



OPTOMETRIC CARE OF NURSING HOME RESIDENTS

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NURSING HOME RESIDENTS**

Prepared by the

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FOREWORD

The "old-elderly" - those ages 85 and older - are the fastest growing segment of the population, increasing by 43 percent by the year 2010. The "old-elderly" are at the greatest risk of being in need of health care, social services, and caregiving by friends and family. They are also most likely to suffer from one or more of the major causes of visual impairment - cataracts, age-related macular degeneration, glaucoma, and diabetic retinopathy. While many persons in this group are in relatively good health, the solution for many "well-but-frail" elderly is to enter a nursing home. The demand for nursing home beds is expected to rise by 50 percent over the next 20 years.

Among nursing home residents, recent research indicates that approximately 3 percent have no vision and 25-48 percent are severely visually impaired.¹ The primary care optometrist has an increasingly important role in helping elderly individuals maintain independent life styles, thereby reducing their need for earlier institutionalization. The optometrist also has a professional responsibility to help enhance the quality of life for those who are institutionalized.

This Manual is designed to provide helpful information in regard to the evaluation of visual function and ocular health among individuals residing in nursing homes or other types of assisted living facilities. The goal of the Manual is to provide knowledge and understanding of the diagnostic and management elements needed for comprehensive evaluation and care of this growing and significantly neglected segment of the patient population. This Manual includes discussions of administrative and professional staffing, the role and clinical responsibilities of the optometric consultant, instrument and equipment needs, and nursing home records and forms, including coding and billing for services. Implicit

in this Manual is the patient care responsibilities for diagnosis and management of nursing home residents by the primary care optometrist. Indeed, geriatric optometry as represented in the care of the persons within nursing facilities provides the fullest realization of primary care services.

Alfred A. Rosenbloom, O.D., M.A.

I. DEMOGRAPHICS OF VISION CARE IN NURSING HOMES

Visual impairment represents one of the most common disabilities among nursing home residents.² It is also one of the most unrecognized disabilities by nursing home staffs.² One study found that visual impairment is 13-15 times more common among the nursing home population than among an age-matched ambulatory population.¹ Multiple studies have shown that few residents receive vision care after admission to a nursing home. Although some variability is seen from study to study, it can be estimated that 80 percent or more of all nursing home residents receive no vision care at any point after admission.² Vision and eye care currently are not mandated services within long term care facilities. Vision care is required to be provided by the nursing home at the request of the resident or family or if indicated by a change in status particularly in the presence of cognitive impairment. The current system of identifying residents in need of vision care services is inadequate.

Prevalence rates for virtually all eye diseases increase with age. Advanced age is a strong risk factor for nursing home placement, but the degree of eye disease among the nursing home population is far in excess of what would be predicted simply based upon age.¹ Virtually all nursing home residents will have at least one ocular pathology, and almost half will have two or more ocular pathological conditions. The most commonly identified ocular problem within the nursing home population is cataract. The prevalence rate of cataract varies considerably from study to study in this population with ranges from 35 percent to over 80 percent.³ Age-related macular degeneration and glaucoma are also more common and found in excess of that in the ambulatory population.

Visual status is important in the overall function of residents. It has been demonstrated that performance of activities of daily living is highly correlated with vision level (i.e., vision better than 20/70) in the nursing home population.²⁻⁴ Residents with low vision have been shown to have greater difficulty in transfer ability, washing the upper and lower body, and dressing than comparable residents without visual impairment. Newly visually impaired persons are known to undergo personality changes, which may

manifest as disengagement from activities, low self-esteem, depression, and high anxiety levels. In the presence of what is assumed to be adequate visual acuity, the nursing home staff may surmise that personality changes due to visual impairment are the result of mental status deterioration. In turn, the visually impaired resident may become increasingly dependent on staff for activities that can possibly be performed with the assistance of appropriate visual appliances or training. Dependence resulting from severe impairment of vision may contribute significantly to the cost of long term care.⁵ Since it has been estimated that teaching a resident visual impairment adaptive skills for self feeding may reduce the annual institutionalized cost by more than \$2,000,⁵ alternative interventions may not only increase independence for the individual but also may reduce the financial burden on society.

II. OVERVIEW OF NURSING HOME FACILITIES

A. TYPES OF FACILITIES

There are three basic types of long term care facilities which exist in the United States: Skilled Nursing Facilities (SNF), Intermediate Care Facilities (ICF), and Adult Congregate Living Facilities (ACLF).

These facilities are categorized based on the type and intensity of care they provide. References to "nursing homes" are almost always describing Skilled Nursing and Intermediate Care Facilities. Within this Manual, Long Term Care Facilities (LTCF) will refer to all three types of facilities.

1. **Skilled Nursing Facilities** - provide rehabilitative and restorative services under the direct supervision of an attending physician or medical director. Residents are typically admitted for additional recovery after a hospitalization for conditions such as hip fracture, fall, or stroke. The length of stay of this type of resident is expected to be relatively short. Residents in this type of facility are assumed to require 24-hour supervision, with the emphasis being on restorative and rehabilitative care provided by speech, occupational, or physical therapists.
2. **Intermediate Care Facilities** - provide a level of care somewhere in between that of the SNF and ACLF. The basic services generally consist of help with activities of daily living (e.g., toileting, feeding, grooming, etc.) and medication management. The distinction between skilled and intermediate care can be blurred. Skilled nursing and intermediate care typically coexist within the same nursing home, with certain numbers of beds allocated to each. It is not uncommon for a person to be admitted as a skilled nursing resident and then be shifted to intermediate care. Intermediate care residents are characterized by the deteriorating Alzheimer's patient who may remain a nursing facility resident for many years.

3. **Adult Congregate Living Facilities** - also known as Residential Care Facilities - provide limited services to their residents which may include dietary, housekeeping, social and recreational support, and limited medical monitoring (such as blood pressure checks). Residents of these facilities are typically high functioning seniors who have sought out the social and recreational interactions of group living. While nursing staff may be available at these facilities, the services they provide are limited. They may provide services such as arrangement of transportation and scheduling of medical visits.

Both SNFs and ICFs are subject to federal regulation under the Medicare Requirements for Long Term Care Facilities, Code of Federal Regulations Title 42, Chapter IV, Part 483. These regulations provide guidelines for operating standards for nursing homes which seek reimbursement through Medicare and Medicaid. The number of beds allocated for SNFs and ICFs is limited and regulated in each state. In some states this may be by certificate of need committees in the same way that hospital beds are regulated or by other regulatory mechanisms.

B. STATISTICS

As of 1995, there were approximately 16,000 nursing homes in the United States.⁶ The majority of these nursing homes are small (under 100 beds) and are run as-for-profit institutions. There are between 1.5 and 2 million nursing home beds available in the United States. This is almost double the number of acute care hospital beds. The occupancy rate for nursing home beds is high, typically above 85 percent.⁶ As the population in the United States ages, tremendous growth will be seen in the nursing home population. The number of nursing home beds is expected to more than double to greater than 5 million over the next 30 years.⁶

At any given point in time 5 percent of the population over the age of 65 resides in a nursing home. The nursing home population is, however, not static. Discharges to home and the acute care hospital, as well as

death, cause a continuous flux in the population. Due to this high turnover rate, the lifetime risk of nursing home placement is underestimated. Some studies have shown that the lifetime risk of a nursing home admission may be as high as 50 percent for those over the age of 65.⁷ A number of risk factors for nursing home placement have been identified including: advanced age, dementia, cerebrovascular accident, urinary incontinence, falls and fall risk, and lack of social support.⁸

Nursing home residents can roughly be divided into two groups based on length of stay: those that reside longer than 6 months and those who stay less than 6 months.⁸ The median length of time spent in nursing homes in the United States is approximately 6 months; however, about 21 percent stay more than 5 years.⁵⁻⁸ Individuals who stay in the nursing home for relatively short lengths of time include those who are admitted with terminal disease and those who need rehabilitation or subacute (skilled nursing) care. Residents who stay more than 6 months can be broadly classified into three groups: those who are primarily cognitively impaired; those who are primarily physically impaired; and those who have both significant cognitive and physical impairment.

Nursing home care is paid for largely through two federal entitlement programs, Medicare and Medicaid. Medicare covers payments to nursing homes for the first 100 days of care after a hospital admission. After the first 100 days, the resident is then required to pay for services out-of-pocket. This period is referred to as the "spend down time." During this time, the life time savings of the resident is spent to pay for nursing home care. After a period of time, the resident's resources are exhausted, rendering him/her indigent and eligible for Medicaid. In terms of absolute dollars, the vast majority of nursing home care is paid for through the Medicaid program. Long term care, in fact, accounts for the largest percentage of Medicaid expenditures. Optometric services within nursing homes are covered under Medicare and Medicaid programs as they are for in-office services (See XIII. Coding and Billing).

C. ADMINISTRATIVE STAFFING

Federal regulations require that all nursing facilities seeking Medicare or Medicaid reimbursement have a governing body and employ certain defined personnel.⁹ The governing body or those empowered to act as the governing body are legally responsible for setting and enacting the policies and procedures of the facility. These same regulations require facilities to employ an administrator, designated nursing staff, social services personnel, dietary staff, an activities director, medical director and staff, pharmacist, dentist, rehabilitation personnel, and housekeeping/maintenance personnel. The roles of key staff as described by federal regulations are outlined below. State and local agencies may place more stringent requirements on facilities. Some latitude is also granted to small and rural facilities in terms of staffing requirements in recognition of the difficulty in recruiting licensed personnel.

1. Nursing Home Administrator. The nursing home administrator is appointed by the governing body. Federal regulations require that a nursing home be supervised by an administrator licensed by the state. The administrator is charged with management of the facility. He/she is expected to administer the facility in a manner that allows each resident to maximize physical, mental and psychosocial well-being.

2. Director of Admissions. There is no separate federal designation for the position of director of admissions. This position frequently exists in nursing facilities to coordinate the large numbers of admissions, discharges, and beds being held for persons in the hospital. The director of nursing, a social worker, an assistant administrator, or other personnel associated with the nursing home may fill this position.

3. Director of Social Services. Each facility is required to provide medically-related social services to attain or maintain the highest practical physical, mental, and psychological well-being of the resident. Facilities with more than 120 beds are required to employ a full-time social worker. The broad mandate of the social worker may include activities such as coordinating eye care, maintaining contact with the

resident's family, coordinating health and medical decisions between staff and residents, and assisting the resident in obtaining legal or other services.

4. Director of Nursing. Each facility must have a registered nurse that serves as the director of nursing. The director of nursing acts largely in a supervisory capacity to ensure that the goals for each resident assessment and care plan are met. The director of nursing may serve as a charge nurse only in small facilities. Unlicensed nursing assistants provide much of the direct care to residents. Federal guidelines describe the type of care that may be provided and educational requirements for these positions.

5. Director of Activities. Each facility must employ a qualified professional to serve as director of the activities program. This may be a therapeutic recreation specialist, or, in some circumstances, an occupational therapist or occupational therapy assistant. The role of the activities director is to provide activities for the residents that help them achieve their highest possible level of function. These are based on the individual resident's preference and might include music, reading, and social gatherings.

6. Medical Director. Each facility must appoint a physician to serve as medical director. The medical director provides, directs, and coordinates medical care in the facility. Duties of the medical director include development of written rules and regulations and delineation of the responsibilities of attending physicians. Coordination of medical care includes liaison with attending physicians to ensure that physicians' orders are written promptly upon admission of a resident, that periodic evaluations of the adequacy and appropriateness of health professional and supportive staff and services are conducted, and that the medical needs of the residents are met.

D. PROFESSIONAL STAFFING

The federal requirements for Long Term Care Facilities also describe the types and roles of various health care professionals, who must be available to provide services to the residents. Brief descriptions of these professionals and the services they provide, as set forth in the federal regulations, are described below.

1. **Attending Physicians.** Each resident is under the supervision of a physician (M.D. or D.O.), selected by the resident or resident's guardian. That physician evaluates and monitors the resident's immediate and long-term needs and prescribes measures necessary for the health, safety, and welfare of the resident. The number of physicians at any facility may vary from one to many. Residents may be admitted and discharged only upon the direct order of a physician. A physician is required to evaluate the resident every 30 days for the first 90 days after admission and once every 60 days thereafter. When absent, an attending physician is required to make arrangements for the medical care of his/her residents. At the time of each visit, the physician reviews the resident's medications and other orders, reviews the plan of care required, and writes, dates, and signs a note on the resident's progress.

2. **Dental Consultant.** Facilities are required to provide routine and emergency dental care for their residents. Each nursing facility must retain a consultant dentist to meet this requirement. The frequency of required routine dental care is specified by state regulations.

Each nursing facility makes arrangements for dental care for residents who do not have a private dentist, including arrangements for transportation to and from the dentist's office. It also arranges for emergency dental care when a resident's attending dentist is unavailable.

3. **Pharmacy Consultant.** Each facility is required to retain the services of a consultant pharmacist. The pharmacist's role is to establish record keeping and oversight monitoring for all medications and biologicals maintained and administered within the facility.

4. Rehabilitation Consultants. Each nursing facility either arranges or provides for specialized rehabilitative services as needed by the resident to improve and maintain functional abilities as outlined in the resident's care plan. Specialized services may include, but are not limited to, physical therapy, speech language therapy, occupational therapy, and mental health rehabilitation services.

5. Other Consultants. The services of a variety of other consultants may be needed within the nursing home such as optometry, podiatry, psychiatry, psychology, and physiatry (i.e., physical medicine). Optometry or other vision care services are not currently mandated for nursing home residents. Nursing homes are required to assist the resident in obtaining an examination if the resident or his or her family makes a request or if a visit is deemed medically necessary. (See IV. Access to Residents)

III. APPOINTMENTS TO NURSING HOME PROFESSIONAL STAFFS

A. OBTAINING AN APPOINTMENT

As with other areas of practice, determining the need for optometric services within local nursing homes is a logical starting point. Lists of nursing homes may be obtained from the state regulatory agency, the state nursing home association, the local area agency on aging, and the local hospitals. More recently, multidisciplinary groups, which supply doctors and other staff to nursing homes, have been formed. These groups typically consist of optometrists, podiatrists, physicians, and physical and occupational therapists among others. Determining if such groups are operating in the local area is also an avenue that can be explored.

Sending a letter to local nursing home administrators introducing yourself, your background, and letting them know of your interest in the area of vision care within long term care facilities is an appropriate starting point. The nursing home administrator is the chief administrative official within the nursing home and will ultimately make the decision as to whether optometric services will be provided in-house. In some rare cases a board of directors may need to approve appointments to nursing home staffs, similar to the system for hospital appointments. Credentialing may be required by some nursing homes as well.

Most nursing homes are delighted to have optometrists interested in providing care within the facility; however, if no contact is received from the nursing home, a follow-up phone call to arrange a face-to-face meeting should be the next step. At this meeting, services to be provided and general contractual arrangements can be discussed. Points of discussion should include who will be the administrative contact person(s) within the nursing home, how scheduling will be accomplished, what space is available for examinations, legal responsibilities of the provider (See IV. C. Governmental Regulations), and ophthalmic policy. The types of contractual arrangements can vary widely, from loosely patterned to more formal agreements requiring the services of an attorney. Once an agreement to proceed is reached, a

second meeting should be arranged to meet with other staff within the facility (e.g., the Medical Director, Director of Nursing, and Director of Social Services). Once the nursing home vision program is started, it is wise to periodically review the agreement with the nursing home and to meet with these key staff to discuss problems.

B. BENEFITS OF OBTAINING HOSPITAL PRIVILEGES

The advent of managed care has brought increases in the number of health care systems providing a continuum of services. In these systems, a single entity may be involved in ambulatory care, inpatient hospital services, home care, and long-term nursing care. In many instances, these systems revolve around the hospital as a focal point. Optometrists who are not members of the hospital staff may find it difficult to obtain privileges to see nursing home residents. Conversely, seeking privileges to see nursing home residents may be a valuable entree into the hospital and ambulatory care network.

Due to the unstable health status of many nursing home residents, hospital admissions with discharge back to the nursing home are not uncommon. These frequent admissions and discharges can make continuing care difficult. The optometrist should be alert to the fact that each new admission to the nursing home may result in a new chart being started. It is possible that during the course of multiple admissions and discharges that ophthalmic medications may be left off of physicians' orders. Obtaining privileges that allow optometrists to evaluate nursing home residents while in the hospital can alleviate this problem. **[A more complete reference and additional information can be found in the American Optometric Association's Optometric Hospital Privileges Manual (See Suggested Readings)].**

IV. ACCESS TO RESIDENTS

A. MEDICARE REQUIREMENTS AND ACCREDITATION FOR LONG TERM CARE FACILITIES

Nursing facilities are regulated by the federal government through rules and operating standards established by the Health Care Financing Administration (HCFA). In response to reports of widespread neglect and abuse in nursing homes, the Congress, in 1987, enacted legislation to reform nursing home regulations and require nursing homes participating in the Medicare and Medicaid programs to comply with certain requirements. This legislation, included in the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987), also known as the Nursing Home Reform Act, specifies that a nursing home "must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care..."¹⁰

These rules and operating standards were established to protect the rights of the residents living in nursing facilities and to guarantee the availability of a minimum level of services to meet their health and psychosocial needs. Nursing facilities must comply with the requirements of the federal government in order to be certified and to receive payment under the Medicare and Medicaid entitlement programs.

A standard survey of nursing facilities, performed on a yearly basis, assures the public that the Life Safety Code Requirements and Resident Care Requirements are being met. The survey is a resident-centered, outcome-oriented inspection and assesses the following areas:

- o The facility's compliance with residents' rights
- o The accuracy of the residents' comprehensive assessments and the adequacy of care plans based on these assessments

- o The quality of services furnished as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutritional services, activities and social participation, sanitation, infection control, and the physical environment.

The Resident Care Requirements for Long Term Care Facilities experienced major revisions in 1989, 1991, and 1994.

In addition to federal laws regulating the quality of care in nursing homes, most states have enacted laws prescribing licensure requirements for nursing facilities in their state. In many states, the state licensing body acts as the federal government's agent in determining whether a facility has met the federal (and state) requirements for Medicare/Medicaid certification. For Medicare/Medicaid purposes, the state laws must be at least as stringent as the federal laws. Some states have adopted laws that are stricter than the federal laws. As an example, California nursing home care and services are regulated under Title 22 of the California Code of Regulations.

At this time, nursing facilities are not specifically mandated to provide routine or emergency vision and eye health services to their residents. Since vision and eye health care is not a required service in nursing facilities, the addition of an eye care program helps to improve the quality of care provided to the residents, and, as an added benefit, may positively impact the outcome of the nursing facility's annual survey.

Nursing facilities are required to assist residents in obtaining eye care if they or their family makes a request for such services or in the case that services are triggered through the Minimum Data Set (MDS)/Resident Assessment Protocol (RAP) system. (See IV. B. Resident Assessment, Care Plan, and the Minimum Data Set) (See Appendix)

B. RESIDENT ASSESSMENT, CARE PLAN, AND THE MINIMUM DATA SET

During the 1980's as the population of citizens residing in nursing facilities increased so did concerns over the quality of care being delivered. The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) mandated a national assessment system for evaluating all residents in nursing facilities in the United States. Each resident admitted to a facility is required to be evaluated using a Resident Assessment Inventory (RAI). The MDS and RAP and triggers are required by federal law to be components of the RAI. States may add other assessment tools or more in-depth data to be collected. Federal statutes also require facilities to screen for mental illness and mental retardation as a part of the initial evaluation at the time of admission. The Preadmission Screening and Routine Review (PASARR) of mental illness along with the MDS and RAP compose a common RAI battery.

When mandating use of the RAI for nursing facilities, legislators recognized the need for uniformity among the data to be collected so that care practices could be monitored. The MDS was developed to meet this requirement.¹¹ (See Appendix) The MDS, now in its second revision, is a multidimensional tool that evaluates a wide range of areas including medical, cognitive, and social-behavioral status. The MDS was designed to give structure and uniformity to the evaluation of long term care residents and has been used as the national assessment model since 1991.

The purpose of the MDS is two-fold: (1) it is a gross assessment of functional status and, more importantly, (2) it serves as the basis by which specific intervention protocols are triggered. It is in relation to the second objective that the MDS can be thought of as a functional assessment tool being used as an indicator of clinical status, rather than the more typical situation where clinical status is used as a proxy of functional status. It includes a section on Vision Patterns that evaluates three areas the designers of the MDS have termed: Vision, Visual Limitations/Difficulties, and Visual Appliances. (See Section D of the MDS in the Appendix)

The Vision subsection categorizes visual acuity (VA) into one of four levels based on reading criteria.

Descriptors directly from the MDS are as follows:

- o Grade 0-adequate, sees fine detail and reads newspaper size print
- o Grade 1-impaired, sees newspaper headlines but not regular print in newspapers
- o Grade 2-highly impaired, limited vision, not able to see newspaper headlines but appears to follow objects
- o Grade 3-severely impaired, no vision or appears to see only lights, shapes, or colors.

Visual Limitation and Difficulties are divided into three categories:

- a) Side vision impaired, bumps into objects or has difficulty seeing objects to the side
- b) Flashes and/or floaters present or halos around lights
- c) None of the above.

Visual Appliances subsection evaluates whether prosthetic devices such as spectacles, contact lenses, or low vision devices are present. The subsection is assessed as: (1) yes or (2) no. As an example, the MDS assessment of someone with adequate visual acuity, no visual field deficit, and wearing glasses would be 0/c/1. That is, "O" indicates adequate visual acuity; "c" indicates no visual limitations and difficulties; and "1" indicates that a prosthetic device is present.

The MDS assessment is required to be completed within 14 days of admission to the facility. It is typically generated through nursing home staff meetings and preadmission sessions with family and staff. Social workers, nursing staff, the activity director, and dietary staff usually attend these meetings. The MDS is intended to be a measure of the resident's status during the past 7 days. The actual plan of care for the resident is developed as a result of the MDS assessment and must be completed within 7 days after the MDS assessment. Understanding the roles of the MDS, RAP, and care plan is crucial in understanding

how care is delivered to a nursing home resident. All care to a particular resident is directed to addressing deficiencies or problems detected within the MDS and RAP system. Changes or deficiencies in the MDS trigger specific interventions that are to be addressed through the care plan. Timetables are laid out for addressing problems noted. The RAP (See Appendix) details specific courses of action for each assessed problem indicated by the MDS. The RAP serves as a crucial bridge between the problems and needs identified by the MDS and the actual plans for care that are developed. In the case of vision, one RAP intervention is a call for professional evaluation by an optometrist or ophthalmologist. Vision care services are not currently mandated in long term care facilities. Unless a deficiency is documented on the MDS or triggered through RAP, residents are not required to receive any vision care services. This makes the MDS assessment of visual status **crucial** in initiating vision care. The MDS is updated yearly, with significant changes in status, or with discharge and readmission. Optometrists can be immensely helpful to nursing facility staff and residents by reviewing and addressing shortcomings in MDS evaluation and care plans for vision. (See Appendix)

C. GOVERNMENTAL REGULATIONS AND REIMBURSEMENT

Access may be the most challenging and important component of providing care to nursing facility residents. Failure to follow regulations can result in fines, penalties, and possible sanctions against those participating in government programs. It is the provider's responsibility to research and understand Medicare/Medical Assistance (Medicaid) policies and to be certain that the optometrist and optometrist's employees are following them. Described below are general concepts regarding government compliance issues. Each state and carrier may have specific rules and regulations unique to that area. Optometrists should research and read all provider manuals and contact their local state association and Medicare/Medical Assistance carriers for specific local policies.

Several different individuals or processes may identify a resident's need for optometric services. These include requests from the director of nursing or social services, the attending physician, the resident or

family themselves, through the MDS assessment process, through a pharmacy request for consultation, or as a referral from a visual screening. While identifying the need for optometric services and obtaining authorization to examine the resident is the first step, following the correct protocols for reimbursement is equally important. Recent interpretations of federal statutes by regional Medicare carriers have made it incumbent upon optometrists to understand the role of the attending physician in approving eye care services. As outlined below the attending physician clearly plays a key role in assuring that optometric services are indicated and therefore covered by third party payors. Interpretation of these guidelines may also cover the ability to access residents even when third party payors are not involved. Individual Medicare carriers are responsible for applying these guidelines to providers in their area. The importance of knowing local third party payor regulations for access to residents and requirements for reimbursement cannot be over emphasized. Many residents have Medicare coverage and, just as in the office, Medicare requires a symptom or complaint for the visit to be covered. Refractions and screenings are noncovered services under the Medicare program.

Each state may have different rules and benefits that cover Medicaid recipients. Some states allow "routine" examinations and eyeglasses, while other states may have less generous benefits. Recipients that are covered by ERISA plans or indemnity plans will have quite different coverages. Health maintenance organizations (HMOs) may have even more specific guidelines and include restrictions such as using a gatekeeper. The provider must be familiar with all plans for which services are provided and be certain to remain in compliance with all of their rules and regulations.

Medicare, a federal program that is administered by state or regional carriers, will be the primary insurance for most nursing facility residents. Although federal statute governs the Medicare program, each carrier may administer the program in slightly different ways. An example of this is a requirement by some carriers that mandates that the resident's primary care physician must first evaluate the resident and issue a written order for a specific optometric service prior to an optometrist being able to see the resident and seek

reimbursement for those services. The following are examples of reimbursement mechanisms or policies which carriers may apply.

- o The carrier will not provide reimbursement for a service or procedure unless:
 1. The resident's attending physician or nurse practitioner evaluates the resident and authorizes the order for the service or procedure.
 2. The resident's attending physician or nurse practitioner evaluates the resident and authorizes the referral to another practitioner.
 3. A named physician, whose attendance is requested only by the resident or the resident's interested family member or legal guardian, evaluates the resident and authorizes the order for the services or procedure. The attending physician must be notified of any change in the resident's physical, mental or psychosocial status, or of the need to alter the resident's treatment significantly.

- o Standing or "prn" orders DO NOT establish medical necessity.

- o Documentation of the attending physician's order for the clinical problem requiring consultation in the nursing home record, as well as accurate optometric record documentation, is critical in complying with these policies.¹²

V. THE TRADITIONAL ROLE OF THE ATTENDING PHYSICIAN

A. COORDINATOR OF RESIDENT'S HEALTH CARE

Health care delivered to a nursing facility resident is under the direction of the attending physician. Medicare Part B guidelines state that a facility must ensure that the medical care of each resident is supervised by a physician and that physician's visits must take into account the resident's total program of care, including medications and treatments.¹⁰ The primary physician retains the overall responsibility for the coordination and direction of the resident's care. In order for an optometrist who provides services to a resident to obtain Medicare or Medicaid reimbursement for those services, the resident's physician must first have a written order for those services. The attending physician not only performs periodic examinations and assessments of the resident but also coordinates the entire care of the individual. If physical therapy, blood tests, or an eye examination is needed, the attending physician must authorize the service through the issuing of a physician order.

B. PROVIDER OF EYE HEALTH CARE

There may be some overlapping of eye care services between the primary care physician and the optometrist in the nursing facility, just as there is in clinical practice. For example, if a resident presents with conjunctivitis and the primary care physician is comfortable in managing it, an order for optometric services may not be written. If, however, the physician is not available to diagnose the condition, or wishes to have an optometrist examine and treat the resident, it is the physician who has the ultimate authority to write the order for optometric services to be performed. Even though the optometrist may have treated the resident previously, the optometrist has no authority to examine the resident and obtain reimbursement unless a specific order has been written by the attending physician. Close communication between the nursing facility staff, nurses, attending physicians, and optometrist is essential for this system to work effectively and in the resident's best interest.

VI. THE ROLE OF THE OPTOMETRIST

A. OPTOMETRIC CONSULTANT TO THE NURSING HOME FACILITY

The role played as an optometric consultant in a nursing facility can be as creative and unique as one desires. In the role of consultant, the optometrist may be asked to assist the nursing home in developing policies or to provide suggestions on ways to improve the function of residents other than providing examinations. Optometrists certainly provide eye care services to the residents, but many other areas of optometric expertise may be needed. Who better to consult regarding floor coverings or wall color selection to enhance visual discrimination and reduce glare effects than the optometrist. Can falls be reduced, resident mobility be improved, and reading enhanced with a change in the facility lighting? How much lighting is optimal for residents and staff? A discussion of computer workstation design may be helpful. Are there large print materials including talking books and magnification devices available for the residents' use? The facility may need an eye safety workplace evaluation and a safety vision program started. How about organizing a health fair for the staff, residents, and families? Many facilities have newsletters that go to not only the residents but their families as well. Timely articles about eye care issues would be most welcomed by the newsletter editor.

As a consultant, the optometrist may be asked to present lectures or inservice training sessions to staff or to residents and their families. Topics of interest might include the aging eye, low vision care, diabetic retinopathy, macular degeneration, cataracts, and glaucoma. Nursing staff members may benefit from a presentation on dry eye, how to instill eye drops, how to correctly administer hot packs or lid scrubs, or how to recognize common subjective symptoms of common eye problems or eye emergencies. Advice may be requested to design the best way to administer the eye portion of the MDS and assess the accuracy of the assessment. What other factors should the nursing staff consider in making appropriate referrals for optometric care? Residents with diabetes should have annual dilated exams. Residents with glaucoma

need follow-up and medications reviewed periodically. Residents on long-term steroids need examinations to detect glaucoma and cataracts.

B. PROVIDER OF EYE HEALTH AND VISION CARE SERVICES

Optometric provision of eye care services is certainly an important facet of the optometric consultant's role. Studies suggest that nearly 80 percent of nursing home residents never receive eye care once they enter a nursing home.³ If optometric services are available within the facility, this number can be dramatically reduced. Although it takes time and effort to transport optometric equipment to the facility, the benefits are tremendous to both the resident and optometrist. Comprehensive examinations or problem-oriented visits can be performed with modern portable equipment. (See X. Instruments and Equipment.) Eyeglasses can be provided when appropriate; however, most optometrists find optical services and dispensing to be a small portion of a nursing home practice. Utilization of optometric assistants is critical to efficiency in delivering care to nursing facility residents. From assisting in the examination to frame selection and dispensing services, optometric assistants play a very valuable role.

VII. THE OPTOMETRIC CONSULTANT'S CLINICAL RESPONSIBILITIES

A. ASSESSMENT OF NEW ADMISSIONS

Newly admitted residents to a nursing facility need to be identified as to their needs for eye care services and whom they want to perform those services. The nursing facility may require the optometrist's assistance in defining the process the facility will use first to identify when a resident needs an optometric examination, and then how he/she will receive it. Some nursing facilities may utilize a form asking the resident or his or her family to either select the in-house consultant as their eye doctor or to specifically name someone else. The form may also identify when the resident last had an examination, if one is needed immediately, or at what later point in time one may be needed.

As discussed in Section VII, federal law requires that each new resident have a resident comprehensive assessment completed upon admission. The MDS section regarding visual problems will help identify who has reduced visual acuity or peripheral vision problems. A recent study, however, found that only 34 percent of these MDS evaluations actually were valid when compared to the results of an examination.¹³ The MDS does not trigger an optometric referral for other important criteria such as glaucoma follow-up, diabetes, high-risk medicines (e.g., corticosteroids), or previously diagnosed ocular diseases such as macular degeneration or cataract or the presence of an intraocular lens implant. The consultant needs to make the nursing facility staff aware of the limitations in the MDS and also assist them in properly administering the visual section of the MDS.

B. REASSESSMENT OF ESTABLISHED RESIDENTS

Once a system has been established to identify a new resident's need for optometric care, one must develop a system to assure appropriate follow-up care. The optometrist needs to assist the nursing facility in addressing the mechanisms to identify residents in need of follow-up. Will the optometrist provide the

recall of residents or is it the responsibility of the facility? Perhaps a system that provides checks and balances itself is desirable. The optometrist may want to indicate in the resident's progress notes when he or she should be examined again. Be certain as to which nursing facility staff person is responsible for tracking this information and scheduling the next appointment. It may be advantageous to track the resident through an optometric recall system, keeping in mind that all visits are ordered by the attending physician and re-evaluation of residents is solely at the discretion of the attending physician.

The optometric consultant will want to make emergency care personally available or through another source. Be certain that this has been discussed with the facility and that a plan has been established. Also, discuss with the appropriate nursing personnel what constitutes an eye emergency and what requires prompt but not immediate care. The optometrist should be available 24 hours a day.

C. MANAGEMENT OF EYE HEALTH AND VISION CONDITIONS

Management of eye health and vision conditions is an integral part of consultation responsibilities. Seventy-two to eighty-four percent of nursing facility residents have been found to have cataracts, 25-37 percent have macular degeneration, and 6-15 percent have glaucoma.^{1,14} The prevalence of dry eye, conjunctivitis, and blepharitis is quite high as well. A nursing home practice may grow into quite a challenging and satisfying primary care practice because of the prevalence of eye disease in this unique population.

Refractive error, of course, is extremely common in nursing home residents. In the over 50 age group, nearly all residents will be presbyopic. Myopia, hyperopia, and astigmatism are quite common in all age groups. Proper correction can improve the visual acuities significantly. Studies have found that 20-40 percent of residents showed marked improvement in visual acuities after a complete eye examination.^{1,15} The optometric consultant is responsible for providing refractive and dispensing services or for arranging

for them. The simple service of routine adjustment of eyeglasses is welcomed by both the staff and the residents. It is important to have this service available.

D. COMANAGEMENT OF SURGICAL EYE CARE

Primary eye care services include the provision of postoperative care to residents. Nursing home residents will require these important services just as clinic-based patients do. With proper portable equipment these important services can be provided to residents without transporting them to the optometrist's office or the office of the surgeon. Postoperative care of residents after cataract extraction requires objective assessment of the cornea, anterior chamber, conjunctiva, the implant, the vitreous, retina, and intraocular pressure. This along with a detailed case history, visual acuity measurement, and review of medicines constitutes a postoperative visit. These services are convenient and cost effective if they can be provided within the facility. The postoperative course of YAG capsulotomies, laser photocoagulation, and glaucoma surgeries, among others, can be followed as well.

E. SUPERVISION OF OPTICAL SERVICES

The vast majority of nursing home residents will not have had a vision examination for a number of years. Studies have estimated that visual impairment can be significantly reduced by the provision of appropriate optical devices.^{1,15-16} Eyeglasses represent the majority of optical prescribing needs within the nursing home. The majority of nursing home residents will be dually covered under both Medicare and Medicaid. Many state Medicaid programs have provisions for eyeglasses. Therefore, it is important to understand the provisions for eyeglasses under the individual state Medicaid program. If the resident is not covered under the Medicaid program for eyeglasses, the family or guardian should be informed regarding the resident's need for eyeglasses. It is often helpful if the family or guardian is approached through a familiar nursing home contact such as the social worker. The social worker is often more familiar with the level of family support for the resident than any other individual and can be an invaluable contact in working with the

family. Once spectacles are prescribed, making sure that the spectacles stay with and are used by the resident is a challenge. Lost glasses are an extremely common nursing home problem. All spectacles provided to nursing home residents should be etched or labeled in some way for identification.

Contact lenses within the nursing facility present a unique challenge. Aphakia or penetrating keratoplasty probably represent the most common conditions requiring contact lenses. The cognitive ability of the resident and his or her manual dexterity to handle and care for the lenses are key factors. If the resident is unable to care for lenses, nursing staff will need to be trained for the task. It is helpful if a contact lens-wearing staff member can be identified.

Visual impairment is extremely common in the nursing home population and many nursing home residents may benefit from low vision devices and/or environmental modifications. Again, the cognitive and physical abilities of the nursing home resident to use low vision devices need to be evaluated.

It is important early on in the negotiations to assist the nursing facility in setting an ophthalmic materials policy. Points to be considered include: what is the emergency and urgency policy; what to do in case of lost or broken spectacles and frame repairs; and the expected length of time for ordering and delivering materials. Setting these policies early can avoid the frustration of receiving an emergency call only to find out that a screw is missing from a frame. It is extremely helpful to train one of the contact persons in the nursing home to make simple repairs on spectacles.

VIII. THE OPTOMETRIC CONSULTANT'S RESPONSIBILITIES IN THE RESTORATIVE CARE PROGRAM

A. OPTOMETRY AND THE REHABILITATION TEAM

One of the important but frequently overlooked aspects of nursing home care is rehabilitation. Patients are frequently admitted to nursing homes for rehabilitation after acute care hospitalizations. These rehabilitation stays can be related to conditions such as injurious falls resulting in hip fractures and cerebrovascular accidents. Rehabilitation may involve many disciplines including occupational, physical, and speech therapists. The optometrist, as the vision consultant for the rehabilitation team, may be called upon to evaluate and make recommendations for vision rehabilitation, document the cause and nature of the vision loss, certify residents as legally blind, make recommendations for visual impairment precautions, provide recommendations to reduce falls, and conduct vision rehabilitation for residents with impairments due to stroke. The optometrist should coordinate treatment recommendations with the resident's physician and therapists. Good communication with the rehabilitation team is imperative for quality patient care.

B. ESTABLISHING A LOW VISION REHABILITATION PROGRAM

Low vision care is an essential component of a comprehensive rehabilitation program. A functional, problem-specific approach is recommended. As with most aspects of nursing home care, the level of cognitive ability of each individual is frequently the limiting factor in the type and complexity of low vision care. A suggested list of low vision devices is found in the Instruments and Equipment section of this Manual. (See pages 22-24.)

IX. ETHICAL ISSUES IN NURSING HOME CARE

As with any aspect of professional care, the optometrist who provides services within nursing homes is expected to display the highest degree of professional conduct and regard for the overall welfare of his or her patients. Nursing home care can present a number of ethical issues in the evaluation of residents, provision of spectacles, and decisions not to treat or provide interventions. The optometrist is expected to evaluate nursing home residents only as requested by attending physicians, to follow all rules of examination and documentation set by governmental and third party agencies, and to bill charges only as appropriate.

Given the level of under utilization of eye care in nursing homes, it might be expected that provision of spectacles would constitute a large portion of nursing home practice. Decisions to prescribe spectacles or to recommend cataract surgery should be tempered by ethical decision making in regard to how beneficial the intervention is likely to be. Residents who are terminally ill or in a persistent vegetative state also represent a unique challenge. The optometrist should assist residents and their families in carefully weighing the benefits and burdens of intervening or not intervening for these individuals. Decisions regarding highly debilitated residents in nursing homes are frequently not clear cut. Seeking input from other professionals within the nursing home, family members, and the resident himself or through the resident's advanced directives can make the process easier. Residents have the legal right and should participate in treatment decisions to the extent that they are able. Foremost in the evaluation of each individual should be the question, "**Am I improving this resident's quality of life?**"

X. INSTRUMENTS AND EQUIPMENT

A. BASIC INSTRUMENTS AND EQUIPMENT FOR NURSING HOME PRACTICE

The key issue in determining the type of equipment needed for a nursing home examination is whether an examining room will be set up in the facility or not. This will depend upon a variety of factors including the size of the facility, frequency of optometry visits, available space, and the type of residents to be seen. Many nursing home patients will be seen in wheelchairs, geri-chairs, or in their own beds, making the setting up of a lane impractical. More often than not the optometrist will be called on to do evaluations in space allocated for another purpose. Spaces may include areas such as dining halls, recreation rooms, offices, beauty parlors, and dental examination areas. Under such circumstances, flexibility is the key. This usually means bringing portable equipment from the optometrist's office to the nursing home. The equipment needed is essentially the same as required for providing hospital 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. A list of possible equipment needed for nursing home service is found below. It is best to remember the golden rule of out-of-office care: "if you think you might need it, bring it with you."

Suggested Equipment for Out-of-Office Examinations:

Distance visual acuity charts (including low vision charts)

Near visual acuity charts

Standard hand-held equipment (occluder paddle, fixation targets, penlights, etc.)

Retinoscope

Retinoscopy lens rack

Refracting instrumentation (trial frame and lenses, Halberg clips, Jackson cross cylinder, Perlstein flip cylinder, etc.)

Direct ophthalmoscope

Binocular indirect ophthalmoscope

Condensing lenses

Hand-held slit lamp

Hand-held tonometer

Hand-held lensometer

Pharmaceutical agents

Small surgical kit (cilia forceps, lid speculum, etc.)

Frames for selection and dispensing/adjusting/repair equipment

Black out drapes, extension cords, outlet adapters

B. OTHER INSTRUMENTS AND EQUIPMENT

Amsler grid

Color vision test

Hand-held autorefractor

Hand-held keratometer

Hand-held fundus camera

Foreign body removal kit

Interferometer

Exophthalmometer

Suggested Low Vision Equipment*

NOTE: This would be a starting list of recommended devices. Depending on the setting, you might need a more extensive inventory, or a much less extensive inventory. The goal is to have an adequate assortment of the various categories of devices, without being "overloaded."

Trial lens and frame set (the most important piece of testing equipment)

Prism readers

Binocular microscopes: +12, +16, +20, 6X (+24), 8X (+32), 10X (+40)

Hand-held magnifiers (illuminated or non-illuminated)

+5

+7

+8 large lens

+8 small lens

+12 large lens

+12 small lens

+16

+20

+24

+32

+40

Stand magnifiers

Plano-convex ("dome") magnifier

Non-illuminated: 3X, 4X, 8X, 10X

Illuminated: 3X, 4X, 5X, 6X, 10X

Illuminated handles: regular bulb, halogen bulb

Telescopes

2.5X clip-on

2.5X head-mounted

4X hand-held

4X head-mounted

Fitover sunfilters

Medium gray

Dark gray

Medium amber

Yellow

Floor lamp - incandescent - gooseneck style

Lap desk

Non-optical devices (e.g., typoscopes, talking watch, signature guide, felt tip pen, bold lined paper)

* This list was produced by Roy Cole, O.D., Paul Freeman, O.D., and Jay Cohen, O.D.

XI. THE NURSING HOME RESIDENT EVALUATION

The approach to a nursing home resident evaluation must be one of flexibility. The examination of the nursing home resident who is primarily physically disabled may be no different than the examination of any other older adult. The evaluation of the cognitively impaired resident requires much the same approach as the evaluation of the very young pediatric patient (i.e., getting the most important information in the least time possible). Cognitively impaired residents will have good and bad days. If the exam is on a bad day, pressing the issue and agitating both the optometrist and the resident are counterproductive. Reschedule, and, if necessary, request that the resident be sedated prior to the visit.

Goals to consider should be:

1. Update the nursing home staff on the functional status of the resident, keeping in mind that statements such as "compound myopic astigmatism" is going to mean little to the staff. Chart notes that will be meaningful to the staff such as "will benefit from spectacles, needs to wear full time."
2. Review the resident's MDS to make sure the visual status is accurate and, if not, suggest modifications. Review the care plan for vision and suggest modifications based on examination findings.
3. Identify if vision can be improved with optical devices and, equally important, if optical devices are justified given the resident's cognitive status. (See IX. Ethical Issues in Nursing Home Care)
4. Treat active eye disease as far as is feasible on site and within the scope of optometric licensure.
5. Identify and ameliorate ocular inflammation and pain.

The following is a suggested examination protocol:

- o History, predominantly from medical chart including all pertinent medical history categories
(subjective history of present illness should be taken within the resident's capacity to respond)
- o Visual acuity
- o Cover test, pupils, extraocular motility (if possible), near point of convergence
- o Anterior segment assessment
- o Intraocular pressures
- o Pupillary dilation
- o Dry or wet retinoscopy
- o Refraction
- o Visual field assessment
- o Posterior segment assessment
- o Charting

XII. NURSING HOME RECORDS AND FORMS

A. NURSING HOME RECORDS

Records of nursing home residents are typically maintained in top or side bound plastic-ring file folders. They will be found at nursing stations throughout the facility. The resident's name, room number, and ID are usually found on the end section of the folder. The top cover of the folder will list any alerts associated with the resident. These alerts might include: name alert (two persons on the same ward with same/similar names); specific drug allergy alert; infectious disease alert (TB, Hepatitis A, HIV positive); or infection control precautions (methacillin resistant staph aureus).

The nursing home record is divided into numerous sections. All appropriate sections should be reviewed prior to the evaluation of the resident so that the current status may be determined. The record typically will include the following sections:

1. **Demographic Data.** This section includes typical identifying information in addition to insurance information.
2. **Admitting History.** This section will include the initial physical evaluation (why the resident was admitted), and his or her previous medical history. It will often contain information on hospitalizations prior to admission, particularly if the nursing home and hospital are in an affiliated network.
3. **Advanced Directives.** This section will include information on issues such as code status (full code vs. no code), designated types of care procedures to be done (e.g., no artificial ventilation, no heroic measures, no elective surgery). It is important to be aware of the code status in the unlikely event of a cardiac arrest during the course of an optometric examination.

4. **Care Plan/MDS/RAP.** Contains the MDS document(s) and any care plan generated by the MDS/RAP process. This is a critical part of the chart to review.

5. **Physician Orders.** This section is essentially the prescription pad within the record. Medications being ordered, requests for laboratory and other tests, dietary, and other action items (e.g., needs dilated eye exam) will be charted in this section. Medications administered to the resident will be listed in this section and may be different from those in the admitting history. Physicians' orders are frequently preprinted with updates handwritten. Physicians' orders are typically reviewed every 1-3 months to assure that medications to be taken on a limited time basis are not administered inappropriately.

6. **Physician's Progress Notes.** This section contains the attending physician's examination notes for the resident. Many facilities may request the optometrist's charting be done in this section of the chart.

7. **Nursing Notes.** This section contains the nurses' charting of their interactions with the resident. It will often include information on when new complaints were first noticed by nursing staff (e.g., resident has red eye, complains of blurred vision).

8. **Laboratory.** This section will contain reports generated by laboratory testing.

9. **Social Service.** This section contains the social worker's evaluations of the resident's interactions with staff, other residents, and family members.

10. **Consultations.** This section will contain notes from examinations done by nonstaff physicians. Specialty evaluations done in physicians' offices (e.g., optometry and ophthalmology) will often appear in this section.

Charting procedures can vary somewhat from nursing home to nursing home. It may be helpful to discuss charting issues with the medical records department shortly after getting approval to see nursing home residents. In most cases, the optometrist will chart within the progress notes or consultation section.

B. FORMS

Nursing homes may have specific preprinted consultation forms that are to be filled out and placed within the consultation section of the record. In other cases, a physician's progress note page of the record can be used. Notes from the examination or procedure performed must be kept in the resident's record. A copy of the examination form should be retained for files in the optometrist's office. Many facilities have two-sheet, auto-carbon consult forms which can alleviate the need for making photocopy duplicates.

An examination finding, request for action (e.g., resident needs a laboratory test), or a procedure performed that needs immediate attention should follow nursing facility procedure for identifying records requiring urgent action. One common way this is done is by folding the examination form so that a portion sticks out of the medical record. The charge nurse, unit secretary, or medical records personnel can give specific procedures used within the facility.

If medications are to be ordered, the optometrist should chart this in the physician's orders section. Again, this should be charted so that it is brought to the nurse's and attending physician's attention.

XIII. CODING AND BILLING

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 Physicians' Current Procedural Terminology (CPT) of the American Medical Association. The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is the basis of diagnosis coding. Individuals should familiarize themselves with these publications in their entirety before beginning to use them. The explanations that follow are intended to explain specific nursing facility coding issues. Please refer to copies of CPT and ICD-9-CM manuals for a complete explanation of these coding systems. ^{*12}

A. EVALUATION AND MANAGEMENT (E/M) SERVICES

Subsequent Nursing Facility Care Evaluation and Management (E/M) Service codes may be used for services rendered by optometrists in a nursing facility 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 optometrist/resident encounter. Nursing Facility E/M codes are classified in three levels of care, with the appropriate classification dependent on very specific criteria involving history, examination, and medical decision making. The record must document these components to justify the code selection.

* 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 record keeping procedures must be followed to document utilization of selected codes.

Proper identification of place of service, dates of service, and referring physician UPIN numbers must accompany the claim for proper reimbursement.

Comprehensive Nursing Facility Assessments E/M codes may not be used by optometrists. These codes are reserved for the admitting physician. Office or Other Outpatient Service E/M codes are not to be used if services are performed in the nursing facility itself.

E/M codes for nursing facility practice include nursing facility inpatient services and consultations (Table 1).¹⁷

Table 1
EVALUATION AND MANAGEMENT SERVICE CODES

<u>Category of Service</u>	<u>CPT Code</u>
Nursing Facility Services	
Subsequent Nursing Facility Care, New or Established Patient	99311-99313
Consultations	
Initial Inpatient Consultations	99251-99255
Follow-up Inpatient Consultations	99261-99263
Confirmatory Consultations	99271-99275

Consultations are services provided by an optometrist whose opinion or advice regarding a specific problem is requested by a physician or appropriate source. The request must be documented in the resident'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 resident'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. Consultation codes are subject to intense scrutiny by local Medicare claims processing companies. Optometrists should take special care to assure that all necessary documentation for the use of consultation codes is being met. It is advisable to seek explicit clarification of when these codes are appropriate from your carrier.

Confirmatory consultations are used to report services provided to residents 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 nursing facility. Five levels of care are recognized in this subcategory.

B. OPTHALMOLOGICAL SERVICES

General Ophthalmological Services codes are also appropriate codes for reporting services provided in long term care facilities. Place of service, of course, must be identified. Special Ophthalmological Services codes (e.g., refraction, gonioscopy, visual fields, serial tonometry services/procedures) may be used, subject to the rules associated with CPT and, for Medicare, the correct Coding Initiative.

Ophthalmoscopy, other specialized services, contact lens and spectacle services, and appropriate surgical codes may also be used (Table 2).¹² A complete listing of these services may be found in the CPT manual and in Codes for Optometry (published by the American Optometric Association) which includes the CPT minibook containing codes for ophthalmology.

Table 2

<u>Service</u>	OPHTHALMOLOGICAL SERVICES	<u>CPT Code</u>
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 payor. This may vary from payor to payor and from region to region. Relative value units (RVUs) are specific to services. Table 3 contains RVUs for some commonly performed nursing facility services.^{12,17} 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.

Table 3

**RELATIVE VALUE UNITS FOR NURSING FACILITY SERVICES
(* EXAMPLE)**

<u>CPT E/M Codes</u>	<u>RVUs</u>
Subsequent Nursing Facility Care	
99311	0.97
99312	1.44
99313	1.92
Initial Inpatient Consultation	
99251	1.41
99252	2.17
99253	2.87
Follow-up Inpatient Consultations	
99261	0.78
99262	1.35
99263	1.98
Confirmatory Consultation	
99271	1.10
99272	1.64
99273	2.32
Intermediate Ophthalmology	
92002	1.39
92012	1.13
Comprehensive Ophthalmology	
92004	2.26
92014	1.66
Extended Ophthalmoscopy	
92225	0.85
Foreign Body Removal Corneal, with slit lamp	
65222	1.53

* **Relative value units, representing the amount of work, overhead expenses, and malpractice costs, vary from locale to locale and change yearly. Please refer to your area's physician's fee schedule for detailed information.¹⁷**

XIV. SUMMARY

The aging of the population in the United States is resulting in an explosion of growth in the nursing home population. This growth will continue well into the next millennium. The visual and eye health care needs of the nursing home population represent a tremendous challenge. Unfortunately, too few residents ever receive the eye care they need. Nursing home care can be very satisfying for the practitioner and provide improved quality of life for a group of persons in need of optometry's unique services. While the delivery of care outside the office has become easier with an array of portable equipment now available, the administrative aspects of services within long term care facilities have grown increasingly complex. This Manual is intended to serve only as an overview of nursing home care. Rules and regulations concerning provision of services in long term care facilities are constantly changing. Optometrists are strongly encouraged to seek out local regulations concerning provisions of services in these facilities. State optometric association committees on nursing home care and third party payors can be extremely helpful.

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XVII. APPENDIX

Appendix A: General Public Fact Sheet Optometry and Nursing Homes

Appendix B: Fact Sheet for Nursing Home Administrators

Appendix C: Minimum Data Set (MDS)

Appendix D: Resident Assessment Protocols for Vision (RAP)

Appendix E: Examples of Care Plans Involving Vision

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APPENDIX C: MINIMUM DATA SET (MDS)