SUPPLEMENTAL QUESTIONNAIRE FOR REFRACTIVE LENS EXCHANGE AND/OR PRELEX

OPHTHALMIC MUTUAL
INSURANCE COMPANY
(A Risk Retention Group)

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OMIC requires special underwriting review of physicians requesting coverage for the performance of refractive surgical procedures. **Coverage is not included under the policy until and unless approved and specifically endorsed.**

If lens extraction is limited to patients who have visually significant cataracts, completion of this form is not required as lens extraction on such patients is considered cataract surgery for underwriting purposes. However, completion of this application and adherence to OMIC's underwriting requirements for refractive lens exchange is required for lens extraction performed on patients who have completely clear lenses and for patients with visible cataract changes that are not visually significant and are not associated with patient complaints about the vision.

EXPERIENCE

1 How many refractive lens exchange/Prelex procedures have you performed as primary surgeon (rough estimates are acceptable):

A. Since completion of your training? ______________________

B. In the past 12 months? ______________________

C. Anticipated for the next 12 months? ______________________

PATIENT SELECTION

2 Who conducts the preoperative evaluations? (Please check all that apply.)

☐ Surgeon ☐ Surgeon's non-physician staff ☐ Surgery center staff ☐ Referring optometrist

3 Patients must meet the following requirements for myopia or hyperopia. Coverage is not currently available for the treatment of emmetropic patients (with or without presbyopia).

- **Myopia.** Patients must be presbyopic, age 40 or older, and have at least 5 diopters and not more than 15 diopters of myopia if PVD is not present or not more than 20 diopters of myopia if PVD is present.
- **Hyperopia.** Axial length must be at least 20 mm, and uncorrected visual acuity must be 20/40 or worse. Patients age 40 and older must be presbyopic and have at least 1 diopter and not more than 15 diopters of hyperopia. Patients under age 40 must have at least 4 diopters and not more than 15 diopters of hyperopia.
- All RLE patients must undergo a complete retinal exam pre- and postoperatively. The retinal exam may be conducted by the surgeon, a retinal specialist, or other qualified ophthalmologist. In addition, **patients must be advised of an increased risk of retinal detachment.**

OMIC is willing to consider exceptions to these patient selection criteria on a patient-by-patient basis due to special situations. However, insureds are encouraged to limit their performance of refractive lens exchange to cases that fall within the above guidelines. Exceptions may be requested only in extenuating circumstances. If you have a patient who falls outside of the above patient selection criteria but for whom you believe refractive lens exchange is the most appropriate option, please complete the attached ***Exception Request Form*** and return it to OMIC for consideration prior to scheduling surgery.

INFORMED CONSENT

4 The informed consent document must be procedure-specific and adequately address the indications, alternatives, benefits, risks, and complications. OMIC has developed sample consent forms for refractive lens exchange. Copies are attached for your convenience. If you will use a consent document other than OMIC's sample consent, please carefully review your form to ensure that it is equivalent. Please confirm whether you will use ☐ OMIC's sample consent form(s) or ☐ other equivalent form.

OPERATIVE PROCEDURES

5 Where do you perform this procedure? (Please check all that apply.)

☐ Accredited ASC ☐ Non-accredited outpatient surgery center approved for cataract surgery ☐ Hospital

Please note that refractive lens exchange procedures may not be performed in the physician's office, laser refractive center, or other facility that does not meet the standards for sterile conditions as required for accreditation. OMIC requires that this surgery be performed only in a hospital or outpatient surgery center approved for cataract surgery. Full sterile technique must be followed.

6 Do you perform this procedure in any states/counties other than the county and state of your primary practice location? ☐ Yes ☐ No

If yes, please indicate which state(s)/county(s), how frequently you travel to that location, and for what duration:

____

7 There must be a **minimum interval** of five days between primary procedures.

POSTOPERATIVE CARE

8 Do you co-manage? ☐ Yes ☐ No

If yes, refer to OMIC's postoperative care guidelines.

ADVERTISING

9 Do you advertise your availability to perform this procedure? ☐ Yes ☐ No

Advertisements must comply with state law and FDA- and FTC-mandated guidelines. Ads and other patient information materials must not be misleading and must not make statements that guarantee results or cause unrealistic expectations. Similarly, satisfaction guarantees, warranties, and similar contracts are not permitted. Please refer to the attached ***Review of Advertisement for Medical Services*** form so that you may evaluate and monitor your compliance with OMIC's underwriting requirements with respect to advertising.

"I have read and hereby agree to comply with OMIC's underwriting requirements specific to refractive lens exchange/Prelex procedures and with OMIC's standard refractive surgery requirements. I also agree to notify OMIC prior to implementing any intended changes to my responses above. **I understand that failure to comply with OMIC's requirements or to notify OMIC promptly of changes in my protocol may result in uninsured risk or termination of coverage."**

______________________________ ____________________

Applicant's Signature (Please do not use signature stamp.) *Date*

____

Applicant's Name (Please type or print.)

EXCEPTION REQUEST FOR COVERAGE OF REFRACTIVE LENS EXCHANGE

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1. Patient's name, initials, or medical record number: ______________________

2. Age: ______________

3. Gender: ☐ Male ☐ Female

4. Preoperative refraction: OD: ______________ OS: ______________

5. Uncorrected visual acuity: OD: ______________ OS: ______________

6. Best corrected visual acuity: OD: ______________ OS: ______________

7. Is PVD present? ☐ Yes ☐ No

8. Axial length: OD: ______________ OS: ______________

9. Degree of cataracts: OD: ______________ OS: ______________

10. Patient's visual complaints: ______________________
____

11. Other options discussed: Reason(s) declined:

☐ LASIK ______________________

☐ PRK ______________________

☐ CK ______________________

☐ Monovision ______________________

12. Other factors supporting rationale for refractive lens exchange: ______________________
____
____

______________________________ ______________________
Insured's Signature (Please do not use signature stamp.) *Date*

____
Insured's Name (Please type or print.)