The following are guidelines for use during your rotation in the Ophthalmology Department at Interim LSU Public Hospital. Although I compiled this handbook, it has not been officially approved by Interim LSU Public Hospital. As with most handbooks, information contained in this handbook continually changes, and it is your responsibility to keep abreast of current regulations and policies.

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A. Ophthalmology Outpatient Clinic

1. Location

The ophthalmology outpatient clinic is located on the third floor of the old Lord and Taylor department store at 1400 Poydras Street, New Orleans, LA 70112. The proper name of the clinic is “Interim LSU Public Hospital Ophthalmology Outpatient Clinic.” Reference to the clinic as “Lord and Taylor Eye Clinic” is inappropriate, as Lord and Taylor is not in the business of providing health care. The phone number of the clinic is 903-1919; the fax number is 903-1932.

2. Parking

Parking is available at New Orleans Centre. Passes for parking are usually passed from resident to resident as their rotations change. Parking for Interim LSU Public Hospital is available for two residents in the Doctors’ Parking Lot (“Purple” Lot). After hours, additional parking is available in the UMOB parking lot at 2025 Gravier Street. If desired, an escort is available to and from the parking lots by calling the hospital police at 903-6337.

3. Ophthalmology Outpatient Clinic Facilities

The Interim LSU Public Hospital Ophthalmology Outpatient Clinic consists of eight fully-equipped examination rooms (numbered 1 through 8), two special testing rooms (one with a Humphrey Visual Field Analyzer, GDx, and Zeiss Atlas Corneal Topography System; the other with a Cirrus HD-OCT (Spectral Domain Technology) and Zeiss digital fundus camera), a laser room with argon and YAG lasers, and a storage room. Room 1 also contains a specular
microscope; room 4 also contains a keratometer and A-scan/B-scan ultrasound equipment.

Computer screens and keyboards are located in each examination room, in the laser room, and in the special testing room with the Humphrey Visual Field Analyzer.

Medical Records is located on the second floor.

Pharmacy is located on the first floor.

4. Ophthalmology Outpatient Clinic Schedule

General ophthalmology outpatient clinic is on Tuesday, Wednesday, and every other (call) Friday. One of the Friday clinics of each month is designated for Lions’ patients. The clinic starts at 8:00 a.m.; residents are expected to be there at that time. The clinic continues until all patients are seen, and all residents are expected to stay until the last patient has been seen, unless excused by staff. Wednesday clinic is scheduled such that it should be completed in time for lectures.

There are two subspecialty clinics:

Glaucoma Clinic is the first Wednesday of each month.
Retina Clinic is the second and fourth Wednesday of each month.

The Bogalusa/Lallie Kemp residents are assigned to these subspecialty clinics; they are assigned to the general clinic on the third Wednesday of each month.

5. Staffing

The ophthalmology outpatient clinic is staffed by three technicians (Robin Cooper, Christine Romero, and Jean Corley) and by the following staff physicians: Bruce Barron (general/cornea); Sean O’Sullivan and Maria Reinoso (retina).

Staff physicians must see every patient.

6. Ophthalmology Outpatient Clinic Resident Responsibilities

The third-year resident is responsible for overseeing all resident activities at Interim LSU Public Hospital.
a. **Dress code**

Appropriate dress are pants, a buttoned shirt, and tie for men; a dress, skirt and blouse, or pants and blouse for women. Alternatively, clean scrubs may be worn. A clean white physician coat is to be worn at all times. On occasion, the temperature in the clinic may become too high for such a coat to be worn comfortably, in which case, the staff physician may give permission to remove it.

b. **Hygiene**

Any person who has contact with a patient must wash their hands with soap and water prior to the beginning of the examination and at the end of the examination. This should be done in front of the patient. Alternatively, gloves may be worn and changed between each patient. The slit lamp paper should be changed and the occluder, phoropter, and forehead rest of the slit lamp should be cleaned with an alcohol pad between each patient. Residents are expected to keep the examination rooms clean and orderly.

Interim LSU Public Hospital has a policy that a bottle of diagnostic eye drops (e.g., phenylephrine, tropicamide, proparacaine, fluorescein/proparacaine) can be used for only one patient. Therefore, these eye drops must be ordered for each patient for whom they are needed.

c. **History, Physical Examination, Assessment, and Plan**

All patients are to be seen and evaluated by residents, with appropriate documentation in the medical record.

Because of the small size of the examination rooms, family members and/or friends should not accompany patients to these rooms unless they are needed for patient assistance or interpretation. For those patients who do not speak English, interpretation can be done via an interpretation telephone system.

All patients should be asked about their chief complaint, history of present illness, and review of systems. Medications and allergies should be noted. A list of the patient’s medications can be found in CLIQ.

All new patients should have a complete eye examination, including refraction for distance and near vision and dilated funduscopic examination, unless there is a contraindication. It is imperative that visual acuity, confrontation visual fields, and pupillary reaction be checked prior to dilation of the pupils.
Return patients should have an eye examination appropriate to their condition.

An assessment and plan, including a plan for follow up, should be made prior to presentation of a patient to the staff physician. (Patients who are to return to the clinic in 3 weeks or less must see the nurse for discharge; those who are to return to the clinic in more than 3 weeks can leave the clinic without seeing the nurse.) Follow up visits for the subspecialty clinics should specify the follow up clinic as well as the follow up time (e.g., “return in 3 months to retinal clinic). 

Documentation of the history, physical examination, assessment, and plan is made in the medical record on Form NCP 032 (R 7/09) (Appendix A). Each box must be checked separately. A vertical line drawn through a column of boxes is not acceptable. Documentation also includes resident identification (i.e., stamp), resident signature, date, and time.

Residents are responsible for the total care of patients, including referral requests, laboratory requests, and special testing requests. (Referral forms can be found in the clinic or can be accessed using the “MCL Referral Forms” tab located in the left hand column on the Patient Search page in CLIQ.) This care includes ordering tests and checking on results.

The ophthalmology outpatient clinic is a busy clinic; therefore, efficiency is of the utmost importance.

d. Prescriptions

Patient care includes asking a patient about spectacles and medication refills. Prescriptions for spectacles are hand written; prescriptions for medications are written via CLIQ, and are printed in the laser room. Any time a medication is prescribed to a woman of child-bearing potential, she should be questioned about pregnancy.

The following ophthalmic medications are on the Outpatient Pharmacy Bulk Formulary, and should be prescribed, if possible, to patients who qualify for free care:

- Azopt 1%
- Bromonidine 0.2%
- Ciloxan ointment 0.3%
- Econopred Plus 1%
- Timoptic 0.5%
- Tobradex ointment 0.3%
- Travatan Z 0.004%
- Vexol 1%
- Vigamox 0.5%
Xalatan 0.005%

In addition, for patients who qualify for free care, a 3-bottle supply of the above medications usually costs the same as a 1-bottle supply, which should be taken into consideration when prescribing these medications to patients who qualify for free care and will be using more than 1 bottle (e.g., glaucoma patients).

Medications other than those listed above may be prescribed, but are not available in the Outpatient Pharmacy.

A patient’s medication list can be found in CLIQ. Any time a medication or dose of medication is changed, the patient’s medication list should be reconciled via CLIQ.

e. Billing and Coding

Part of resident education is to learn proper ophthalmic coding. Therefore, residents are responsible for completing the billing sheet (Appendix B) with the proper ICD-9 code (International Classification of Diseases code) and CPT code (Current Procedural Terminology code). In addition, residents should indicate the location and date of service, and sign the billing sheet and include their ID number at the top of the sheet. The billing sheet should be completed prior to presentation of the patient to a staff physician. Two resources that are helpful with coding are 2011 ICD-9 Ophthalmology Book and 2011 Ophthalmic Coding Coach Book, both of which are available through the American Academy of Ophthalmology.

Note should be made that certain ophthalmic procedures have “global periods,” which means that there is a time period after surgery during which visits are considered postoperative follow-up visits. These visits are bundled with the surgical fee, and are not billable as office visits. (They are coded with the CPT code 99024.) Most major ophthalmic procedures, such as phacoemulsification with intraocular lens implantation, have a global period of 90 days. Other procedures have either no global period or a global period of 10 days (Appendix C). At the present time, code 99024 is not included on the billing sheet, and must be hand written.

Code 92015 is “determination of refractive state,” and has been a separate identifiable billable procedure since 1992. Refraction is excluded from Medicare coverage. It is a non-covered benefit for which the patient may be billed, but it is not subject to the waiver of liability provision, so an ABN (Advanced Beneficiary Notice of Noncoverage) is never required. Most physicians typically consider refraction included in follow-up care for cataract extraction, and do not bill for it during the global period. At the present time, code 92015 is not included on the billing sheet, and must be hand written.
f. Dictation and Medical Records

All patient encounters are to be dictated on the day the patient is seen. The appropriate staff physician should be identified by first and last name for each dictation. Instructions for dictations are in Appendix D. These dictations are not electronic medical records per se, and do not replace paper medical records. They are summaries of patient care intended for easy retrieval. Therefore, these dictations should be concise and contain only pertinent information. When medical records switch to electronic medical records in July, 2012, patients’ paper medical records will no longer be available. Therefore, dictations should contain sufficient information for follow up visits after the switch to electronic medical records. (These dictations will be accessible via CLIQ.)

At the beginning of the rotation, each resident should go to Medical Records for a five-minute training session (with Dorothy Jones, Terrie Collins, or Elvira Brown) regarding chart dictations. This training will allow charts to be signed via an electronic signature. However, if dates and times are not provided on chart notes, then these notes must be taken care of by going to Medical Records. Incomplete and delinquent medical records must be addressed in a timely fashion.

g. HIPAA

All patient-related activities must be HIPAA compliant. There is a container for documents to be shredded that is located in the nurses’ area.

7. Non-LSU Clinic Days

If a patient needs to be seen on a non-LSU clinic day, the patient should be scheduled to return to the clinic at a time when it does not interfere with Tulane’s clinic. This is usually early in the morning.

8. After-hours and Weekends

The ophthalmology outpatient clinic is not open after hours or on weekends. Therefore, if a patient needs to be seen during those times, they should go to the emergency room.

The most efficient way to meet a patient after-hours and on weekends is to have the patient ask that you be paged as soon as they are registered in the emergency room. Under no circumstances should a patient be seen until they are registered. No clandestine meetings are allowed.
9. Secured Patients (i.e., Prisoners)

The “Offender Collaborative Care Communication Form, Summary of Care and Recommendations” (Appendix E) should be completed at every inmate visit. The form is usually with a prisoner’s paperwork, but can be accessed by use of the “Inmate Follow-up” tab located in the left hand column on the Patient Search page in CLIQ.

The “Summary of Care and Recommendations” form is designed to convey information back to the correctional facilities, and is for their use when requesting follow up. It also serves to remind Interim LSU Public Hospital providers that many of the prisons have their own medical providers and that they can provide routine follow up and then ask for assistance if needed.

Prisoners should not be directly informed of appointment or surgery dates.

Non-emergency surgery on prisoners must be pre-approved, the form for which is in Appendix F.

10. Procedures Performed in the Ophthalmology Outpatient Clinic

The procedures most frequently performed in the ophthalmology outpatient clinic are laser procedures, intraocular injections, and incision and curettage of a chalazion. Preoperative consent must be obtained for any procedure done in the ophthalmology outpatient clinic (see below for the standards for consents). In addition, a Universal Protocol (time-out) sheet must be completed (Appendix G), and post-procedure vital signs must be obtained. For laser procedures, the Laser Record (Appendix H) must also be completed and kept in the laser room. Time-out must occur immediately prior to starting the procedure, inducing anesthesia, and making the incision. All team members must agree on the correct patient identity, correct site, and correct procedure to be done.

B. Surgery

Currently, LSU has block time at interim LSU Public Hospital on Mondays and Thursdays. Surgery should be scheduled on Mondays, if possible. If the schedule becomes heavy, then Thursdays of LSU weeks can be used. Surgery starts at 8:30 a.m. on Mondays, and at 7:30 a.m. on Thursdays. However, surgery usually starts before these times, particularly on Mondays. Ophthalmology procedures are performed in OR 7.

Residents should be in the operating room no later than 1 hour prior to start times in order to make sure that everything is taken care of. No surgery can be
started without the presence of a staff physician. Cases should be scheduled such that different staff physicians are not required on the same day, if possible. If different staff physicians are required, the cases should be coordinated, after discussion with the involved staff physicians.

The EAC (Elective Admission Clinic) requires at least 3 working days to process a patient for elective surgery.

Residents are responsible for the total care of surgery patients, including making sure that all proper evaluation is done preoperatively, and that all preoperative paperwork, including consent(s), are completed.

Preoperative evaluation includes assessment of a patient’s health (particularly with regard to diabetes and hypertension), and whether a referral for preoperative medical clearance is necessary. It also includes the recognition that certain medications, such as blood thinners and alpha-adrenergic blockers (e.g., Flomax) may increase the risk of surgery. In general, blood thinners (i.e., warfarin, aspirin, nonsteroidal anti-inflammatory drugs, and other anti-platelet drugs, such as Plavix) should be stopped for the appropriate time preoperatively, with the permission of the physician who prescribed them. Also, attention should be given to specific surgical requirements, such as an intraocular lens with an unusual power or design (e.g., plano convex) and tissue (e.g., corneal tissue, amniotic membrane, etc.). All abnormal lab results need to be addressed before the day of surgery.

1. Paperwork

The following paperwork needs to be completed when scheduling a patient for surgery (Appendix I):

a. Operating Room Schedule Sheet
b. History and Physical Examination
   On the day of surgery, this needs to be updated.
c. Elective Pre-surgical/Procedural Orders
   Preoperative orders must be specific with regard to preoperative dilating drops. The medication, strength, dosage, eye, and frequency must be specified (i.e., “phenylephrine 2.5% 1 drop OD Q10 minutes X 3 doses starting when the patient arrives in one-day stay”). TetraVisc Forte is usually ordered and applied by the resident in the preoperative area.
d. EAC Pre-admit Checklist
e. Consent
f. Intraocular Lens Order Form (if applicable)

Because the time this paperwork takes to complete may interfere with the flow of patients in the clinic, surgery patients are usually asked to make an
appointment for a preoperative evaluation (usually at 7:30 a.m. on a Wednesday).

Once the preoperative paperwork is completed, the nursing team in the clinic makes the EAC appointment and sends the preoperative packet to the EAC; sends the patient to the outpatient lab/radiology department for ordered testing; and schedules any medical consultations that have been ordered. The EAC nursing staff interviews and assesses the patient, reviews all test results, sends the patient for financial clearance, and confirms the surgery date. Anesthesia also evaluates the patient and reviews test results. If an abnormality is identified, additional consultations may be ordered, which the EAC facilitates. The primary team responsible for the surgery and the physician who scheduled it are contacted if there are any preoperative concerns that must be addressed by them, or that may cause a potential delay in surgery.

If a referral for medical clearance or any other concern is indicated at the time of the visit for the ophthalmologic preoperative evaluation, then referral for this should be instituted at that time (via the “Pre-OP Evaluation: Referral for Medical Clearance” form or other appropriate form that can be found in CLIQ) rather than waiting for the EAC to initiate the referral. Patients who require a preoperative referral should not be scheduled for surgery until the referral and all necessary preoperative recommendations from that referral are completed.

2. Consents

Written informed consent must be obtained for all procedures.

In 1990 the Louisiana legislature created the Medical Disclosure Panel, whose task was to define what risks (i.e., “material risks”) must be disclosed for any given procedure.

Consent forms for the following specific ophthalmology procedures have been developed by Interim LSU Public Hospital (Appendix J), and are available in the ophthalmology clinic or can be accessed by use of the “Consents” tab located in the left hand column on the Patient Search page in CLIQ.

- Avastin Injection
- Blepharoplasty
- Cataract Surgery with or without Implantation of Intraocular Lens
- Chalazia Incision and/or Excision
- Corneal Surgery: Corneal Transplant, Pterygium, or Other
- Cryotherapy
- Enucleation or Evisceration (removal or eye or its contents)
- Eye Muscle Surgery
- Glaucoma Surgery
- Laser Capsulotomy (creation of opening in lens membrane)
Laser Treatment of Eye (glaucoma or retina problems)
Panretinal Photocoagulation with Retrobulbar Anesthesia
Radial Keratotomy (reshape cornea by multiple cuts)
Retina (nerve layer of eye)/Vitreous (central gel-like substance in eye) Surgery
Intravenous Injection of Radiopaque Contrast Media (Both ionic and nonionic)

For a procedure not listed above, the Blank Master Consent Form is to be used. Note that some procedures require two consent forms. (For example, cataract surgery combined with glaucoma surgery.)

Although these consent forms list the material risks for any given procedure, as developed by the Medical Disclosure Panel, other risks may and, in some instances, should be added. For example, the Avastin Injection consent form does not list decreased vision, loss of vision, loss of eye, increased intraocular pressure, and infection as risks.

In general a properly executed consent form should include:

- Name of the facility where the procedure will occur;
- Name of the specific procedure(s) being consented;
- Name of the healthcare practitioner(s) performing the procedure(s) (the box under 6e on the consent should be completed);
- Signature of the patient or their legal representative;
- Date and time the consent was signed (in the patient's handwriting);
- Date, time, and signature of the witness to consent (this must be a person not involved with the procedure, and is most commonly a technician or technologist in the clinic or a nurse in the hospital);
- Name of the healthcare provider who obtained the consent;
- List of the material risks that were discussed (these are included on the preprinted consent forms).

In addition to the above, a consent form must be legible and written without abbreviations and in a way that a lay person can understand it. (For example, “2° ACIOL OD” is unacceptable and should be written as “Anterior chamber intraocular lens implantation in the right eye [placement of an artificial lens in the front part of the right eye].”)

A signed consent form is valid for 90 days.

In addition to obtaining informed consent, a note should be written in the medical record that the procedure, alternatives, risks, and benefits were discussed with the patient, and the patient’s questions were answered.
3. Dictations

Surgical procedures must be dictated on that same day as the procedure. The first and last name of the appropriate staff physician must be included in the dictation, as well as a statement regarding his or her participation in the procedure (e.g., “Dr. Bruce Barron was the staff physician and was scrubbed for the entire procedure,” or “Dr. Bruce Barron was the staff physician and was scrubbed for the key portions of the procedure,” etc.)

C. Inpatients

Patients who require hospitalization are admitted to Interim LSU Public Hospital, and the appropriate staff physician must be notified immediately. The paperwork need for admission includes the Admitting Order Form and the Case History from (Appendix K).

D. Inpatient Consultations

Routine inpatient consultations should be seen and presented to the appropriate staff physician within 24 hours of notification of the consultation. Emergency inpatient consultations should be seen and presented to the appropriate staff physician as soon as possible. The above consultations may be performed in the eye room located in the Emergency Room.

The order for the consultation to the billable, the order for the consultation and the physician ordering the consultation must be in the medical record.

E. Emergency Room

Consultations from the Emergency Room are seen and presented to the appropriate upper level residents and staff physician as soon as possible. Any time an emergency room physician requests a consultation, the patient should be seen ASAP, no questions asked, so to speak. (All patients for whom a request for a consultation is made should be seen, whether or not the request appears to be medically indicated.)

Evaluation of emergency room patients should follow the guidelines for the evaluation of outpatients outline above. It is imperative that a complete history and physical examination by performed, and an assessment and plan be formulated and instituted.

It is the residents’ responsibility to keep the Emergency Room eye room in an orderly fashion, and to make sure that any equipment removed from that room (e.g., B scan ultrasound equipment) is promptly returned after its use.
LSU and Tulane alternate call, from Monday 7 a.m. to the following Monday at 7 a.m. Call schedules for Interim LSU Public Hospital are to be created by the third-year resident at Interim LSU Public Hospital, and should be given to Gale Abbass by the 15th of each month that precedes the call month (i.e., the call schedule for December should be completed and distributed by November 15th, etc.). Once a call schedule is distributed, it cannot be changed without the permission of Dr. Barron. During the day, the third-year resident and the second-year resident assigned to the Interim rotation must be on call (i.e., residents who are assigned to rotations that are out of town cannot take call during the day). All emergency room and inpatient consultations must be answered during this time. The time of notification, not when the patient arrived in the emergency room or was admitted, and not whether the patient has an “L” or “T” number, determines which service is responsible for these consultations. For example, if a patient arrived in the emergency department at 2 a.m. on a Sunday, and an ophthalmology consultation is requested at 8 a.m. on Monday, the service that is on call at 8 a.m. on Monday is responsible for the consultation.

When taking call, a resident must promptly answer their page or phone.

Out-of-hospital call is allowed as long as the patient is seen in a timely manner. However, if this arrangement interferes with a timely response to a request for a consultation, then call will be taken in the hospital. Occasionally a resident must leave clinic to see a patient.

Residents not assigned to the Interim rotation who take night call (i.e., from 5:00 p.m. to 7:00 a.m.) must be on time for their assigned rotation responsibilities the next day. Sometimes this will necessitate resident-to-resident transfer of patient care prior to completion of patient care. (For example, a resident assigned to the VA rotation who takes night call must report to the VA on time when his/her VA responsibilities commence the next day, and should not stay and wait for the results of a CT scan, etc.)

In addition to the regular call schedule, LSU is responsible for Code Grey (hurricane) call from June 1, 2013 through November 30, 2013. The chief residents are responsible for creating this call schedule among the third-year residents.

G. Acceptance of Referrals

Under no circumstances can a resident accept a referred patient without getting approval of the appropriate staff physician. A direct patient transfer from another emergency room cannot be accepted by residents; a transfer from another emergency room must be done ER-physician to ER-physician.

Routine outpatient referrals are triaged by Dr. Barron.
H. Vacations/Interviews

Interim LSU Public Hospital requires at least a 30-day notice to reduce or cancel clinics. Therefore, vacation requests and requests for fellowship/job interviews must be received at least 30 days prior to the planned absence. Requests should be co-ordinated through the chief resident(s) and Gale Abbass, and must be approved by Dr. Barron. The third-year resident and the second-year resident at Interim LSU Public Hospital cannot be absent at the same time. The third-year resident at Interim LSU Public Hospital and the third-year resident at Bogalusa/Lallie Kemp cannot be absent at the same time. The residents at Interim LSU Public Hospital cannot be absent during LSU call, and except for extenuating circumstances, requests for such will not be approved.