facilitate better rapport and patient response. The medical emergency help is available when and if they are needed. Often times the patients are highly appreciative of an O.D. who is willing to make house calls as they seldom interact with outside people and will truly enjoy the personal contact. Knowing that this service is desperately needed combined with some of these positive factors makes mobile services especially rewarding.

In order to provide the best possible service to any patient a complete and thorough knowledge of clinical optometry and how it relates to the disabled, aged patient is essential. To become proficient in these skills requires continuing education for optometrists and revised didactic curriculum in the schools and colleges of optometry for the students.

A cirriculum for gerontology and geriatric optometry has been proposed by ASCO for the schools and colleges of optometry.[10] It is suggested that individual optometrists interested in participation in geriatric optometry consult state chapters of the AOA as well as state associations for listings of related lecture topics such as; out of phoropter exams, the psychology of the institutionalized patient, utilization of low vision techniques, proficiency of ancillary office personnel[11], updates on medicare-medicaid and third party reimbursement procedures and perhaps the normal and pathological age related ocular and somatic changes of the geriatric population.

Finally, in evaluating how best to serve the nursing home patient, consider the supplemental information needed for vision examinations on older people.(table 1)

DEVELOPING AN EYE CARE POLICY

To initiate a mobile practice an appreciable amount of leg work must be done to contact the potential "out-of-office" patient. Do not attempt to seek individuals but rather offer your services to whole institutions.[12] Plan to visit residential care facilities

and personally discuss the institution's eye care policy directly with the administrator. It is helpful to initially draft a letter offerring to become a vision consultant to their residents and staff. A phone call should follow to secure an appointment with the administrator to present the details of the proposed service treatment in a positive way.

The optometrist may offer to take a leadership role to serve as a vision consultant in the development of the policy statement and should be prepared to offer suggestions concerning the following:

- Type of patient to be examined, considering physical and mental limitations and those likely to benefit.
- What should be evaluated and by what methods?
- Who involved in making the evaluations?
- When should ocular evaluations be made; Before or at admission, when health status changes or on an annual basis?
- How can information be most meaningfully translated from the examination to the overall care plan developed for each person?
- How will various procedures and services be paid for?

Finally, consult with your lawyer when designing a contract to confirm the agreement to be on staff as a vision consultant. Outline the scope of your service fees and terms of the agreement (usually one year in most cases). It is important to include an escape clause in the event the optometrist or the institution becomes dissatisfied.

TIMELY CONSIDERATIONS

A rule of thumb is only to accept a facility if it is willing to use you on a full scale program. This usually includes exclusivity as a vision consultant and control of the amount of patients seen at one visit (a minimum of 3-5 patients). It is acceptable to break this rule when servicing some of the smaller facilities or in facilities where there are patients with desperate immediate visual needs.

The optometrist must also consider proficient ways to make the portable service

feasible both economically and logistically. Here are some factors to use in your overall plan:

- Distance to travel and travel time
- Number of facilities seen per day
- Time to set up and tear down over and above exam time
- Seeing more than five patients per visit
- Time required to assess visual needs
- Portability and working condition of the equipment
- Coordinated delivery and dispensing of prescribed materials

Other obstacles to efficient service arise when considering a single patient's visual needs. Often times the optometrist must deal with several decision makers before an examination can be scheduled. These include the administrator, director of medical services, head nurse, primary physician, the patient's family and finally the patient, any one of whom may have a say about the patient's needs. For example: A legal guardian of the patient responsible for payment of the medical bills may decide that the patient is too old to benefit from vision services and refuse to pay. With no prior agreement as to payment it is not advisable to provide portable services. In these instances it is the patient who suffers.

In California, a physician must authorize vision care since Medi-Cal requires it and 90% of the nursing home patients are Medi-Cal recipients.[13]

This authorization protocol is best taken care of in the eye care policy such that the facility's director of medical services or your mobile service coordinator prearranges all authorizations.

It is to the adminstrator's, and especially, the owner's advantage to utilize mobile services because they save the expense of transportation and special handling fees paid an orthopedic nurse.

Some physicians do not authorize and prefer the patients see an

ophthalmologist. They are acutely aware of spending public funds and try to hold the line on services.[14] Usually the decision lies with the administrator who, ultimately, has controls over the primary/attending physician.

SCHEDULING

The head nurse acts as gatekeeper by keeping health records, filing insurance forms and making appointments for the patients. It is wise to be especially nice to this key staffer.

FINDING YOUR PATIENTS

When screening patients, nurses and/or office staff can be used to select patients. The eye care policy and in-service to the facility should cover the method of screening. Usually a simple series of questions are asked.

- Have you had an eye exam in the last two years?
- Do you have glasses?
- Do your eyes bother you?

With NO answers to the first two questions, an exam authorization is the first step. If the attending physicians turn down these requests a consultation may be in order either with the administrator or directly with the physician. The third question needs interpretation. Often times the patient seeks attention or is incapable of a reliable reply. In such cases professional discretion is advised.

Speed is always important in a nursing home setting. Once authorization is obtained the exam must follow promptly to avoid pitfalls such as, the patient moving to another facility, dying, or moving home with a relative. The turnover rates are especially high in skilled nursing homes as compared to conventional convalescent homes where the residents are longer term.

PLANNING

In-service education programs for the nursing staff and attending physicians can serve to facilitate a better understanding of the services. General questions should be

answered as mentioned in the eye care policy. Seminars can be adapted and repeated for older patients, interested family members, and staff members from other services.

The institution's medical director, social worker, and optometrist collaborate on the drafting of a formal letter informing attending physicians of the proposed evaluations and requisitions for services. This letter can be sent in the monthly correspondence to the physician by the facility's billing department.

Have the office receptionist or mobile service coordinator arrange and confirm with the facility's medical director, or head nurse, all scheduled exams at a particular institution for that day. Always reconfirm the day before so that the facility can prepare the patients.

HOW - PROCEDURES

In preparation for out-of-office exams, plan the equipment list separately from the in-office instruments used. Since time and readiness is important, never try to assemble the necessary equipment each time an out-of-office call is made. Inevitably something will be forgotten or damaged while attempting to pack and unpack.

Make your equipment portable such that it all fits into appropriate containers. Some expensive equipment, such as low vision aids, can be used in or out of the office, as long as they are returned to the proper container.

Arrange your equipment in no less than five containers. Make sure not to exclude even the smallest item if you want to do a complete job. An inventory of possible equipment and its arrangement is listed under *equipment.*

AT THE FACILITIES

Immediately upon arriving at the facility, go directly to the business office to arrange all the necessary paperwork. The attending physician's authorization for your evaluation must be arranged prior to your arrival. Make sure the patient's charts have a copy of the Health Insurance Claim numbers for billing MEDICARE and MEDICAID. Appropriate insurance forms should also accompany your patient's chart. Finally,

arrangements for any dispensing, future appointments and special patient considerations should be made at this time.

Do not perform exams for patients who are not scheduled and do not provide services unless your reimbursement has been clearly arranged (you will either bill the patient's family or receive third party money).

LOCATION

In most instances the optometrist is limited in examination space. Often times the exam is confined to the patient's room, while in bed. Other possible locations are shower areas, recreation rooms, bathrooms, hallways, and closets. Be certain that the chosen location has adequate lighting.

THE EXAM

CASE HISTORY

Start the exam with basic case history questions. Many patients will be unable to give exact information, such as date of last vision exam. To save valuable time it is more important to try to learn all the details possible about their vision problem immediately.

NEUTRALIZATION

The next step is to neutralize the patient's habitual prescription. Then check distance visual acuity with and without glasses. Use a 360° marked grid for hand neutralizing the cylinder.

RETINOSCOPY

Retinoscopy can be performed with the patient wearing habitual bifocals using the add as a working distance lens. If the glasses are single vision, use Halberg Clip-ons and insert a $+2.00^{D}$ to $+3.00^{D}$ working distance lens. Generally, better reflex

interpretation is seen with a closer working distance lens, especially if there are lens opacities.

OPHTHALMOSCOPY

Ophthalmoscopy follows if the pupils allow. It is helpful to use a MIO or to do a dilated fundus exam when the ocular health view is limited. Observation of the lens for cataract formation is performed using a direct ophthalmoscope with a plus 10 - 15 ^{D} lens at eight inches. Gradually reduce the plus power as the cornea is approached. This technique allows the optometrist to get a sequential view of the ocular tissue and media from the corneal apex towards the posterior pole.

FAR REFRACTION

The refraction can be performed directly over the patient's glasses or with a trial frame.[14] If the patient has 20/20 acuity, use a +0.50 ^{D} trial lens sphere to see if vision blurs. If acuity is not 20/20, start with -0.50 ^{D} and +0.50 ^{D} spheres, asking which the patient prefers, and continue the refraction from there.

The cylinder determination starts with either a +0.25^{D} sphere and a -0.50^{D} cylinder or a +0.50^{D} and a -1.00^{D} cylinder held in front of the eye being tested at 90, 180, 45 and 135 degrees. The best subjective cylinder axis is combined with lenses on a trial frame, or Halberg Clip-ons and further refined with a hand-held +0.50^{D} JCC lens.

NEAR REFRACTION

When distance acuities are 20/20, the expected near acuities are usually the same or slightly worse. Therefore, a plus build-up to 20/20 acuity at the patient's comfortable reading distance is done to determine the near Rx.

When the acuity is 20/30 or worse, the theoretically appropriate high plus add for reading the desired print size at near is determined. This special reading add is calculated by taking the denominator of the far snellen acuity and dividing it by the denominator of the desired near snellen acuity , coming up with the necessary

magnification required for reading. For example, far acuity is 20/60, desired near acuity is 20/40. The magnification is 60 divided by 40, or 1.5X. The standard reference distance of 16 inches or 2.50^D is used. The magnification times the reference add gives the theoretical dioptric amount for an appropriate reading add. In this case 2.50^D times 1.5X equals $+6.25^D$, and the reading material is held at 6.25^{-1} or 6.3 inches away. A rule of thumb for decentering the near add is 1 mm per dioptric amount per eye, or (6.25 X 2) equals 12.5mm total base-in decentration from the near p.d. This is done to assure comfortable binocular vision while reading.

The Hoffritz neck magnifier can be a useful reading aid which increases near acuities and frees up the patient's hands. It is equipped with a neck strap to support the optical center six inches above the chest area. This is useful for reading in bed or for the handicapped person unable to support a book close to the eyes. It can also be hand held.

PHOROMETRY

The near-far cover tests combined with loose neutralizing prisms are used to determine lateral and vertical phorias. Maddox rod phorias can also be used. Ocular versions can be assessed at this point to rule out any limitations in gaze.

TONOMETRY

Intraocular pressure is measured most easily with an electronic tonometer which provides a permanent record. The hand held Goldmann tonometer is more portable and requires no electrical outlet, however it does require a local anesthetic and fluorescein.

SLIT LAMP EXAM

If a dilated fundus exam is indicated an estimation of the anterior chamber angles is necessary. Hand held slit lamps are useful for cataract grading and assessment of inflammatory processes. This equipment is optional and can be used both in and out of the office.

POTENTIAL ACUITY METER

In those patients with degradation of vision due to cataracts, retinal integrity must be assessed in order to justify surgery. Providing this service can save the patient and facility money by eliminating the cost of sending the patient to a doctor's office. It is also reassuring to the patient to know that there is a possibility to see better again. A portable inferometer, using white light and directional grids called the SITE IRAS and manufactured by Randwal Instruments Inc., provides the optometrist the ability to assess retinal function and visual potential. The IRAS focuses on the retina directly bypassing refractive error or cloudy media enabling the practitioner to effectively evaluate retinal acuity and to differentiate refractive error from retinal dysfunction. Since it uses line orientation responses it can be used on illiterates and malingerers. Regular use of the IRAS can lead to early detection of cystoid macular edema (CME), macular holes and cysts. It also can be used to monitor post operative aphakes for such complications as retinal detachment and CME.[15]

DISPENSING

Now is the time to assist the patient in selecting a frame, measuring a P.D., segment height, instructing on the use of optical aids and writing up the lab orders. Carry a good selection of frames from major manufacturers. The older patients will probably prefer frames that are outdated for your office and the younger patients may prefer more fashionable styles. It is important to write up the lab order right away to eliminate extra paperwork in the office. This will save time in the long run to reduce mistakes. Tell the patient approximately when the glasses will be delivered and fitted, usually in one month. This will give more time to arrange for additional exams at that particular nursing home or at a nearby facility at the time of delivery. It is possible to contract with a dispensing optician to handle the lab orders, adjustments, and deliveries.

Equipment

First Container:

Electronic or hand held Goldmann tonometer

Second Container:

Ophthalmoscope, retinascope, extension cords, extra bulbs, transilluminator and portable lamps

Third Container:

Trial lens set, PD ruler, Halberg trial lens clip-ons, extra ballpoint pens, plus $.50^{D}$ hand held Jackson Cross Cylinder

Fourth Container:

Frames stored in plastic frame holders that hold six frames per-holder, extra tonometer paper, receipt book, self-addressed envelopes, and an ICD-9 code book

Adjustment Tools: Screws, screw drivers, Snip nose pliers, anvil, plunger hammer, nose pads, hinge file, adhesive nose pads, temple covers, temples

Fifth Container:

Referral forms, Medicare forms, Medical and other state forms, examination forms, frame catalogues, spherical high plus glasses 9^{+}–13^{+} in one diopter steps for aphakic refractions, two binocular loupes(4" and 8"), two Aloe telescopes (far and near), Hoffritz neck magnifers, 20 ft Snellen wall chart, 10 ft Snellen wall chart, near point reading cards, 360˚ grid for hand neutralizing cylinder, lab-book, and rectangular magnifier

Misc.

Portable interferometer (SITE IRAS mfg. by Randwal Intruments Inc.) assesses retinal function and visual potential, and a hand-held portable slit lamp

BILLING FOR SERVICES AND MATERIALS

MEDICARE

Medicare is a federally administered, two-part, national health financing program for persons age 65 and older, and certain persons who are blind, disabled, or suffer with end-stage renal disease. Medicare has a uniform eligibility and benefit structure throughout the United States.[16]

The Social Security Administration, which runs Medicare, contracts with various insurance carriers known as fiscal intermediaries, to oversee claims and benefit payments in each state. The policies for submitting claims may vary from state-to-state depending upon the fiscal intermediary's policies (In Oregon Aetna Life Insurance Co.).[16]

Medicare benefits are of two basic types: Part A provides hospital insurance and is financed by mandatory payroll taxes. Part B, the Supplementary Medical Insurance (SMI) program, is voluntary; it provides coverage for physician's services including optometric services for aphakes. Part B is financed by beneficiaries premiums which covers one-quarter of the cost of services, and three-quarters by an appropriation from general tax revenues.

Medicare patients are required to pay a Part B deductible, currently set at $75 a year, and a 20% co-insurance on each claim. The program does not pay for routine eye exams, eyeglasses or low vision aids. Since the Medicare Act specified coverage for physician services only, the Medicare Aphakic Amendment was implemented in 1981 to expand the role of the optometrist and hereby referred to them as Doctor of Optometry whose services are limited to the condition of aphakia.

To obtain Medicare reimbursement, the Doctor of Optometry must file a separate, signed claim for services provided to each patient. Multiple services to one patient by one optometrist may be billed on the same form.

Medicare fiscal intermediaries generally supply forms, preprinted with appropriate provider information to doctors who have a valid Medicare provider

number. To obtain a provider number and billing forms, write to the Provider Certification Department of the Medicare Fiscal Intermediary.

Medicare claim forms must be properly and completely filled out to avoid delay or denial of payment.

- Be sure the patient's data is completed in the subscriber's information section.
- Affix the Health Insurance Claim Number on form. This is not the same as the social security number.
- Make sure the patient signs the form.
- The date and place of each examination and ophthalmic dispensing service must be listed. It is required that each individual service be listed and accompanied by the appropriate procedure code and description of services or materials.
- When reporting aphakia services, use the procedural codes specified by your area Medicare Fiscal Intermediary. These are generally consistent with Current Optometric Procedural Terminology. The COPT is available through the AOA or you may use procedure codes found in the AMA's Current Procedural Terminology (CPT-4).

An example form of the Optometric Diagnostic and Treatment Services and the corresponding codes are found in table 2.

Those aphakic Medicare patients who have chosen to be covered under Part B, Supplementary Medical Insurance, and have paid the $75 annual deductible, are eligible for payment of 80% of their optometric examination services excluding the refractive portion of the exam. Reimbursable optometric services include:

- Case history
- External examination
- Ophthalmoscopy
- Biomicroscopy
- Tonometry
- Ocular motilities
- Binocular function

- Evaluation of contact lenses and provisions of ophthalmic prosthesis services

Aphakic patients are also eligible for 80% reimbursement of ophthalmic materials and material services. Medicare pays 80% of the *reasonable charge* for covered optometric services which are billed on a fee-for-service basis. Reasonable charges are the optometrist's median fee for services, or the prevailing charge for that service in your area. Prevailing fee data, which is arranged according to procedure, locality, and specialty, is available from your Medicare carrier.

MEDICAID

A national health assistance program enacted by Congress in 1965, reaches about 22 million poor people, many of whom are also aged, blind, handicapped or otherwise disabled. Operating in every state, Medicaid is administered by the states and its cost is shared with the federal government. Although the States' shares vary, their average share of the cost is currently 45%.

HOW IT WORKS

Medicaid is available to all persons, with few exceptions, who are aged, blind, and disabled and receive Supplemental Security Income. About half the states also cover people who are medically needy but whose income exceed qualifications for welfare. Eligibility standards must conform with federal guidelines.

Payment for services is made directly to health care providers by the state administering agency or its representatives. Patients with both Medicare and Medicaid, or (Medi-Medi), have the remaining 20% paid for by Medicaid after Medicare has paid 80%.

Vision care is an optional service and each state has its own guidelines. The Medicaid system of third-party reimbursement includes optometry under "other professional" services which accounts for less than 2% of the Medicaid dollar.[16]

ADULT AND FAMILY SERVICES (AFS)

This a division of Medicaid for which all welfare patients are included for billing purposes. Optometric procedural codes are for services performed only by Doctors of Optometry as opposed to codes beginning with either "9" or "M" which may be performed by either a physician or an optometrist. See your State Medicaid Representative for diagnostic and procedural codes.

MAJOR MEDICAL HEALTH INSURANCE

For major medical billing the optometrist must use CPT-4 codes for procedures and ICD-9 codes for diagnosis. Any health insurance claim form can be used as long as it is approved by the AMA Council on Medical Services or by the Health Care Financing Administration of the insurance carrier. Some important items to remember when submitting claims are:

- Identify services and diagnosis on a superbill
- Have patient, or Medical Director complete the patient's portion of the standardized major medical insurance form.
- Attach superbill to insurance form
- Note: Do not have anything to do with glasses on the superbill or it will be rejected
- An insurance letter is mailed if rejected.

The superbill is that receipt your office uses to bill for private services. An example of a Health Insurance Claim form is found in table 3. When billing nursing home patients, reimbursement should always be made directly to the provider (the optometrist) and not to the subscriber.

Conclusion

Nursing homes and other institutions are bulging with patients who are in desperate need of vision care. The aging of our population presents many existing challanges to optometrists and other health care professionals that provide older Americans with opportunities for leading more productive lives. It is up to optometrists

as professionals, to be leaders in providing vision care in the overall health plan for the elderly population.

TABLE 1
Supplemental Information needed from Vision Examinations on Older People in Institutions

1. Near Vision
   - How would this affect the person's ability to read?
   - What are the implications for dining or self feeding?
   - What are the implications for dressing, grooming and personal hygiene? Ask similar questions as to the activities and preferences of the individual (playing table games, taking medications etc..)

2. Far Vision
   - How is the person's ability to recognize faces influenced?
   - What are the implications for residents finding their way to the bedroom, bathroom, dining room, nursing station and front entry?
   - How should a patient be best positioned and seated when participating in large-group socia events (films, chapel, etc..)?
   - Will their T.V. veiwing be affected?
   - Inquire about other indoor and outdoor interest.

3. Mobilitiy
   - How might vision influence standing, walking or wheeling?
   - Might vision be a factor with disorientation or wandering?
   - Vision and mobility can be integrated with physical therapy?

4. Fear, Security, Fire/life Safety
   - Are any aspects of vision loss likely to contribute to fear (real or imagined), anxieties or depression?
   - Do any particular measures need to be taken in order to insure personal safety and security in terms of accidents , victimization or vulnerability?

5. Sensitivities
   - Consider glare sensitivity
   - How will peripheral vision be affected?
   - Consider other sensitivities: drug/vision factors, lacrimation, sunlight and color descrimination

6. Special implications of Eye conditions
   - How adaptive is the patient to changing veiwing habits when using optical aids?
   - How might other factors influence vision (stroke, vertigo, eyelids irregularities, posture, musculoskeletal conditions, hearing sensitivity touch and pain)?

TABLE 2

DIAGNOSTIC AND PROCEDURAL CODES

FAMILY MEMBER	DATE	PROFESSIONAL SERVICES RENDERED	CHARGE	PAYMENT	BALANCE	PREVIOUS BALANCE	NAME

ATTENDING PHYSICIANS STATEMENT

D I A G N O S T I C & T R E A T M E N T S E R V I C E S

	Office New	Office Estab	Hospital New	Hospital Estab	Skilled Nurs. New	Skilled Nurs. Estab	Nursing Home New	Nursing Home Estab
Minimal		90030						90430
Brief	90000	90040	90200	90240	90300	90340	90400	90440
Limited	90010	90050		90250		90350	90410	90450
Intermed.	92002	92012	90215	90260	90315	90360	90415	90460
Comprehen.	92004	92014	90220	90280	90320	90370	90420	90470

MICROBIOLOGY

Smear	87205
Culture (Screen)	87081
Culture (Def. O_2)	87040
Culture (Anaer.)	87075

PROSTHETIC

Ocular Prosth.	92330

INDEPENDENT DIAGNOSTIC

External Photog	92285
Conioscopy	92020
Visual Fields	92081
Tonometry, serial	92100
Provoc. for Glaucoma	92140
Extended Ophthalmos.	92225
Fundus Photography	92250
Ophthalmodynamometry	92260
Electroretinography	92275
Visual Evoked Response	92280
Extended Color Exam	92283

LOW VISION AID

Single Element	92354
Compound lens	92355

VISION THERAPY

Diagnostic:

Developmental	95881
Cognitive tests	95882
Sensorimotor	92060

Treatment:

Orthoptic Tr.	92065
F.B. Removal	65222
Nasolacrimal	68820

CONTACT LENS TREAT.

		Rx#1	Rx#2
Corneal	92310		
Aphakia, Uni	92311		
Aphakia, Bil	92312		
Disease	92070		
Replacement	92326		

LENS TREATMENT

	Non-aph	Aphak
Mono	92340	92352
Bif	92341	92353
Multi	92342	
Temp.		92070

FRAMES

Dispensing	V2035

D I A G N O S I S

ACUITY

Accommodative D.	367.55
Amblyopia	368.00
Aniseikonia	367.32
Anisometropia	367.31
Astigmatism	367.20
Prof. Impair. Both eyes	369.00
Mod.-Profound	369.10
Mod./Severe Both eyes	369.20
Unequal, both	369.30
Blindness, Legal	369.40
Hyperopia	367.00
Myopia	367.10
Presbyopia	370.40

CORNEA

C Abrasion	918.10
C Edema	371.24
C Foreign Body	930.00
C Ulcer	370.00
Dendritic Ulcer	054.42
Keratitis	370.90
Kerat. Sicca	375.15
Keratoconus	371.60
C Burn	368.13
C Dystrophy	371.50
C Erosion	371.42

LENS

Aphakia RL	379.31
Cataract	366.10

VITREOUS

V. Opacity	379.24
V. Hemorrhage	379.23
V. Floater	379.24

GENERAL

Diabetes	250.5
Hypertension	401.9
Headache, Tension	784.0
Headache, Migrain	346.0
Nephritis	583.9
Dermatitis	692.89
Thyroid	240.0
Photophobia	368.13

SCLERA/CONJUNCTIVA

Conj. Allergic	372.14
Conj. Infective	372.03
Episcleritis	379.00
Pinguecula	372.51
Pterygium	372.40
Subconjun. Hemo	372.72

EXTERNAL MUSCLE

Anomalous Corr.	368.34
Converg. Excess	378.84
Converg. Insuff.	378.83
Diplopia	368.20
Esophoria	378.41
Esotropia	378.00
Exophoria	378.42
Exotropia	378.10
Fusional Dysf.	368.30
Hyperphoria	378.43
Hypertropia	378.31
Nystagmus	379.50
Paresis	378.55
Pursuit defic.	379.58
Track (Oculomot)	378.9
Saccadic-Fixat.	379.57
Suppression	368.31

LIDS

Blepharitis	373.00
Blepharo Spasm	333.81
Chalazion	373.20
Ectropion	374.10
Entropion	374.00
Hordiolum	373.11
Ptosis	374.30
Trichiasis	374.05
Zanthelasma	374.51
Cyst	374.84
Burn	940.1
Verruca	078.1

ANTERIOR CHAMBER

Glaucoma Open A	365.11
Glaucoma Narrow	365.20
Glaucoma suspec.	365.00
Iritis	364.31
Ocular Hyperten	365.04

RETINA

Color Defic.	368.50
Diabetic Retin.	362.01
Hypertensive R.	362.10
Macular Degen.	362.50
Retinal Degen.	362.60
Retinal Detach.	361.00
Ret. Ischemia	362.84
Ret. Hemorrhag.	362.81
Scotoma	368.40

PERCEPTUAL VISION

Learning Disab.	315.20
Vis. Mot. Dysf.	315.90
Visualization D	315.5

NORMAL	65.50

1 2 M A T E R I A L S

CONTACT LENSES

	Sphere	Toric	Bifoc	Extend		Rx#1	Rx#2
PMMA	V2500	V2501	V2502				
Gas Perm	V2510	V2511	V2512	V2513	R		
Hydro	V2520	V2521	V2522	V2523	L		

LENSES (per lens)

	Sph	Cyl 2	4	6	∞	
±20 / ±12	V2 02	V2 14	(V2 17 Lentic)			
±7	V2 01	V2 11	V2 12	V2 13		R
±4	V2 01	V2 07	V2 08	V2 09	V2 10	L
Pl	V2 00	V2 03	V2 04	V2 05	V2 06	

1=SV 2=Bif 3=Tri

LOW VISION

Hand Held	V2600
SV Lenses	V2610
Compound	V2615

PROSTHETIC EYE

Stock	V2621
Custom	V2623

LENS EXTRAS

Over 28 Seg	V2 19
Over +3.50	V2 20
Balance	V2700
Slab Off	V2710
Prism	V2715
Special B.C.	V2730
Hardcote	V2760
Oversize	V2780

TINTS

Pl Rose 1,2	V2740
Pl Other	V2741
GL Rose 1,2	V2742
GL PGX	V2744
GL Other	V2743
Anti-reflec.	V2750
UV-400	V2755

FRAMES

New	V2020
Replacement	V2025
Repair	V2030

DR.

OPTOMETRIST

I authorize payment of health care benefits to ______ for the services describ

I understand that I am responsible for payment of any charges not covered by my insurance.

Signature of Financially Responsible Party

Do/Do Not Accept Assignment

Date Symptoms Appeared or Accident Occurred ______

RETURN: _____Days_____Weeks_____Months

NEXT APPT.

PLEASE DO NOT STAPLE IN THIS AREA

3

TABLE 3

FORM APPROVED
OMB NO. 0938-0008

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

☐ MEDICARE (MEDICARE NO.) ☐ MEDICAID (MEDICAID NO.) ☐ CHAMPUS (SPONSOR'S SSN) ☐ CHAMPVA (VA FILE NO.) ☐ FECA BLACK LUNG (SSN) ☐ OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
2. PATIENT'S DATE OF BIRTH
3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
5. PATIENT'S SEX — MALE ☐ ☐ FEMALE
6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS)
7. PATIENT'S RELATIONSHIP TO INSURED — SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐
8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)
☐ INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

TELEPHONE NO.

9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)
10. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT — YES ☐ ☐ NO
B. ACCIDENT — AUTO ☐ ☐ OTHER
11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.
11.a. CHAMPUS SPONSOR'S: STATUS ☐ ACTIVE DUTY ☐ DECEASED ☐ RETIRED — BRANCH OF SERVICE

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING)
I AUTHORIZE THE RELEASE OF ANY MEDICAL 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 DATE

13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.

SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF: ◀ ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES
16.a. IF EMERGENCY CHECK HERE ☐
17. DATE PATIENT ABLE TO RETURN TO WORK
18. DATES OF TOTAL DISABILITY — FROM — THROUGH
DATES OF PARTIAL DISABILITY — FROM — THROUGH
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES — ADMITTED — DISCHARGED
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ ☐ NO CHARGES:

23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE
1.
2.
3.
4.

B. EPSDT YES ☐ ☐ NO
FAMILY PLANNING YES ☐ ☐ NO
PRIOR AUTHORIZATION NO.

24. A. DATE OF SERVICE FROM TO	B.* PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN — PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G.* T.O.S.	H. LEAVE BLANK

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)

DATE:

26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES ☐ ☐ NO
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. YOUR SOCIAL SECURITY NO.
31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.
32. YOUR PATIENT'S ACCOUNT NO.
33. YOUR EMPLOYER I.D. NO.
I.D. NO.

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK
REMARKS:

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form **HCFA-1500 (C-2) (SC) (1-84)** Form **OWCP-1500**
Form **CHAMPUS-501** Form **RRB-1500**

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAM.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 is completed, the patient's signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program and renders payment for health benefits provided through membership and affiliation with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned "Insured"; i.e., items 3, 6, 7, 8, 9 and 11.

BLACK LUNG AND FECA CLAIMS: The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered a 'incident' to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that neither I nor any employee who rendered the services are employees or members of the Uniformed Services (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422 510).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION.

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and BLACK LUNG programs. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act as amended and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards and other organizations or Federal agencies as necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor.

With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether workers' compensation will pay for treatment. Section 1877 (a) (3) of the Social Security Act provides criminal penalties for withholding this information.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request. I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductibles and coinsurance.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally rendered by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete.

I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

PLACE OF SERVICE CODES:

1 - (IH) - Inpatient Hospital
2 - (OH) - Outpatient Hospital
3 - (O) - Doctor's Office
4 - (H) - Patient's Home
5 - - Day Care Facility (PSY)
6 - - Night Care Facility (PSY)
7 - (NH) - Nursing Home
8 - (SNF) - Skilled Nursing Facility
9 - - Ambulance
0 - (OL) - Other Locations
A - (IL) - Independent Laboratory
B - (ASC) - Ambulatory Surgical Center
C - (RTC) - Residential Treatment Center
D - (STF) - Specialized Treatment Facility
E - (COR) - Comprehensive Outpatient Rehabilitation Facility
F - (KDC) - Independent Kidney Disease Treatment Center

TYPE OF SERVICE CODES:

1 - Medical Care
2 - Surgery
3 - Consultation
4 - Diagnostic X-Ray
5 - Diagnostic Laboratory
6 - Radiation Therapy
7 - Anesthesia
8 - Assistance at Surgery
9 - Other Medical Service
0 - Blood or Packed Red Cells
A - Used DME
F - Ambulatory Surgical Center
H - Hospice
L - Renal Supplies in the Home
M - Alternate Payment for Maintenance Dialysis
N - Kidney Donor
V - Pneumococcal Vaccine
Y - Second Opinion on Elective Surgery
Z - Third Opinion on Elective Surgery

FASTEN HERE

DO NOT STAPLE IN BAR AREA

TABLE 4 (MEDI-MEDI FORM)

1. CLAIM CONTROL NUMBER — F.I. USE ONLY

[PR]OVIDER NAME AND ADDRESS

2. MEDI-CAL PROV. NO.

3. MEDICARE PROV. NO.

6. ZIP CODE

PROFESSIONAL/SUPPLIER CLAIM FORM

4. ☐ MEDI-CAL
5. ☐ MEDICARE

AFFIX LABEL HERE | AFFIX LABEL HERE

7 (AREA) ◀ PROVIDER PHONE NO.

[Elit]e Pica

PLEASE TYPE ALL REQUIRED INFORMATION
Typewriter Alignment

Elite Pica

PATIENT'S COMPLETE NAME, AND ADDRESS

9 MEDICARE NUMBER | 10 SEX M/F | 11 WAS CONDITION RELATED TO EMPLOYMENT Y N | 12 DATE OF ONSET MM DD YY | 13 TAR CONTROL NUMBER

14 MEDI-CAL I.D. NUMBER | CHECK DIGIT | 15 DATE OF BIRTH MM DD YY | 16 PATIENT ACCOUNT NUMBER

SERVICES RELATED TO HOSPITALIZATION: 17 FROM MM DD YY | 18 THRU MM DD YY | 19 EMER CERT ATTACHED | 20 OTHER COV. | 21 BILLING LIMIT EXCEP | 22 ATTACH-MENTS | 23 D.M.E. CODE | 24 MEDICARE STATUS

PATIENT'S PHONE NUMBER
25 (AREA)

26 NAME & ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE) | 27 FACILITY PROVIDER NO.

OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICY HOLDER, [PLA]N NAME, ADDRESS AND POLICY NUMBER

29 OUTSIDE LAB | 30 LABORATORY NAME AND ADDRESS

31 NAME OF REFERRING PROVIDER | 32 REFERRING PROVIDER NUMBER

[PRI]MARY DIAGNOSIS DESCRIPTION
33

34 PRIMARY ICD-9-CM | 35 SECONDARY DIAGNOSIS DESCRIPTION | 36 SECONDARY ICD-9-CM

[DE]SCRIPTION	BILLING PROVIDER CHARGE FOR OUTSIDE LAB SERVICES	DELETE		DATE OF SERVICE	PLACE OF SERVICE	FP/CHDP	RENDERING PROV. NO. IF OTHER THAN BILLING PROV.	PROCEDURE CODE MOD	QUANTITY	SERVICE CHARGES
	38	39	1	40 MM DD YY	41	42	43	44	45	46
47	48	49	2	50 MM DD YY	51	52	53	54	55	56
	58	59	3	60 MM DD YY	61	62	63	64	65	66
	68	69	4	70 MM DD YY	71	72	73	74	75	76
77	78	79	5	80 MM DD YY	81	82	83	84	85	86
	88	89	6	90 MM DD YY	91	92	93	94	95	96
97	98	99	7	100 MM DD YY	101	102	103	104	105	106
	108	109	8	110 MM DD YY	111	112	113	114	115	116

[RE]MARKS/EMERGENCY CERTIFICATION STATEMENT:

MEDI-CAL

117 BLOOD PINTS | 118 BLOOD DEDUCT | 119 TOTAL CHARGES
120 MEDICARE DEDUCTIBLE | 121 MEDICARE CO-INSURANCE | 122 MEDICARE PAID
123 MEDICARE DISALLOWED | 124 PATIENT'S SHARE OF COST | 125 OTHER COVERAGE | 126 DEDUCTIONS
127 DATE OF EOMB MM DD YY | 128 DATE BILLED MM DD YY | 129 NET AMOUNT BILLED

FI USE: 130 | 131 | 132 | 133 | 134

MEDICARE: 135 TOTAL CHARGES | 136 AMOUNT PAID | 137 ANY UNPAID BALANCE DUE

[S]IGNATURE REQUIRED FOR EMERGENCY CERTIFICATION — DATE / /

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING). I authorize the release of any Medical Information necessary to process this claim and request [pay]ments of Medicare Benefits either to myself or to the party who accepts assignment.

SIGNED — DATE

This is to certify that the information contained above is true, accurate, and complete and that the provider has read, understands, and agrees to be bound by and comply with the statements and conditions contained on the back of this form.

139 SIGNED — DATE

Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form.

140 ☐ I DO ACCEPT ASSIGNMENT
141 ☐ I DO NOT ACCEPT ASSIGNMENT

40 1C 12/82

FORWARD TO APPROPRIATE F.I.

IMPORTANT

MEDI-CAL PAYMENTS

The services listed on this form have been personally provided to the patient by the provider or, under his direction, by another person eligible under the Medi-Cal Program to provide such services, and such person(s) are designated on this form. The services were, to the best of the provider's knowledge, medically indicated and necessary to the health of the patient. The provider understands that payment of this claim will be from Federal and/or State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and/or State laws. The provider agrees to keep for a minimum period of three years from the date of service all records which are necessary to disclose fully the extent of services furnished to the patient. The provider agrees to furnish these records and any information regarding payments claimed for providing the services, on request, to California Department of Health Services; Medi-Cal Fraud Unit, California Department of Justice; Medi-Cal Audits Project, Office of State Controller; U.S. Department of Health and Human Services, or their duly authorized representatives.

Medical care services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

MEDICARE PAYMENTS

A patient's signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If the "Other Health Insurance Coverage" block is completed, the patient's signature authorizes release of the information to the insurer or agency shown. In assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the carrier, if this is less than the charge submitted.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare regulations.

For services to be considered as 'incident to' a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his employee, 2) there was a covered physician's service rendered of which the other services are an integral, although incidental part, 3) they must be of kinds commonly furnished in physicians' offices, and 4) the services of nonphysicians must be included on the physicians' bill.

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable federal laws.

What do you see nurse, What do you see?
What are you thinking when you look at me?
A crabby old woman, not very wise,
Uncertain of habit, with far away eyes,
Who dribbles her food, and makes no reply,
When you say in a loud voice, "I do wish you'd try !"
Who seems not to notice the things that you do,
And forever is losing a stocking or shoe.
Who, unresisting or not, lets you do as you will
With bathing and feeding, the long day to fill.
Is that what your thinking, is that what you see?
Then open your eyes, your're not looking at me.
I'll tell you who I am as I sit here so still,
As I move at your bidding, as I eat at your will.
I am a small child of ten with a father and a mother,
Brother and sisters who love one another.
A girl at sixteen with wings at her feet
Dream that soon now a lover she'll meet.
A bride soon at twenty, my heart gives a leap,
Remembering the vows that I promised to keep.
At twenty-five now I have a young of my own
Who need me to build a secure happy home.
A woman of thirty, my young now grow fast,
Bound to each other with ties that should last.
At forty my young now soon will be gone,
But my man stays beside me to see I don't mourn.
At fifty once more babies play around my knee,
Again we know children, my love one and me.
Dark days are upon me, my husband is dead,
I look at the future, I shudder with dread,
For my young are all busy rearing young of their own
And I think of the years and the love I have known.
I'm an old lady now and nature is cruel,
'Tis her jest to make old age look like a fool.
The body it crumbles, grace and vigor depart,
And now there is a stone where I once had a heart.
But inside this old carcass a young girl still dwells,
And now and again my battered heart swells.
I remember the joys, I remember the pain,
And I am loving and living life over again.
I think of the years all too few, gone so fast,
And accept the stark fact that nothing can last.
So open your eyes, nurse, open and see,
Not a crabby old woman, look closer, see me.

ANONYMOUS

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Addendum:

Additional resource:

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