



American Optometric  
Association

# OPTOMETRIC HOSPITAL PRIVILEGES

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## **FOREWARD**

The American Optometric Association has taken an active role in assisting optometrists in obtaining hospital privileges for many years. Numerous publications, national symposiums, state association hospital committee projects, and state and regional educational programs have added to the profession's awareness and knowledge of hospital practice. This manual is a compilation of many years of work and should serve as a practical source of information on how and why to obtain hospital privileges.

## **I. INTRODUCTION**

The health care delivery system in the United States is changing. Whether it is called health care reform, managed competition, managed care, or simply, market-driven integration of delivery, the fact is optometry must be prepared to deliver its services in a variety of new forms. Patients need access to optometrists in their offices, in long-term care facilities, at home, and in hospitals. Optometrists must be prepared to provide services in all of these locations. Hospitals will play an important role in future health care delivery and optometrists must continue to seek and be granted hospital privileges.

This Manual serves to educate optometrists about the advantages of hospital privileges and the importance of optometry to the hospital. Important information about hospital bylaws and legal issues is also covered in detail. A section on how to obtain privileges can serve as a guideline for optometrists interested in applying for hospital privileges. The use of this guideline must be tempered by the specific situation presented by the particular hospital to which you are applying. For those optometrists who already have privileges or for those optometrists new to the hospital environment, the Manual has sections on the optometric examination, equipment, laboratory tests, imaging, and other diagnostic procedures; diagnostic coding and charting are also covered.

A recent health care publication reports, “Competing successfully in the new environment will mean streamlining and integrating delivery of care. Central to this integration will be the formation of strong physician-hospital linkages.”<sup>1</sup> This Manual may help optometrists in their efforts to succeed and flourish in this new environment.

## **II. THE ADVANTAGES OF HOSPITAL PRIVILEGES TO AN OPTOMETRIST**

Optometrists are usually considered office-based primary eye care providers. So why do they need hospital privileges? The reasons can be as different as the communities they live in and as varied as their individual practice modes. Having hospital privileges ensures continuity of care for patients by providing a heightened awareness of the need for and value of in-hospital eye health care. Optometrists are able to serve their already established patients who may suffer eye-related symptoms or complications while hospitalized. This may include providing glaucoma medication, or monitoring and evaluating sudden onset of ocular pain, as well as flashes or floaters in the eye.

The benefits of having hospital privileges can be simply summarized as follows:

- Continuity of care for patients
- Improved access to supplementary diagnostic tests
- Networking and referral opportunities with primary care and specialist physicians and others within the mainstream of health care
- Inclusion on provider panels
- Continuing education and library resources
- Participation in interprofessional research studies
- Benefits resulting from hospital marketing efforts
- Participation in community educational programs and health care screenings.

### **III. THE IMPORTANCE OF OPTOMETRY TO THE HOSPITAL**

Optometrists are widely recognized as valuable members of today's health care delivery system. The provision of optometric services in a hospital setting is beneficial to all parties concerned. The improved access to eye health care services is a benefit to the community; patients receive accessible, excellent care and the hospital realizes revenues and cost savings resulting from appropriate utilization of resources and staff.

The American hospital industry is undergoing significant fundamental change, prompted in part by government reform, but more importantly by the health care buyers: insurance companies, employers, and individuals. Changes in reimbursement to hospitals by Medicare and other third party payers have had significant impact on their profitability. All third parties are demanding more cost-efficient care with outcomes data to justify appropriateness. As a result, hospitals have had to make changes in the past few years. The average number of hospital beds is decreasing. Inpatient services are relatively stable, while outpatient services are dramatically increasing. These changes have forced many services, traditionally provided in hospitals, to be shifted to freestanding outpatient facilities.

The trend to outpatient services has forced hospitals to re-evaluate their position in the medical marketplace. Less efficient hospitals are closing; others are being purchased by larger systems. All hospitals are concerned about ways to decrease expenses and are exploring options such as physician hospital organizations (PHOs) and other structural links to providers. Managed care and an increased emphasis on primary care are recognized trends throughout the health care industry.

Optometrists fit very well into many of the above segments of a changing hospital operating scheme. Optometrists, being primary care providers, can help the hospital deliver eye care services in a very efficient manner. As buyers of health care services continue to demand an appropriate level of care from primary care providers, with specialist services performed only when necessary, optometrists will continue to find an increased role in hospital practice. Outpatient services continue to provide a higher proportion of a hospital's income. Optometrists are primarily providers of and referral sources for outpatient services, and are valuable contributors both directly and indirectly to hospital income. Hospitals can only generate income through patient services, and patient services primarily are derived from a good blend of providers, both at the primary level and at the surgical and specialty level.

Cataract surgery is the most frequently performed surgery for Medicare recipients. It is a major potential revenue source for hospitals, both large and small, metropolitan and rural. It is an outpatient procedure, and one that can be performed with measurably good outcomes in the patient's own "local hospital." In the Battelle study of cataract surgery patients, 74 percent of the postoperative care for cataract surgery was delivered by optometrists.<sup>2</sup> The typical optometric practice has thousands of patients who are age 55 and older, the same age group that not only may need cataract surgery services, but also accounts for most inpatient hospital bed use. This is an asset that hospitals recognize and continue to foster.

Many rural hospitals have added cataract surgery to their list of services. Woods Memorial Hospital in Tennessee added optometrists to their staff and began offering cataract surgery services in 1995. Through the utilization of mobile equipment, very little expense was incurred by the hospital for equipment or overhead expense. Within two years the hospital was providing services for nearly 175 cataract surgeries per year. Most importantly, however, was the 47 percent rate of first time patients coming to Woods for health care services.<sup>3</sup> This might translate into added future revenues from the new patients who had good surgical outcomes and a pleasant experience in their hometown hospital.

Utilization of laboratory and imaging services is another direct increase in revenues that a hospital may realize by having optometrists on staff. While optometry does not generate high volumes of these services, cultures, CT scans, orbital x-rays, MRIs, carotid Doppler ultrasounds, blood tests, etc. are ordered by optometrists. As a primary care provider, optometrists need access to specific diagnostic tests provided by hospitals. Examples may include but are not limited to:

- A culture to identify the specific microorganism causing a corneal ulcer and a sensitivity test to determine the appropriate antibiotic for treatment are common procedures needed in the optometric practice.
- A sedimentation rate to rule out temporal arteritis or glycosylated hemoglobin and/or a fasting blood sugar to rule out diabetes are examples of blood tests that may be needed.
- Optometrists commonly remove corneal foreign bodies. An orbital X-ray may be needed in the case of a high velocity foreign body to rule out penetrating foreign material.
- A patient with suspected low tension glaucoma may need imaging tests to rule out other causes of optic nerve disease before initiating glaucoma therapy.
- Visual fields are performed daily in optometric offices and often find defects indicative of intracranial strokes or other neurological diseases. Diagnostic imaging, including CT scans and MRIs, are ordered in many of these cases to more specifically diagnose the patient's disease and either begin optometric treatment or make the appropriate cost-effective referral.

Optometrists, available as staff members, give the hospital access to eye care services both in the emergency room and for inpatient services. Ocular trauma, infections, foreign bodies, and corneal abrasions are common reasons for emergency room visits. Inpatients may need an eye consultation for dry eyes, flashes and floaters, headaches, diplopia, or any other ocular symptoms that optometrists diagnose and treat in their offices each day. The hospital and the staff medical physicians need to have access to optometric consultation services for their patients. Affordable equipment that is already owned by the optometrist can be used in the hospital setting without any outlay of expenses by the hospital.

Laser vision correction is a growing procedure performed in the United States. The lasers required to perform these procedures are often located in freestanding laser centers or ophthalmological surgery centers, but sometimes they are also in hospitals. If the setting is a hospital, optometrists should be a part of the referral network and an integral part of the hospital staff providing both pre and postsurgical care, ensuring cost-effective use of the laser and associated staff.

Optometrists perform nearly 70 percent of the primary eye care examinations in the United States<sup>4</sup> and are often the providers that patients consult first regarding refractive surgery. With most refractive surgery being performed in larger metropolitan areas, rural hospital emergency rooms may be faced with postoperative complications. When they occur, new decisions regarding evaluation of the postrefractive surgical cornea after trauma must be made. Optometrists can provide these services in hospital settings, just as they do in their offices.

Managed care is impacting all elements of health care including hospitals. Hospitals have realized the importance of linking with providers, both at the primary care and specialty care levels. This may be through a very structured affiliation, such as employment of providers, or through a loose link, such as a physician hospital organization (PHO). The ability to capture and provide all of the health care for a patient is becoming much more important. Eye care is one aspect of this complete package and the availability of optometric services is extremely important to hospitals. Optometrists can provide numerous eye care services; they have a

database with thousands of patients that are important to hospitals as potential patients. Hospitals may start eye departments and employ or contract with optometrists. They may bring optometrists into the PHO as providers or, as many hospitals have done, bring optometrists onto the hospital staff through the same credentialing and privileging process that medical physicians undergo.

Hospitals need optometrists both for direct generation of revenues and for the indirect benefits of access to more primary care patients and the associated surgical care of these patients. Hospitals can benefit by utilizing optometrists to provide timely and appropriate eye care to inpatients, outpatients, and emergency room patients. Optometrists can provide increased revenues through increased utilization of laboratory and imaging services. Hospitals are the uniting force in many communities. As they help direct the coordination of providers, inpatient and outpatient services, and urgent and emergency care, optometry can prove to be a valuable asset to hospitals.

## **IV. HOSPITAL BYLAWS**

Hospital bylaws are written documents that govern each individual hospital. Hospital bylaws state policies and governance procedures, identify staff levels of appointment, describe the credentialing and privileging process, and provide the rules and regulations for the hospital. Bylaws can vary considerably from one hospital to another and must be evaluated closely prior to applying for hospital privileges. Always obtain a copy of the hospital's bylaws and analyze the following key areas: Definitions, staff appointment categories, the credentialing and privileging process, the bylaws amendment process, and the fair hearing process, if denied privileges.

The bylaws will categorize and specifically define the staff into levels such as active, honorary, consulting, affiliate, allied, associate, etc. These definitions can be very different from one hospital to another. An optometrist must be included in a specific category in order to have privileges granted. This may be accomplished by specifically identifying optometrists as providers who may fit in a particular category or may simply be defined by a broad statement (e.g., health care provider, health care professional, practitioner, other licensed professional, etc.). Such terms may also be defined in the bylaws and need careful study and possibly modification.

Optometrists are not commonly identified in bylaws as a provider group who may hold hospital privileges. This invariably requires the optometrist and the sponsor to amend the bylaws. Many of the optometrists who currently have staff privileges have amended their hospital bylaws in order to apply for privileges. Do not be discouraged; it is just one more step that must be resolved in the process. This has been done successfully on numerous occasions across the nation. Many bylaws were written in times when only medical physicians were requesting staff privileges and only medical physicians had scope of practice licensure appropriate for examining patients in hospitals. The bylaws will describe the process for bylaws amendment, so you will know the necessary process.

Once the bylaws are in proper form to allow you a staff level of appointment, you are ready to consider making application. The bylaws will guide you in knowing the committees that will review and act upon your application and what recourse you might have, should your application be denied. Specific wording in bylaws may vary, so each set of bylaws must be read critically and carefully. An attorney well versed in health care law should be consulted if a question arises.

## **V. LEGAL ISSUES IN HOSPITAL PRIVILEGING**

### **A. GENERAL TRENDS**

Hospitals are increasingly looking to secure market share by consolidating, such as, buying other hospitals, clinics, and physician practices. This move into the ambulatory care setting has made hospitals more receptive to optometrists becoming affiliated with them. There are, however, barriers that can exist and an application for hospital staff privileges does not always meet with success.

### **B. LEGAL ISSUES**

The legal issues surrounding hospital privileges are complex. The following provides a brief summary of issues and points to consider prior to proceeding with any action relating to obtaining hospital privileges. It does not constitute legal advice. Individuals should seek legal counsel from an attorney experienced in hospital law.

#### **1. State Law**

Hospitals are governed by state law. There are states that specifically identify, within statutory law, who is eligible to hold medical staff positions within a hospital. In other cases, it is likely that optometrists are not named either as eligible or ineligible. This ambiguity can lead to problems. In many cases, the statute grants to the individual hospitals the right to determine the types of providers who may obtain privileges. For optometrists interested in pursuing privileges, state optometric association hospital committees or legal counsel can be helpful in finding and reviewing pertinent statutory law.

#### **2. Hospital Bylaws**

Hospital bylaws internally govern each hospital; they state policies, governance procedures, the types of medical staff positions, the types of health care providers who may hold those positions, and the mechanisms for applying for hospital staff membership. Since bylaws can vary considerably from one hospital to another, the optometrist, when seeking hospital affiliation, must closely evaluate each individual facility's bylaws.

Active medical staff is the level of staff most intimately involved with hospital practice. In addition to actively seeing patients, active medical staff members are eligible to vote, admit patients, hold office, and serve on hospital committees. Many times optometrists will not be eligible for active medical staff under the definitions used in the bylaws. Generally, optometrists will not be named as individuals who can hold staff privileges in any category. Invariably this requires amending the bylaws to include optometrists as individuals who, by definition, may be staff members. Optometry may be defined as a named provider group, physician, practitioner, or by some other definition of provider. Depending on this definition and the bylaws category definition, a category of appointment can be determined. Active medical staff level of appointment may be possible, but another category such as independent allied health, consulting, or affiliate staff may be more likely.

## **C. REASONS FOR DENIAL**

### **1. Needs of the Hospital**

Probably the most common reason for denial is that the hospital already has an adequate number of providers to cover the necessary services.

### **2. Economic Credentialing**

Traditionally, the awarding of hospital privileges has been made by the medical staff based solely on the professional credentials of the applicant. Recently, the concept of economic credentialing has also entered into the decision making process. The basic premise of economic credentialing is that economic factors may also be used in determining who is eligible for hospital staff positions. Health care providers may be excluded from a medical staff based solely on economic considerations (e.g., resource utilization and outcomes data, admission casemix, generating potential, malpractice claims).

## **D. POINTS TO CONSIDER**

1. Are optometrists named in the bylaws as individuals who can hold hospital privileges and included as “other nonphysician providers” or are they specifically excluded? Optometrists are almost always not named and, therefore, bylaws must be changed.
2. What is the procedure for changing bylaws? This may be a very slow and tedious process. Consult the bylaws of your hospital for the procedure to change or amend existing bylaws. Consulting other hospital bylaws that allow optometrists on staff may be very beneficial.
3. What are the staff categories? Where does the optometrist fit? You must know what the categories are and into which category you will fit before applying for hospital privileges.
4. Who will review requests for clinical privileges? What is the procedure for fair hearing if privileges approved are not adequate? It is important that this process be fair and that the hearing committee understand optometry’s expanded role in providing eye care services.
5. Are there state laws that allow you the right to judicial review if denied hospital privileges? In most cases, the answer to this question will be no.
6. Are there specific state laws which prohibit or do not specifically allow optometrists to obtain hospital privileges? State statutes must be searched to answer this question. If the answer is yes, these laws should be changed.
7. Did the hospital follow its bylaws in reviewing your application for staff? Hospital bylaws outline the process for applying for privileges and they must be followed.
8. Can I sue based on antitrust? Perhaps. The chances of winning are extremely small. These cases can be time-exhaustive and extremely expensive. Optometrists should carefully consider whether this option is desirable before proceeding with litigation. Consulting a lawyer experienced in antitrust law and hospital privileges is mandatory.

## **VI. HOW TO OBTAIN HOSPITAL PRIVILEGES**

### **A. ASSESSING THE PLAYERS**

Obtaining hospital privileges can be similar to the process of passing a bill in the legislature. Being prepared and laying the groundwork before getting started are crucial. It is important for the optometrist to know prior to applying for privileges what the reaction will be to that application. Will there be opposition? Where will the opposition come from? Are there specific privileges that are being requested that will be controversial? What committees will be involved (bylaws, credentials, privileges, etc.)? Submitting an application cold without preliminary discussions with key individuals is much more likely to meet with resistance.

Many optometrists find it advantageous to have a sponsor help facilitate the process. This may be a physician on the medical staff, the hospital administrator, or other individual familiar with the application process. Frank discussions with the hospital administrator, chief of staff, and other appropriate members of the medical staff can lay the groundwork and avert last minute surprises. The next step is to make the application.

### **B. MAKING APPLICATION**

Some hospitals have a formal application form that must be filled out; in other cases, the hospital may simply need a letter indicating that the optometrist is interested in applying for privileges (See Appendix A for a sample application form). As part of making the application, the optometrist will be asked to specify the position for which he/she is applying.

It is important for the optometrist to understand the categories of providers within the individual hospital. The hospital bylaws will answer most of these questions, so be sure to review them thoroughly before beginning the process. Optometrists should request the highest appointment level when possible. The active medical staff level allows the broadest privilege consideration and gives you the opportunity to serve on hospital committees and attend staff meetings.

Once the category of staff has been determined, the optometrist needs to determine the clinical privileges or the exact clinical procedures he/she is requesting. How this is done can vary considerably from one hospital to another. Some hospitals will require a detailed list of each individual test and procedure the doctor will provide; others prefer a more broad and general document. In either case, the privileges requested will be submitted to the appropriate committee (typically a standing privileges committee) for review. The AOA has developed model documents that can help with this process (See Appendix B, AOA Guidelines for Delineation of Hospital Privileges). Be aware that all information and data supplied on the application document will be verified.

The optometrist's scope of practice within the hospital is determined by this process and does not necessarily have to follow state law (e.g., hospitals may choose to limit the scope of practice). Optometrists should request privileges that appropriately allow practice at the fullest scope possible in the hospital setting. As part of the credentialing process, the optometrist will be asked to document the ability to perform each of the procedures requested.

### **C. CREDENTIALING**

Credentialing (assuring professional competency) is an important part of the hospital application process. Credentialing demonstrates that you are qualified to perform the procedures you have requested. Credentialing usually requires documentation of proof of graduation, state licenses, diagnostic and therapeutic certification,

malpractice insurance, completion of continuing education requirements, professional experience, curriculum vitae, and other similar documentation. It is wise to gather these documents before beginning the process. Credentials will typically be reviewed at the time of the request for staff membership. The hospital will also query the National Practitioner Data Bank (NPDB) prior to granting privileges and upon credentialing.

#### **D. PRIVILEGING**

The process of applying for and obtaining hospital privileges can be a long and arduous one. The number of committees and their structure will vary from hospital to hospital. The greater the number of committees that the application must pass through, the slower the process will be; these committees may only meet annually, biannually or quarterly. Applications from optometrists are likely to be new to the hospital and will move more slowly simply because of their uniqueness. Bylaws changes, if they must be made, can be very slow, requiring review and passage by multiple committees. Credentials and privileges are typically reviewed by the medical staff and proceed at a somewhat faster pace. Ultimately, staff membership and bylaws changes have to be approved by the hospital board. The entire medical staff may, at some point, have the opportunity to vote on both bylaws and staff membership. Patience and persistence are keys. It may take a year or more to complete the entire process. Remember that at any point in the process you may remove your application from consideration. This may be necessary if denial seems inevitable and more time is needed to educate committee members about your qualifications. Managed care applications or future hospital staff applications may ask “Have you ever been denied hospital privileges?” Take the appropriate steps to be certain that your application is approved or remove your application from consideration prior to a negative vote.

#### **E. OPTOMETRIST’S RECOURSE IF DENIED**

Recourse can be limited if the hospital denies privileges for valid reasons. It is important that the hospital provide in writing the reasons for denial. It is important to make sure that the hospital followed its own rules, as outlined in the bylaws, during the review process. It is also important to determine if an appeal process is available to you.

## **VII. THE HOSPITAL-BASED OPTOMETRIC EXAMINATION**

### **A. PROCEDURES**

The examination procedures used by an optometrist in the hospital setting and how that exam is performed can vary widely depending on the individual situation. This depends largely on how integrated into the hospital the optometrist becomes. Optometrists with a full-time staff position may have an office and perform primary care services within the hospital. The services provided might be no different than those in any private office. All needed equipment would likely be provided by and owned by the hospital itself. Optometry in the Department of Veterans Affairs system is the most common example of this type of model.

Most optometrists are less intensely involved in the hospital setting and are called, on an as needed basis, to provide a variety of services. These services might include coverage of the emergency room for eye care, dilated eye examinations of patients with diabetes, preoperative and postoperative evaluation of cataract or refractive surgery patients, and routine eye care to those who are bed bound. Most evaluations within the hospital setting will be chief complaint-oriented and follow the SOAP (Subjective, Objective, Assessment, Plan) format.

One important point to remember is that the provider's hospital privileges determine what type of services can be provided. Hospitals have a great deal of latitude in the types of services that they may allow a provider to perform. The services approved by the hospital may be quite different than those allowed by state law. As an example, state law may allow the optometrist to treat glaucoma. However, the hospital, in granting privileges, may not approve glaucoma treatment. Therefore, within the hospital, the optometrist may not treat glaucoma. Failure to comply can result in sanctions or loss of hospital privileges. The importance of this point cannot be stressed enough; it is the reason that adequate documentation of the education and experience of the optometrist must be provided upon initial application for privileges.

All hospital medical records are subject to review, and the optometrist's records will be no exception. The records will be reviewed for clarity and quality of care provided.

### **B. EQUIPMENT**

The type of equipment needed will vary depending on what services are to be provided and what, if any, equipment the hospital is willing to supply. Under some circumstances the hospital may be willing to set up a complete examination lane or office directly within the hospital. As with any other business venture, the hospital will be looking at a return for their investment. It would be difficult to justify setting up an office if the optometrist is only going to provide care within the hospital one-half day per month. If the optometrist is providing preoperative and postoperative care for cataract or refractive surgery patients, a strong argument could be made that the hospital should provide a slit lamp. The more integrated the optometrist's practice is in the hospital, the greater the expectation that the hospital will provide some, if not all, of the equipment and support staff needed. This point needs to be addressed in the early stages of negotiations with the hospital administrator.

More often than not, the optometrist will be called on to do evaluations as needed. This usually means bringing portable equipment from the optometrist's office to the hospital. The equipment needed is essentially the same as required for providing nursing home or other out-of-office services. A variety of hand-held equipment is now available including lensometers, tonometers, slit lamps, autorefractors, and binocular indirect ophthalmoscopes. Following is a list of suggested equipment needed for out-of-office examinations:

- Direct ophthalmoscope
- Indirect ophthalmoscope
- Condensing lenses
- Hand-held tonometer
- Hand-held autorefractor
- Foreign body removal kit
- Small surgical kit (cilia forceps, lid speculum, etc.)
- Distance and near acuity charts
- Trial frames and trial lenses
- Refracting supplies
- Pharmaceutical agents
- Other supplies as needed.

One tip concerning selection of equipment for evaluation within the hospital is to be sure to determine the nature of the evaluation required prior to leaving your office for the hospital. If the optometrist is being called to remove a superficial foreign body, there may be no need to bring equipment other than a foreign body removal kit. By the same token, it can be extremely frustrating to get to the hospital to learn that the patient needs a comprehensive eye examination and not have the appropriate equipment. The simple step of speaking to someone about the nature of the service required can avoid frustration and loss of valuable time. It is best to remember the golden rule of out-of-office care. If you think you might need it, bring it with you.

### **C. LABORATORY, IMAGING, AND OTHER DIAGNOSTIC PROCEDURES**

The role of a primary care optometrist is to diagnose, treat, and manage conditions of the eye and vision system and be responsible to detect systemic disease that may present itself in the eye. This not only involves traditional procedures such as ophthalmoscopy, slit lamp examination, pupil responses, and refractive measurement, but also may include radiological imaging, microbiological laboratory tests, hematological and blood chemistry testing, and urinalysis. The hospital can play an important role in providing access to many of these needed procedures.

Radiologic imaging includes several different procedures. CT scans, MRIs, x-rays, and ultrasounds are the most useful diagnostic procedures for a primary care optometric practice. CT scans are collimated x-ray beams that allow better contrast and resolution than plain film x-rays. It is the procedure of choice in evaluating blowout fractures and detecting bone fractures and calcification. CT scans are also useful in detection of certain intracranial and orbital tumors.

MRIs utilize a magnetic field and radio frequency waves to analyze structural characteristics. They are best for imaging soft tissue defects found in tumors of the posterior visual pathway, brain stem, and the pituitary gland. MRIs are also used in the diagnosis of multiple sclerosis.

Plain film x-rays are the least expensive imaging technique. Intraocular foreign bodies, trauma to the orbit, and sinusitis are evaluated through this technique.

A Doppler ultrasound examines the integrity of the carotid arteries. A common presenting symptom of optometric patients is an episode of transient ischemic attack or the presence of Hollenhorst plaque. Carotid auscultation performed in the optometric office might indicate a positive bruit and further testing with Doppler may be indicated.

Diagnosis and treatment of external eye disease are large facets of most optometric practices. In most uncomplicated disease situations, a correct diagnosis can be arrived at through history-taking and physical

examination. There are clear indications for laboratory testing when additional information is needed to diagnose or manage a patient more effectively. Cytological testing examines the body's cellular response to disease. Specific cytological stains (e.g., Wright's, Giemsa, and Papanicolaou) identify inflammatory and neoplastic cells as well as inclusion bodies. Microbiological testing by smears, scrapes, and impressions helps identify specific pathogens and isolates their sensitivity to specific antibiotics. Indications for laboratory testing include ulcerative keratitis, severe or nonresponsive conjunctivitis, cellulitis, toxic reactions, and dacryocystitis.

Hematological testing is used routinely in medical practice. It is useful in optometric practice, as well, to screen for systemic disease, establish baseline information, monitor patients when prescribing certain medications, and establish differential diagnosis. Tests such as complete blood count (CBC) and erythrocyte sedimentation rate (ESR) are helpful in identifying inflammations and infections, anemia, and collagen disorders. Studies of blood chemistry are useful in identifying diabetes, hyperlipidemia, hyperthyroidism, leukemia, Lyme disease, toxoplasmosis, sarcoidosis, rheumatoid arthritis, and other systemic diseases that affect the eye. Optometric patients presenting with eye symptoms suggestive of these diseases or diagnosis of uveitis, retinal hemorrhage, dry eye, proptosis, etc., may need blood testing. In addition, certain medications such as acetazolamide require blood tests to establish potassium levels and rule out kidney disease before initiating therapy.

Urinalysis is another laboratory test that may be useful in optometric practice. Analysis of pH, glucose, ketone, proteins, blood, and other urine components aid in the diagnosis of many conditions. Examples include galactosemia cataracts, diabetes, ectopia lentis, and nutritional and toxic amblyopia. Used by itself or as an adjunct to other laboratory tests, urinalysis plays a role in optometric care.

#### **D. CHARTING**

Hospital medical records traditionally have been maintained in bound ring file folders. However, many settings are now utilizing electronic medical records. They will be found at nursing stations throughout the hospital. The patient's name, date of birth, room number, hospital identification number, or other identifiers are usually found on the end section of the folder. The top cover of the folder will list any alerts associated with the patient. These alerts might include: name alert (two persons on the same ward with same/similar names), specific drug allergies, infectious disease alert (TB, Hepatitis A, HIV positive), or infection control alert (requires gown, gloves, mask, booties to enter room).

The medical record is divided into numerous sections typically including: demographic data, discharge summary, admitting history and physical (H & P), physician progress notes, consultations, pharmacy notes, dietary notes, laboratory, pathology, and x-ray/radiology reports, operative reports, physician orders, and nursing notes. Individual services (e.g., cardiology, pulmonary, GI) may also have their own sections. All appropriate sections should be reviewed prior to evaluation of the patient so that the patient's current status may be determined.

- The admitting history will often be combined with the demographic section at the beginning of the chart. This section will include the initial physical evaluation (why the patient was admitted) and the patient's previous medical history.
- The physician progress notes contain the attending physician's examination notes for the patient. This section may also include consultation, pharmacy, and dietary notes.
- Laboratory, pathology, and x-ray/radiology reports are included.

- Operative reports contain the surgeon’s dictated notes concerning the examination and the procedures performed during surgery. For example, the description of the type of cataract surgery performed would be found here.
- The physicians’ orders section of the chart is essentially the prescription pad within the hospital record. Medications being ordered, requests for laboratory and other tests, dietary, and other procedures (e.g., needs dilated eye exam) will be charted in this section. The most up-to-date medications taken while in the hospital will be listed in this section and may be different from those in the admitting history.
- Nursing notes contain nurses’ charting of their interactions with the patient. This will often include information on when complaints were first noticed by the nursing staff (e.g., patient has red eye, complains of blurred vision).

In most cases, the optometrist will chart within the consultation section of the medical record. Many hospitals will have specific preprinted consultation forms that are to be filled out and placed within the consultation section of the medical record. In other cases, a consultation note may be written in the physicians’ progress note section. Notes from the examination or procedure performed must be kept in the patient’s medical record. A copy (photocopy or carbon) of the examination form should be retained in the optometrist’s office files. If medications are to be ordered, the optometrist should chart this in the physicians’ orders section.

Charting procedures may vary from one hospital to another. The provider may be required to undergo security checks and training to access the electronic medical records. It may be helpful to discuss charting with the Medical Record Department staff shortly after your staff appointment.

An examination finding, medication orders, or requests for action (e.g., lab test or procedure performed) that need immediate attention should be “flagged.” This is typically done by folding the examination form so that a portion sticks out of the medical record. This is a universal sign that something in the chart needs to be brought to the nurse’s and attending physician’s attention.

Abbreviations, in general, should be avoided when charting. They can lead to confusion among providers of different disciplines. They are, however, a fact of life in the hospital setting. The list contained in Appendix C is by no means comprehensive but is a list of commonly used abbreviations in the hospital setting. Since each hospital may have its own approved abbreviation list, it is important the provider confirm the hospital’s standardized list before charting begins.

## **E. PROCEDURE CODING**

Reimbursement for optometric care begins with proper coding of procedures and services and proper coding of the diagnosis. The basis for service coding is the Physician’s Current Procedural Terminology (CPT) of the American Medical Association. The International Classification of Diseases, 9<sup>th</sup> Revision, Clinical Modification (ICD-9-CM) is the basis of diagnosis coding. The provider should be familiar with these publications in their entirety before beginning to use them. The explanations that follow are intended to explain specific hospital coding issues. Please refer to copies of CPT and ICD-9-CM manuals for a complete explanation of these coding systems.\*

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\* Coding is constantly changing and is subject to local variations and modifications. Please refer to specific carrier policies and current year coding manuals for specifics to your practice. Proper patient record keeping procedures must be followed to document utilization of selected codes.

## 1. Evaluation and Management (E/M) Services

Evaluation and Management (E/M) Service codes may be used for services rendered by optometrists in a hospital setting. These codes provide a classification system based on the key components of history, examination, and medical decision making. Additionally, counseling, coordination of care, and the nature of the presenting problem are contributory factors in selecting the appropriate E/M level of care. The final component, time, is considered as the key component only when counseling and/or coordination of care involves more than 50 percent of the patient/optometrist encounter. E/M codes are classified in five levels of care, with the appropriate classification dependent on very specific criteria involving history, examination, and medical decision making. The patient record must document these components to justify the code selection. Proper identification of place of service, dates of service, and referring physician UPIN numbers must accompany the claim for proper reimbursement.

E/M coding does have a classification of new and established patients. A new patient is one who has not received any professional services from the optometrist within the past three years. No distinction is made for new and established patients in the emergency department.

E/M codes also have category and subcategory classifications. For hospital practice these include outpatient and inpatient services, consultations, and emergency department services (Table 1).<sup>5</sup>

Office or other outpatient services codes are to be used if a patient is examined as a hospital outpatient (this may include examination in a holding area of the hospital) or in an ambulatory care facility. Five levels of care are recognized in each of the two subcategories. If the patient is admitted to the hospital, hospital inpatient services – subsequent care codes are to be used. Three levels of care are recognized in the subsequent hospital care subcategory. (Table 1)

Consultations are services provided by an optometrist whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or appropriate source. The request must be documented in the patient's medical record. The consultant's opinion and any services ordered or performed must also be documented in the medical record and communicated to the requesting physician. When billing consultation codes, you must have documentation in the patient's record that all qualifying criteria have been met. Five levels of care are recognized in the initial inpatient consultations subcategory and three levels of care are recognized in the follow-up inpatient consultations subcategory.

Confirmatory consultations are used to report services provided to patients when the consulting optometrist is aware of the confirmatory nature of the opinion sought (e.g., a second opinion confirming a cataract). Confirmatory consultations may be provided in any setting including the hospital. Five levels of care are recognized in this subcategory.

Emergency Department Services are used to report services provided in the hospital emergency department. An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. Care must be available 24 hours a day.

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**Table 1**  
**Evaluation and Management Service Codes**

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<b>Category of Service</b>	<b>CPT Code</b>
Office or Other Outpatient Services	
New patient	99201-99205
Established Patient	99211-99215
Hospital Inpatient Services	
Subsequent Hospital Care	99231-99233
Consultations	
Initial Inpatient Consultations	99251-99255
Follow-up Inpatient Consultations	99261-99263
Confirmatory Consultations	99271-99275
Emergency Department Services	99281-99288

---

## 2. Ophthalmological Services

General Ophthalmological Services codes are also appropriate codes for reporting hospital examinations; place of service, of course, must be identified as the hospital. Special Ophthalmological Services codes (e.g., refraction, gonioscopy, visual fields, serial tonometry services/procedures) may be used. Ophthalmoscopy, other specialized services, contact lens and spectacle services, and appropriate surgical codes may also be used (Table 2).<sup>5</sup> A complete listing of these services may be found in the CPT manual and in *Codes for Optometry* (published by AOA) which includes the CPT minibook containing codes for ophthalmology.

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**Table 2**  
**Ophthalmological Services**

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Service	CPT Code
General Ophthalmological Services	
Intermediate, new patient	92002
Intermediate, established patient	92012
Comprehensive, new patient	92004
Comprehensive, established patient	92014
Special Ophthalmological Services	92015-92140
Ophthalmoscopy	92225-92260
Other Specialized Services	92265-92287
Contact Lens Services	92310-92326
Ocular Prosthetics	92330-92335
Spectacle Services	92340-92371
Supply of Materials	92390-92396
Unlisted Ophthalmological Service or Procedure	92499

---

The appropriate fee is determined by each individual optometrist. Actual reimbursement, of course, is determined by each individual third party payer. This may vary by payer and region. Relative value units (RVUs) are specific to services. Table 3<sup>5,6</sup> contains RVUs for some commonly performed hospital services. The RVU can be multiplied by a specific dollar amount (i.e., conversion factor) to set an appropriate fee level or to determine a reimbursement amount. **RVUs for particular CPT E/M codes may change each year. You should check the yearly Medicare Fee Schedule (MFS) that the Centers for Medicare and Medicaid Services publishes for the most up-to-date information regarding RVUs.**

**Table 3**  
**Relative Value Units for Hospital Services**

(These are examples only and may change yearly. Please check the current Medicare Fee Schedule for the most up-to-date RVUs.)

CPT E/M Codes	RVUs
Office Evaluation & Management	
99201 .....	0.63
99202 .....	1.25
99203 .....	1.91
99211 .....	0.24
99212 .....	0.63
99213 .....	0.91
Hospital Inpatient – Subsequent Care	
99231 .....	0.89
99232 .....	1.47
99233 .....	2.09
Office Consultations	
99241 .....	0.90
99242 .....	1.85
99243 .....	2.48
Initial Inpatient Consultation	
99251 .....	0.95
99252 .....	1.91
99253 .....	2.61
Confirmatory Consultation	
99271 .....	0.64
99272 .....	1.22
99273 .....	1.71
Emergency Department Services	
99281 .....	0.44
99282 .....	0.73
99283 .....	1.64
Intermediate Ophthalmology	
92002 .....	1.25
92012 .....	0.98
Comprehensive Ophthalmology	
92004 .....	2.40
92014 .....	1.60
Extended Ophthalmoscopy	
92225 .....	0.55
Foreign Body Removal Corneal with Slit Lamp	
65222 .....	1.25

## F. ADMISSIONS AND DIAGNOSTIC RELATED GROUPS (DRGS)

Hospital patient admissions may be classified into diagnostic related groups (DRGs) for purposes of determining payment under the prospective payment system. Cases are classified into surgical or medical DRGs using ICD-9-CM diagnosis and procedure codes. Classification is based on principal diagnosis, up to eight additional diagnoses (complications or comorbidities [CC]), and up to six operating room (OR) procedures performed during the stay, as well as age, sex, and discharge status of the patient. Nonsurgical procedures or minor surgical procedures, not performed in an operating room, generally do not affect DRG classification.<sup>7</sup> Table 4 contains a list of eye-related medical DRGs.<sup>7</sup>

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**Table 4**  
**Eye-Related DRGs**

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<b>DRG #</b>	<b>Diagnostic Related Group</b>
43	Hyphema
44	Acute major eye infections
45	Neurological eye disorders
46	Other disorders of the eye age >17 with CC
47	Other disorders of the eye age >17 without CC
48	Other disorders of the eye age 0-17
462	Rehabilitation

---

Hospital admissions for eye-related problems are quite rare regardless of provider type. Less than 0.4 percent of all hospital discharges have eye-related DRGs. However, there may be circumstances in which optometrists may need to admit patients (e.g., conditions such as serious eye infections, hyphema, or some neurological eye disorders). Optometrists who currently have admitting privileges should admit in conjunction with family physicians or internists. This protocol is patterned after podiatrists who have admitting privileges.

The DRGs under which optometrists might admit include eye-related DRGs 43-48. Optometrists involved in low vision rehabilitation could potentially admit patients under DRG 462. The traditional services of refraction, binocular vision evaluation, and spectacle and contact lens fitting are not covered under DRGs and admission for these problems is not appropriate. These services may be provided during the course of a hospital stay for a non-related illness.

## VIII. REFERENCES

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3. Campbell P. Woods Memorial Hospital 1995-96 Report. Presented at the Tennessee Optometric Association Hospital Privileges Seminar, Memphis, TN, August 1996.
4. Bennett I, Edlow RC, Aron F. State of the profession. *Optometric Economics* 1996; 6(1):17-23.
5. American Medical Association. Physicians' Current Procedural Terminology CPT '98, 4<sup>th</sup> ed. Chicago: American Medical Association, 1997: 9-13, 17-8, 20-9, 239, 357-60.
6. United States Office of the Federal Register, National Archives and Records Administration. *Federal Register*, vol 62, no 211. Washington, DC: U.S. Government Printing Office, 1997:59165, 59212-3, 59225.
7. United States Office of the Federal Register, National Archives and Records Administration. *Federal Register*, vol 62, no 168. Washington, DC: U.S. Government Printing Office, 1997:48081.

## IX. APPENDIX

### APPENDIX A. SAMPLE APPLICATION FORM

#### Application For Appointment To The Medical/Dental Staff

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#### INSTRUCTIONS

This form should be typed. If more space is needed than provided on the original, attach additional sheets and reference the question being answered. Submit copies of the following documents with this application:

State Medical License(s)  
Board Certification (if  
applicable)  
Curriculum Vitae

DEA certificate  
Certificate of Insurance  
ECFMG (if applicable)

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#### 1. IDENTIFYING INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

Degree \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone (\_\_\_\_) \_\_\_\_\_ Birthdate \_\_\_\_\_ Birthplace \_\_\_\_\_

Citizenship \_\_\_\_\_ Social Security # \_\_\_\_\_ Name of Spouse \_\_\_\_\_

Medicare UPIN # \_\_\_\_\_ Medicare Provider # \_\_\_\_\_ Medicaid Provider # \_\_\_\_\_  
(Same as Physician UPIN)

If you currently do not live in the immediate area, do you plan to relocate to this area?  Yes  No

---

I am requesting appointment to (please check one):

- "Provisional" Active Medical Staff (admitting privileges)
- "Provisional" Courtesy Medical Staff (admit up to 12 patients/year)
- "Provisional" Consulting Medical Staff (no admitting privileges)
- "Provisional" Active Denial
- "Provisional" Courtesy Denial
- Locum Tenens (initial period of 35 days)

NOTE: All physicians initially applying for staff privileges are on "Provisional" status for initial 9-12 months, at which time they will be reviewed for advancement to the Active, Courtesy, or Consulting Staff.

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## APPLICATION FOR APPOINTMENT TO THE MEDICAL/DENTAL STAFF

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### 2. PRACTICE INFORMATION

Name of Office/Clinic/Hospital \_\_\_\_\_

Office Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Telephone (\_\_\_\_) \_\_\_\_\_ FAX Number (\_\_\_\_) \_\_\_\_\_

Practice Limited To \_\_\_\_\_

Other Medical Interests in Practice, Research, etc. \_\_\_\_\_

Practicing with Whom and Nature of Affiliation \_\_\_\_\_

### 3. MEDICAL EDUCATION

Medical School \_\_\_\_\_ Grad. Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Address \_\_\_\_\_

License # \_\_\_\_\_ State \_\_\_\_\_ DEA # \_\_\_\_\_

### 4. PRE-MEDICAL EDUCATION

College or University \_\_\_\_\_ Degree \_\_\_\_\_

Address \_\_\_\_\_ Date of Graduation \_\_\_\_\_

College or University \_\_\_\_\_ Degree \_\_\_\_\_

Address \_\_\_\_\_ Date of Graduation \_\_\_\_\_

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## APPLICATION FOR APPOINTMENT TO THE MEDICAL/DENTAL STAFF

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### 5. POST-GRADUATE TRAINING

#### Internship

Hospital \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Type of Internship \_\_\_\_\_ Specialty \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

#### Residencies

Preceptorships; teaching appointments; post graduation. (Chronological order: Hospital name, address, city, state, zip, dates, Chief of Staff). Use separate sheet if necessary.

Hospital \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Specialty \_\_\_\_\_ Chief of Staff \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Office Telephone (\_\_\_\_\_) \_\_\_\_\_

#### Fellowships

American College of \_\_\_\_\_ Date \_\_\_\_\_

American College of \_\_\_\_\_ Date \_\_\_\_\_

Other Specialty Colleges \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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## APPLICATION FOR APPOINTMENT TO THE MEDICAL/DENTAL STAFF

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### 6. CERTIFICATION

Certified by State Medical Association or American Medical Association recognized board(s).

Name of Board \_\_\_\_\_ Date \_\_\_\_\_

Name of Board \_\_\_\_\_ Date \_\_\_\_\_

Have you been recertified?     Yes     No

If so, list Boards and dates:

Board \_\_\_\_\_ Date \_\_\_\_\_

Board \_\_\_\_\_ Date \_\_\_\_\_

Have you applied for Board Certification? \_\_\_\_\_

Date of Application \_\_\_\_\_

If not, give current status \_\_\_\_\_

### 7. LICENSING

License # \_\_\_\_\_ State \_\_\_\_\_ Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

Drug Enforcement Adm. # \_\_\_\_\_ Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

ECFMG \_\_\_\_\_

Other state medical licenses, current and past

State \_\_\_\_\_ Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

State \_\_\_\_\_ Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

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## APPLICATION FOR APPOINTMENT TO THE MEDICAL/DENTAL STAFF

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### 8. HOSPITAL

Previous affiliate with this hospital?     Yes     No

What Capacity \_\_\_\_\_ Date \_\_\_\_\_

List all current and previous hospital affiliations, starting with the most current. If necessary, use a separate sheet.

Name \_\_\_\_\_ Location \_\_\_\_\_

Status \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Name \_\_\_\_\_ Location \_\_\_\_\_

Status \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

### 9. BIBLIOGRAPHY

Attach separate sheet. Include reprints if possible.

### 10. MEMBERSHIP IN PROFESSIONAL SOCIETIES

List professional college or academy of which you are a member.

Name \_\_\_\_\_ Membership Status \_\_\_\_\_ Date Elected \_\_\_\_\_

Name \_\_\_\_\_ Membership Status \_\_\_\_\_ Date Elected \_\_\_\_\_

Are you a member of or applicant to any county, state, or national medical societies?     Yes     No

Name of Society \_\_\_\_\_

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## APPLICATION FOR APPOINTMENT TO THE MEDICAL/DENTAL STAFF

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### 11. CONTINUING MEDICAL EDUCATION

To what official recording body (e.g., CMA) do you report your CME hours? Please list:

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### 12. MEDICAL REFERENCES

Include three peer physicians familiar with your most recent clinical practice; for example, Chief of Staff, Chief of Department, or Chief of Residency Program (if recent graduate). **Only one reference may be an associate.**

NOTE: References will be evaluated primarily by the extent of direct clinical observation and other work with the applicant.

1. Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Degree \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone # (\_\_\_\_) \_\_\_\_\_

2. Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Degree \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone # (\_\_\_\_) \_\_\_\_\_

3. Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Degree \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone # (\_\_\_\_) \_\_\_\_\_

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**APPLICATION FOR APPOINTMENT TO THE MEDICAL/DENTAL STAFF**

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**13. PREVIOUS PRACTICE**

All previous office addresses, military experience (list chronologically):

Address \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Address \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

NOTE: Please provide dates of your academic activities or medical practice in your curriculum vitae if they are not evident on the application.

**14. PRESENT STATUS**

What is your present practice status? Check one:

Full-time Practice       Part-time Practice       Military Status      Discharge Date \_\_\_\_\_

What are your plans for coverage of your patients when you are unavailable?

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**15. PRIVILEGES DESIRED**

Please list specific privileges desired on separate sheet.

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## APPLICATION FOR APPOINTMENT TO THE MEDICAL/DENTAL STAFF

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### 16. ATTESTATION QUESTIONS

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS “YES,” PLEASE GIVE FULL DETAILS ON A SEPARATE SHEET.

- Yes    No   A. Have there been previously successful or are there currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or have you voluntarily or involuntarily relinquished your licensure or registration?
- Yes    No   B. Have your privileges at any hospital ever been suspended, diminished, revoked or not renewed voluntarily or involuntarily – or is any such action pending?
- Yes    No   C. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization – or is such action pending?
- Yes    No   D. Have you ever resigned from a medical staff to avoid disciplinary action?

### 17. HEALTH STATUS

- Yes    No   1. Have you been hospitalized anytime in the last five years?
- Yes    No   2. Have you been denied health, life, or disability insurance?
- Yes    No   3. Do you have any limitations on your health, life, or disability insurance?
- Yes    No   4. Do you currently have any problems with alcohol or drug dependency?
- Yes    No   5. Are you currently taking any medications that may affect either your clinical judgment or motor skills?
- Yes    No   6. Are you currently under any limitations, in terms of activity or work load?
- Yes    No   7. Are you currently under the care of a physician?

**Attach explanation for any “Yes” answers above; and also describe on a separate sheet any other medical condition that may affect your ability to practice.**

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## APPLICATION FOR APPOINTMENT TO THE MEDICAL/DENTAL STAFF

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### 18. PROFESSIONAL LIABILITY

Insurance Carrier \_\_\_\_\_ Amount \_\_\_\_\_

Yes     No    Have any judgments or settlements been made against you in professional liability cases or are any cases pending?

If "Yes," give details on a separate sheet.

List all other carriers used during the past five years.

Carrier \_\_\_\_\_ Dates \_\_\_\_\_

Carrier \_\_\_\_\_ Dates \_\_\_\_\_

Carrier \_\_\_\_\_ Dates \_\_\_\_\_

### 19. CONSENT AND RELEASE

I understand that the medical staff of this hospital is responsible for the evaluation of my professional competence and qualifications, and has the obligation to inquire into my professional training, experience, professional conduct and judgment, and to make appropriate recommendations to the governing body of this hospital.

I agree to abide by the Bylaws of the Medical Staff in this regard, and specifically to the items under section(s) of the Bylaws of the Medical Staff, as follows:

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## APPLICATION FOR APPOINTMENT TO THE MEDICAL/DENTAL STAFF

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### 20. EFFECT OF APPLICATION

By applying for appointment to the Medical Staff, each applicant:

- a. Signifies his willingness to appear for interviews with the Credentials and Privileges Committee or Medical Executive Committee in regard to his application;
- b. Authorizes the Credentials and Privileges Committee and Medical Executive Committee to consult with others who have been associated with him and/or who may have information bearing on his competence and qualifications;
- c. Consents to the Medical Executive Committee's and the Credentials and Privileges Committee's inspecting all records and documents that may be material to an evaluation of his professional qualifications and competence to carry out the clinical privileges he requests, of his physical and mental health status and of his professional ethical qualifications;
- d. Releases from any liability the Medical Executive Committee, the Credentials and Privileges Committee, the President, and the Board for their acts performed in good faith and without malice in connection with evaluating the applicant and his credentials;
- e. Releases from any liability all individuals and organizations who provide information to the Medical Executive Committee, the Credentials and Privileges Committee, the President, or the Board in good faith and without malice concerning the applicant's competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for staff appointment and clinical privileges;
- f. Authorizes the release of and consents to provide inquiring medical staffs, medical associations, licensing boards, and other organizations concerned with the practitioner's performance with any information relevant to such matters that the Medical Center may have concerning him, and releases for doing so, provided that such furnishing of information is done in good faith and without malice;
- g. Acknowledges that the President will establish a record for each applicant that contains information regarding initial appointment, subsequent reappointment, and deficiencies noted through approved quality assurance mechanisms. This record which is maintained in the Medical Staff office may be reviewed by the applicant during normal business hours;
- h. Agrees to submit to a physical and/or psychiatric exam at the request of the Medical Executive Committee; and
- i. Acknowledges that adverse actions taken with respect to the practitioner's staff membership or clinical privileges will be reported as required by state and federal law.

The effect of the application is continuing in nature and will apply to the reappointment process and during the entire time that the staff member has staff membership or exercises clinical privileges at the Medical Center.

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**APPLICATION FOR APPOINTMENT TO THE MEDICAL/DENTAL STAFF**

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I hereby affirm that the information furnished by me to the staff is true to the best of my knowledge and is furnished in good faith. I understand that willful and substantial omissions or misrepresentations may result in denial, modification, or revocation of my medical staff membership and/or clinical privileges.

I, \_\_\_\_\_, DO HEREBY MAKE FORMAL APPLICATION  
Print name here

FOR MEDICAL STAFF MEMBERSHIP AND PRIVILEGES AT \_\_\_\_\_  
Name of Institution

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**APPENDIX B.**

**AMERICAN OPTOMETRIC ASSOCIATION**

**GUIDELINES FOR**

**DELINEATION OF CLINICAL PRIVILEGES**

**FOR OPTOMETRY**

## INTRODUCTION

Delineation of privileges refers to the process by which clinical privileges are requested, recommended, and granted.

An optometrist who is licensed to practice optometry in the state is eligible to apply for hospital privileges and/or medical staff membership and to request permission to provide patient care services independently in the hospital, within the limits based on his/her professional license, experience, competence, ability and judgment. These services may include but are not limited to general optometric services, pre and postoperative eye care, emergency eye care services, and the use of pharmaceuticals in the diagnosis and treatment of eye disease as well as optometric specialty areas such as contact lens, low vision rehabilitation, and vision therapy services.

Evaluation of the optometrist's competence to carry out the diagnostic and treatment procedures requested should be performed by the applicant's peers. If optometrists are not already members of the medical staff, the hospital should seek outside consultation from the optometric profession so as to obtain peer recommendations. The granting of initial or renewed/revised clinical privileges should be based on fair, objective analysis and uniformly applied requirements as those used in evaluating other medical specialties.

The Guidelines for Delineation of Clinical Privileges for Optometry are designed to serve as models for hospitals to establish, review, and modify hospital specific criteria for their individual privilege delineation process. A categorical approach, a privilege list approach, or a combination categorical and privilege list approach may be used in the delineation of privileges process.

The Categorical Approach model provided in this document uses predefined criteria for two categories/levels of optometric practice. These professionally developed criteria specify the education, training, experience, and documented evidence of the practitioner's current competence to be applied as a basis in the evaluation and granting of clinical privileges to the optometric applicant. Privileges assigned to each category may vary according to each hospital's local needs and resources. *An applicant may apply for certain privileges not appearing on this list or are at a higher category based on or influenced by the practitioner's scope of practice.*

The Privilege List Approach model provided in this document is representative of possible optometric consultative, diagnostic, and treatment services that could be applied to optometrists in any state. **It should be understood that this is only a representative sample and should be customized to the particular situation.**

**AMERICAN OPTOMETRIC ASSOCIATION  
GUIDELINES FOR DELINEATION OF CLINICAL PRIVILEGES  
FOR OPTOMETRY**

**CATEGORICAL APPROACH**  
*SAMPLE ONLY/NOT TO BE USED AS IS*

**CATEGORY I** Privileges in this category allow the optometric practitioner to independently examine, diagnose, treat and manage common ocular conditions, diseases and injuries, as specified by the State Board of Optometric Practice. Appropriate consultation will be sought when needed.

Criteria for requesting Category I privileges:

The applicant must demonstrate:

- Graduation from an accredited school or college of optometry, and
- Valid state license to practice optometry, and
- Appropriate certification by a state board of optometry when applicable, and
- Current evidence of competence and an adequate volume of clinical experience with acceptable results in the privileges requested for patients of all applicable age groups.

**CATEGORY II** In addition to Category I consultative services, privileges in this category allow the optometric practitioner to independently examine, diagnose, treat and manage difficult or complex ocular disorders. Category II providers are expected to request consultation when appropriate.

Criteria for requesting Category II privileges:

The applicant must demonstrate:

- Graduation from an accredited school or college of optometry, and
- Valid state license to practice optometry, and
- Appropriate certification by a state board of optometry when applicable, and
- Current evidence of appropriate knowledge, skill and proficiency to treat eye disease and perform optometric specialty procedures and an adequate volume of current clinical experience with acceptable results in the privileges requested for patients of all applicable age groups.

Examples of Category II privileges may include but are not limited to:

- Administration of medication by injection
- Corneal epithelial debridement
- Dilation and irrigation of lacrimal apparatus
- Meibomian gland expression/massage
- Minor surgical procedures of the eyes and adnexa
- Removal of nonperforating foreign bodies from cornea and conjunctiva
- Urgent and emergent management of nonsurgical eye conditions

**REVIEW AND DELINEATION OF CLINICAL PRIVILEGES**

**FOR:** \_\_\_\_\_

In accordance with the Guidelines for Delineation of Clinical Privileges for Optometry and on the basis of my education, training, experience and competence, I hereby request the specific privileges in the Department of \_\_\_\_\_ as identified on the preceding pages.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Department Chair

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Credentials Committee Chair

\_\_\_\_\_  
Date

\_\_\_\_\_

\_\_\_\_\_

**AMERICAN OPTOMETRIC ASSOCIATION  
GUIDELINES FOR DELINEATION OF CLINICAL PRIVILEGES  
FOR OPTOMETRY**

**PRIVILEGE LIST APPROACH  
SAMPLE ONLY/NOT TO BE USED AS IS**

<b>R</b>	<b>PROCEDURE</b>	<b>C</b>	<b>M</b>	<b>G</b>	<b>D</b>	<b>MODIFIED</b>
<input type="checkbox"/>	Admitting privileges	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Burns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Co-management of ocular conditions with other physicians	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Comprehensive eye health and vision examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Conjunctival/ocular irrigation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Corneal epithelial debridement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Corneal micropuncture for recurrent corneal erosion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Developmental and perceptual vision evaluation and treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Diagnosis and management of conditions of the visual system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Diagnosis, treatment and management of diseases and conditions of the eye, orbit, and adnexa (visual system)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Dilation and irrigation of lacrimal apparatus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**LEGEND**

- R = Privilege requested
- C = Category (level of training or experience required for this privilege)
- M = Monitoring required (monitoring by another optometrist or physician is required for a specific time before privilege is granted)
- G = Privilege granted
- D = Privilege denied
- Modified = Designate if any limitations to the privilege are indicated.

**This list is representative of possible optometric consultative, diagnostic, and treatment services that could be applied to optometrists in any state. However, the list is not all inclusive and should not be used as a means of limiting or restricting an optometrist’s scope of practice; nor is the list applicable in its entirety to all optometrists.**

<b>R</b>	<b>PROCEDURE</b>	<b>C</b>	<b>M</b>	<b>G</b>	<b>D</b>	<b>MODIFIED</b>
<input type="checkbox"/>	Electrodiagnostic testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Fluorescein angiography	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Incision and drainage of abscess	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Incision and drainage of lacrimal gland or sac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Low vision evaluation and related services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Medical laboratory tests: order and interpret	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Minor procedures of the eye and adnexa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Ocular microbiology laboratory tests: order and interpret (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Ophthalmic ultrasonography: A and B scans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Punctal occlusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Radiological imaging tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Repair of superficial ocular laceration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Utilization of injectable ophthalmic therapeutic pharmaceutical agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Utilization of oral legend drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Utilization of oral narcotic pharmaceutical agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Utilization of topical ophthalmic pharmaceutical agents (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	Vision therapy/orthoptics related services (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**REVIEW AND DELINEATION OF CLINICAL PRIVILEGES**

**FOR:** \_\_\_\_\_

In accordance with the Guidelines for Delineation of Clinical Privileges for Optometry and on the basis of my education, training, experience and competence, I hereby request the specific privileges in the Department of \_\_\_\_\_ as identified on the preceding pages.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Department Chair

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Credentials Committee Chair


\_\_\_\_\_  
Date

\_\_\_\_\_

\_\_\_\_\_

## APPENDIX C. COMMONLY USED ABBREVIATIONS IN THE HOSPITAL SETTING

AKA .....	above knee amputation	HTN .....	hypertension
ASA .....	aspirin	Hx .....	history
ASAP .....	as soon as possible	HZV (HVZ) .	herpes zoster
ASHD .....	arteriosclerotic heart disease	ICA .....	internal carotid artery
AVM.....	arteriovenous malformation	I & D .....	incision and drainage
BCC (BCE)...	basal cell carcinoma	I & O .....	intake and output (fluids)
BIH .....	benign intracranial hypertension	IPP.....	interpersonal psychotherapy
BKA .....	below knee amputation	IVP.....	intravenous pyelogram
BPM .....	beats per minute	JVP.....	jugular venous pulse
BUN .....	blood urea nitrogen	K .....	potassium
τ.....	with	Meq.....	milli equivalent
CA .....	cancer	MI .....	myocardial infarction
CAD .....	coronary artery disease	MICU.....	medical intensive care unit
CABG.....	coronary artery bypass graft (“cabbage”)	MM .....	multiple myeloma
CCU.....	coronary (cardiac) care unit	MRI.....	magnetic resonance imaging
CHF .....	congestive heart failure	MRSA .....	methacillin resistant staph aureus
CIS.....	carcinoma in situ	MVA .....	motor vehicle accident
CK .....	creatinine kinase	NAD.....	no acute distress
c/o .....	complains of	NAS .....	no added salt
COPD .....	chronic obstructive pulmonary disease	N/C.....	no complaints
Creat .....	Creatinine	ND.....	not done
C & S .....	culture and sensitivity	N/S .....	normal saline
C & P .....	cytoscopy and pyelogram	O & E.....	observation and examination
CT scan.....	computerized tomography scan	OR.....	operating room
CVA .....	cerebrovascular accident	ORIF .....	open reduction with internal fixation
DC (D/C) .....	discontinue	PA .....	posteroantero
D & C .....	dilation and curettage	P&A .....	percussion and auscultation
Derm.....	dermatology	PO <sub>2</sub> .....	oxygen pressure, alveolar
DJD.....	degenerative joint disease	PCN.....	penicillin
DM .....	diabetes mellitus (IDDM-insulin dependent, NIDDM-noninsulin dependent)	PUVA.....	psoralen and ultraviolet A radiation
DNR .....	do not resuscitate	PTCA .....	percutaneous transluminal coronary angioplasty (“balloon”)
DTR .....	deep tendon reflex	PVC.....	premature ventricular contraction
DVT.....	deep vein thrombosis	RAI .....	radioactive iodine
E & A .....	evaluate and advise	ROM .....	range of motion
ECG (EKG) ..	electrocardiogram	R/O.....	rule out
Echo.....	echocardiogram	ROS.....	review of system
EES.....	erythromycin ethyl succinate	RRR .....	regular rate and rhythm
EMG.....	electromyogram	S <sub>1</sub> S <sub>2</sub> .....	heart sound 1 and 2 (normal sounds)
ESR.....	erythrocyte sedimentation rate	τ.....	without
FBS.....	fasting blood sugar	SAH .....	subarachnoid hemorrhage
Fib.....	fibrillation	SCC.....	squamous cell carcinoma, or small cell carcinoma
FTA-ABS .....	fluorescent treponemal antibody absorption (syphilis)	SDAT.....	senile dementia of Alzheimer’s type
fx.....	fracture	SICU .....	surgical intensive care unit
GTT .....	glucose tolerance test	S/P.....	status post (i.e., previous)
HA .....	headache	STAT .....	drop everything and do something now (e.g., STAT ESR)
Hb .....	hemoglobin	URI .....	upper respiratory infection
Hct .....	hematocrit	UTI.....	urinary tract infection
HCTZ .....	hydrochlorothiazide	WO.....	without
HEENT.....	head, eyes, ears, nose, throat	W/U.....	work up
H/O.....	history of		
H & P.....	history and physical		



American Optometric Association  
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