OPTOMETRIC CARE OF NURSING HOME RESIDENTS

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The American Optometric Association’s manual, Optometric Care of Nursing Home Residents is meant to be helpful to optometrists in caring for nursing home patients and in seeking nursing home care access. This manual does not guarantee that access to patients will be granted, nor does it define scope of practice in every nursing home setting. Each facility sets their own criteria for privileging and/or physician access and optometric scope of practice laws will differ from state to state.

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FOREWORD

The older adult population in the U.S. has increased more than 9-fold in the 20th Century, and the age group ≥65 years will increase 89% over the next 20 years; those ≥85 years will grow 74% during the same period (16). These values translate to 70 million Americans age ≥65 years and 8.5 million ≥85 years by 2030. At current nursing home (NH) usage rates, these population increases will approximately double the current number of residents requiring NH care (17) 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.

A recent survey indicates that, among nursing home residents age 65 and older, 27 % have vision impairment. 2 The primary care optometrist plays 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 with 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 are 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.

I. DEMOGRAPHICS OF VISION CARE IN NURSING HOMES

“Never before have so many people lived for so long. Life expectancy has nearly doubled over the last century, and today there are 35 million Americans age 65 and older. The aging of the population – in past decades and in the foreseeable future – presents a challenge and an opportunity.” Richard J. Hodes, MD
Director, National Institute on Aging

The 21st Century will bring significant challenges to health care providers to accommodate the growing needs of the aging baby boomer population. It is anticipated that 51.6 million people will be age 65 or older by 2030 (U.S. Population Age 65 and Over, 2005)[i] In the past century, the population of elderly in the U.S. has tripled, and more than 60% of those people 65 and older can expect to live to their mid-80’s[ii] By 2050,there will be a rapid growth of elderly people in the United States. It is anticipated that 88.5 million people will be age 65 or older by 2050. Therefore we can expect the population to double the 40.2 million that was projected in 2010. 3

On an average day, nearly four percent of the US population (1.6 million Americans) is residing in a nursing home. In 2020, 12 million Americans will need long-term care. Visual impairment represents one of the most common disabilities among nursing home residents. It is also one of the most unrecognized disabilities by nursing home staffs. 4 Visual impairment amongst nursing home residents is 13-15 times higher than community dwelling older adults. Regrettably, more than half of nursing home residents receive no eye care, even though the facility has contracted eye care services. National surveys show that only one in eight nursing homes in the United States have optometric services on-site. It is mandated that ―the facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity...including

vision. However, 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 or if an known ocular disease process is present. The current system of identifying residents in need of vision care services is woefully inadequate. The criteria for provision of eye care are typically based on the patient complaining of a vision ailment, or the family requesting the 2 service. Since most catastrophic vision loss has no signs or symptoms the patient and family refuse care if it is offered. There is currently no consideration for prevention and early treatment, so the patient is exposed to much higher risk for potential visual loss.

A. EYE CONDITIONS COMMONLY ENCOUNTERED IN NURSING HOMES:

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 U. S. nursing home population is far in excess of what would be predicted simply based upon age. 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.5 Cataract prevalence is expected to increase to 30.1 million within the next decade. The prevalence of open-angle glaucoma is predicted to increase by 50 percent, or approximately 3.36 million by 2020. Glaucoma is a crucial example of the importance of nursing home resident eye exams – it is anticipated that approximately 50 percent of patients with glaucoma will suffer unnecessary vision loss because the patient has no symptoms and they or their family decline care. Approximately 4.1 million U.S. adults (3.4 percent) suffer from diabetic retinopathy and exhibit no clinical signs or symptoms of vision loss. It is well documented that early diagnosis of diabetic retinopathy, through dilated fundus examinations, would identify patients who are at highest risk and might most benefit from proactive therapy. Age-related macular degeneration (AMD) is the fourth most prevalent eye diseases affecting nursing home residents. Its prevalence is approximately 1.47 percent of the U.S. population over age 40 or 1.75 million individuals, and this number is expected to increase to three million individuals by 2020.

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. Residents with low vision have been shown to have greater difficulty in transfer ability, washing the upper and lower body, and self-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 levels4 . In the presence of what is assumed to be adequate visual acuity, the nursing home staff 4 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 after a careful comprehensive eye examination and the prescription of appropriate visual appliances or training. Dependence resulting from severe impairment of vision may contribute significantly to the cost of long term care. 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; 6 and alternative interventions may not only increase independence for the individual but also may reduce the financial burden on society.
A 2015 study estimated that approximately 3.2 million adults in the U.S. suffered vision impairment and 1.2 million blindness (26) . Vision problems were estimated to cost $145 billion annually in 2014. (27) Vision impairment and blindness are associated with significantly increased costs for medical care, and if informal care and diminished health are considered, the aggregate economic impact of vision loss is $5.5 billion for home care patients (28) and, with increased prevalence of vision loss in nursing homes, this financial burden is even larger (12). Approximately 75% of blindness in the world population can be

treated or prevented. Prevalence and trends of disease can be managed and interventional strategies introduced and implemented (29). Vision impairment has been associated with increased prevalence of chronic diseases, depression, and social isolation. Prior studies have suggested mechanisms by which vision impairment lead to increased physical disability, reduced mental well-being, anxiety and severe depressive symptoms described by Frank and Owsley (30, 31) or overall mortality (3, 4). Approximately 85% of nursing home residents are age ≥65 years and older and 16.5% of those experience falls. (20) There are significant costs ($19 billion with non-fatal falls) associated with fall related injuries among older adults. More than 46% of adults aged ≥65 years with severe vision impairment experienced falls, compared with 27.7% of those without severe vision impairment. (5, 32) An effective interventional strategy, such as careful vision analysis combined with modified environmental risk factor interventions (33) may have an appreciable impact on the incidence and healthcare costs associated with falls, potentially decreasing the incidence and healthcare costs of these injuries(34).

50% of nursing home residents were diagnosed with Alzheimer's disease or related dementias (ADRD). Both vision and hearing impairments have been associated with greater likelihood of cognitive impairments and dementia (3, 35, 36). Therefore, it is essential to identify sensory variables that may influence cognition with sufficient granularity to predict future cognitive performance and that may be amenable to early detection and treatment critical to care planning and resident centered care. (37)

These issues and many others are addressed in the context of this manual.

II. OVERVIEW OF NURSING HOME FACILITIES

"Nursing homes are sad, scary places to most of us. They often inspire shame -- potential residents may be embarrassed by impairments or illnesses that render them unable to care for themselves, family members might feel guilty about their inability to take care of a loved one, and even grandchildren along for a visit may be uncomfortable about their youth in the midst of all this aging. It's the last resort, and sometimes, the last stop, in housing options" -Molly Edmonds.

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 the first two - 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 6 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, and 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. 7

B. STATISTICS

There are approximately 1.7 million licensed beds in the 15,600 nursing homes in the U.S., with 90% of nursing home residents requiring assistance with activities of daily living (ADL). (1, 2)The majority of these nursing homes are small (under 100 beds) and are run as-for-profit institutions. There are between 1.5 and two 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.2 As the population in the United States ages, tremendous growth will be seen in the nursing home population.

At any given point in time at least four percent (1.6 million Americans) of the population over the age of 65 resides in a nursing home9 . 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, and individuals with schizophrenia have nearly four times the likelihood of being institutionalized in nursing homes. 4,10 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.11

Nursing home residents can roughly be divided into two groups based on length of stay; those that reside longer than six months and those who stay less than six months.12 The median length of time spent in nursing homes in the United States is approximately six months; however, about 21 percent stay more than 5 years.6,11-13 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 six 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. 8

Nursing home care is paid for largely through two federal programs, Medicare and Medicaid. Medicare is a federal program affiliated with social security and Medicaid is a joint federal and state program. 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. Medicaid eligible patient’s have common characteristics, such as the elderly or disabled, and those who meet certain financial requirements,e.g. income and assets below certain minimum levels. There are many different eligibility groups in the Medicaid program, and each has its own requirements. Medicare is available to those recipients aged 65 and

older, regardless of income. 14 Medicaid policies differ by state (Affordable Care Act's Medicaid changes (2014) to states' programs). 15 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.11The governing body or those empowered to act as the governing bodies 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 9 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 wellbeing 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 10 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. 11

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. The 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. There is also increasing involvement by Physician Assistant's and Nurse Practitioner's in nursing homes. These health care providers currently play active roles in the delivery of health care to residents in nursing homes. 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. 12

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, audiology, 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) 13

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 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.
The initial contact with a local nursing home administrator should always be by personal phone call, 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. This initial contact would be followed by a letter that includes the paperwork (license, malpractice insurance) required by that facility. 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; and the next step involves arranging a face-to-face meeting with the administrator, medical director, director of nursing and social worker. 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 14 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 the nursing home vision program is started, it is wise to periodically review the agreement with the nursing home and to meet with the appropriate 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 http://www.aoa.org/optometrists/tools-and-resources/clinical-care-publications/hospital-andnursing-facility-practice.] 15

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 Centers for Medicare & Medicaid Services (CMS). In response to reports of widespread neglect and abuse in nursing homes, in 1987, Congress enacted a major policy 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..."16

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: 17

- The facility's compliance with residents' rights
- The accuracy of the residents' comprehensive assessments and the adequacy of care plans based on these assessments 16
- 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 . The current updates are available under Title 42, Public Health Part 483. (Found at: http://www.gpo.gov/fdsys/pkg/CFR-2013-title42-vol5/pdf/CFR-2013-title42-vol5-part483.pdf) 18

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 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. For example, California nursing home care and services are regulated under Title 22 of the California Code of Regulations19 (Found at: www.ccld.ca.gov pg .htm).

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) 17

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 found at: http://www.socialsecurity.gov/OP_Home/comp2/F100-203.html Section 4211 mandated a national assessment system for evaluating all residents in nursing facilities in the United States. To the present day, 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 (PASRR) 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.20 The MDS, now in its third 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. The Vision subsection categorizes visual acuity (VA) into one of four levels based on reading criteria. Descriptors directly from the MDS are as follows: 18

- Grade 0— adequate, sees fine detail, including regular print in newspapers/books
- Grade 1— impaired, sees large print but not regular print in newspapers/books.
- Grade 2— Moderately impaired, limited vision, not able to see newspaper headlines but appears to follow objects
- Grade 3— Highly impaired, object identification in question, but eyes appear to follow objects
- Grade 4— severely impaired, no vision or appears to see only lights, colors or shapes.

Visual Limitation and Difficulties are divided into three categories. 21

a. Glaucoma
b. Cataracts
c. Macular degeneration

Assessment of visual fields and impact on mobility have been eliminated as categories. Visual Appliances subsection was also eliminated in MDS 3.0.

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. 19 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.

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 contractor 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 contractor 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 20 equally important. Interpretations of federal statutes by regional Medicare contractors 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 payers. Interpretation of these guidelines may also cover the ability to access residents even when third party payers are not involved. Individual Medicare carriers are responsible for applying these guidelines to providers in their area. The importance of knowing local third party payer 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 non-covered 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. Managed care organizations (MCOs) 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 contractors, 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 contactors 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. 21

The contractor 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.

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

- Documentation of the attending physician's order for the clinical problem identifies the need of a comprehensive vision examination in the nursing home record, as well as accurate optometric record documentation, is critical in complying with these policies.22 22

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.16 The primary physician retains the overall responsibility for the coordination and direction of the resident's care. 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. 23

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. 24

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.
Falls are a high priority concern in nursing homes. The incidence of falls and fall-related injuries increase steadily in the elderly. Incidence rate for falls in nursing home residents is two to three times greater than that in community-dwelling elderly (about 1.7 falls per bed annually). Ten to 25% of falls among institutionalized elderly result in a fracture, laceration, or need for hospital care[iii]. It is mandatory by regulatory guidelines that each nursing home resident receive a comprehensive assessment, a Minimum Data Set (MDS) is generated, and this

process must be completed within 14 days of the patient admission to a nursing home. There are key indicators on the MDS that indicate a resident's risk of falling. When the MDS is completed, a resident who has one or more of these key indicators, also known as triggers, will prompt a falls Resident Assessment Protocol (RAP). Tools like the RAP may provide clues to possible causes of falls. However, the patient may already have developed high risk profiles and the RAP may be too late to be used as an effective preventative tool for some residents who are at increased risk for falling from the time of admission.

It is crucial that interdisciplinary teams of health care and multicultural team builders be created to provide residents at high risk of falling optimal diagnostic and preventative assessments. An educational effort to bridge the the health care disciplines is the Downstate Team-Building initiative by State University of New York, Downstate Medical Center. Seven health care disciplines participated and the goal was to create a interdisciplinary team-building model for patient care that has a broader impact on delivery of patient care[iv]Many nursing facilities have taken the initiative and are creating fall committees composed of interdisciplinary teams. Optometry participation in the fall committees is a wonderful way to demonstrate how are skills can be applied beyond the parochial administration of eye exams, treatment and provision of spectacles and management of organic problems amongst the resident population. The committee is a vehicle for interdisciplinary communication and an opportunity for proactive analysis of potential risk factors for falls and to identify possible interventions to minimize the risk of falling and fall-related injuries. In addition, the team performs ongoing treatment evaluation to determine the effectiveness of the the individualized fall prevention programs for each resident. The treatment effectiveness is monitored, resident response is documented and interventions implemented. Falls are a vehicle for the optometrist to demonstrate that, through interdisciplinary communication and cooperation amongst heatlh care providers, falls may reduced, resident mobility be improved for residents in a manner that is more effective than care by individual disciplines independently.

Optometrist's also play a crucial role in nursing homes through participation in Alzeimer disease multidisciplinary teams. They make critical contributions in the diagnosis, treatment and management of Alzeimer's disease[v] Optometrist's in nursing homes play an important role in the provisioneye of eye care services to the terminally ill through cooperation with Hospice. Hopsice focuses on the palliation of terminally ill patients' symptoms, thereby improving the quality of their remaining life. For optometry, this includes any acute or chronic ocular condition that may induce pain, or may simply be the provision of an optical correction that allows the patient to see more efficiently to help them enjoy reading, tv, or seeing family faces in their final days.

Many facilities have newsletters that go to not only the residents but their families as well. Timely articles about from the health care "team" at the facility (including optometry, medical director, physical therapy, social worker, etc.) demonstrates their holistic concern for each resident's independence and dignity, and reflects positively on the professionalism and compassion of the facility.,

As a consultant, the optometrist may be asked to present lectures or in-service 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. 27

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. Only 12.5 percent of all United States nursing facilities provide in-house eye care for their residents Studies show that few residents of nursing homes ever receive eye care. One study detailed that medical records showed no record of or reference to an eye examination for 66 percent of enrollees despite 90 percent having health insurance.26

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 the 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. 28

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 (section B1000). The nursing facility staff should be made aware that a recent study showed that for residents who were rated on the MDS as having adequate vision, 45.9 percent had distance acuity worse than 20/40 in the better eye, 72.8 percent had near acuity worse than 20/40 in the better eye, and 85.8 percent had contrast sensitivity less than 1.50.27

The MDS can also trigger an optometric referral for other important criteria such as; cataracts, glaucoma, macular degeneration (Section I6500) and diabetes (section I2900). However, the MDS typically does not trigger evaluation for other previously diagnosed ocular diseases, the presence of an intraocular lens implant, or when the patient is on high risk medications such as corticosteroid and plaquenil. 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. 29

B. REASSESSMENT OF ESTABLISHED RESIDENTS

Once a system has been established to identify a new resident's need for eye 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 available 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. Studies show that among nursing home residents, 13.8 to 32.5 percent have been found to have cataracts, 4.6 to 9.3 percent have macular degeneration and 2.7 to 8.2 percent have glaucoma.26,28

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 30 all age groups. Proper correction can improve the visual acuities significantly. A complete eye exam can show marked improvement for residents. One study showed nearly 20 percent of 102 nursing home residents binocular visual acuity improved with at least one line on the Snellen Chart by adjustment of refraction error.29 While another study revealed that residents that had refractive error corrected had higher scores on the Nursing Home Vision-Targeted Health-Related Quality-of-Life Questionnaire subscales of general vision, reading, psychological distress, activities and hobbies, and social interaction (all $P< .04$) and the VF-14 ($P < .001$); as well as fewer depressive symptoms on the Geriatric Depression Scale ($P= .003$), adjusting for mental status and baseline outcome variables30

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. 31

E. SUPERVISION OF OPTICAL SERVICES

The vast majority of nursing home residents will not have had a vision examination many years. It is suggested that visual impairment can be significantly reduced by the provision of appropriate optical

devices.[34,35] 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. [32]

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. [33]

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 36-37.) 34

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 underutilization 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?" 35

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, fundus cameras, 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." 36

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
- Prism rack

- Refracting instrumentation (trial frame and lenses, Halberg clips, Jackson cross cylinder, etc.)
- Direct ophthalmoscope
- Binocular indirect ophthalmoscope
- Condensing lenses
- Hand-held slit lamp
- Hand-held tonometer
- Portable lensometer
- Hand-held auto refractor
- Pharmaceutical agents
- Hand sanitizer, alcohol wipes, etc.
- Small surgical kit (cilia forceps, lid speculum, etc.)
- Frames for selection and dispensing/adjusting/repair equipment
- Black out drapes, extension cords, outlet adapters 3

B. OTHER INSTRUMENTS AND EQUIPMENT TO CONSIDER
- Amsler grid
- Color vision test
- Hand-held keratometer
- Hand-held fundus camera
- Foreign body removal kit
- Interferometer
- Exophthalmometer
- Pachymeter
- A/B Scan 38

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 (+6, +8, +10)
- Binocular microscopes: +12, +16, +20, 6X (+24), 8X (+32), 10X (+40)
- Monocular Microscopes: +16, +20, 6X (+24)
- 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 (only if using Eschenbach Products) Telescopes
- 2.5X clip-on
- 2.5X head-mounted
- 4X hand-held
- 4X head-mounted
- Fit over sun filters
- Medium gray
- Dark gray
- Medium amber
- Dark amber
- Yellow
- Floor lamp - incandescent - gooseneck style or OTT Floor Lamp
- Desk Lamp-OTT Task Lamp
- Lap desk
- Non-optical devices (e.g., typoscopes, talking watch, signature guide, felt tip pen, bold lined paper) *

This list was originally produced by Roy Cole, O.D., Paul Freeman, O.D., and Jay Cohen, O.D. *This list was edited by Harvey Richman, O.D. and Maria Richman, O.D 39

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 whether 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. 40

The following is a suggested examination protocol:

- 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)
- Visual acuity
- Cover test, pupils, extra ocular motility (if possible)
- Anterior segment assessment
- Intraocular pressures
- Pupillary dilation
- Dry or wet retinoscopy or auto refraction
- Refraction, when necessary
- Visual field assessment (confrontation fields)
- Posterior segment assessment
- Charting including clear concise assessment and plan 41

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. However, some nursing facilities are converting to electronic records and eliminating paper charts. The charts 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 may 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). These alerts may be found inside the chart if not listed on the front or inside cover of a paper chart.

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. Ensure this information is current. You may need to ask for a listing of insurance information from the business office.

2. **Admitting History / Admission / History and Physical**. 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. 42

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. (See appendix for details)

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. This section is the most accurate and up-to-date section from which to obtain the patient's current medications and treatments.

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). 43

8. Laboratory. This section will contain reports generated by laboratory testing such as the most recent Hemoglobin A1c results for diabetic patients.

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 non-staff physicians. Specialty evaluations done in physicians' offices (e.g., optometry and ophthalmology) will often appear in this section. Note that the Physician's progress note section could also contain some referral notes from outside physicians so both sections should be carefully reviewed to avoid duplication of care.

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. 44

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.

Some optometrists and other providers use special forms approved by the facility. An eye care specific form or electronic medical records printed report could be completed, signed and left with the facility to put placed in the patient's nursing facility chart. Often these provider specific forms are a color other than white – yellow or blue for example.

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. 45

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, 10th Revision, Clinical Modification (ICD-10-CM) is the basis of diagnosis coding. The current United States version of ICD-10-CM can be downloaded from the CDC website at no charge. (https://www.cdc.gov/nchs/icd/icd10cm.htm)

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-10-CM manuals for a complete explanation of these coding systems.32

Subsequent Nursing Facility Care Evaluation and Management (E/M) Service codes may be used for services rendered by optometrists in a nursing facility setting. Initial Nursing Facility Care Evaluation and Management (E/M) services are used for admission to the facility and not used in evaluations that optometrists would be performing. 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 different 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. These coding levels are similar to the Evaluation and Management code series often used in an office.
* 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.

Relative Value Units (2019)

Subsequent Nursing Facility Care	**RVUs (Facility)**	**RVUs (Non-facility)**
99307	1.24	1.24
99308	1.94	1.94
99309	2.58	2.58
99310	3.82	3.82
Inpatient Consultation		
99251	1.38	1.38
99252	2.11	2.11
99253	2.87	2.87
General Ophthalmological Codes		
92002	1.36	2.37
92004	2.81	4.26

92012	1.49	2.49
92014	2.25	3.57
Fundus Photography		
92250	1.43	1.43
Domicile, Rest Home, Custodial Care		
99324	1.56	1.56
99325	2.26	2.26
99326	3.92	3.92
99327	5.26	5.26
99328	6.19	6.19
99334	1.7	1.7
99335	2.68	2.68
99336	3.82	3.82
99337	5.47	5.47

The appropriate fee is determined by each individual optometrist. Actual reimbursement, of course, is determined by each individual third party payer. This may vary from payer to payer and from region to region. Relative value units (RVUs) are specific to services. Table three contains RVUs for some commonly performed nursing facility services.35 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.

One important piece of information that needs to be gathered at each visit is whether the patient being seen is under Medicare payment or not. The nursing facility will have to identify the patients to be seen who are covered by Medicare. Often these patients are referred to as Medicare patients or Part A patients. Medicare only covers the first 100 days for nursing facility care when certain conditions apply. During this first 100 days, the patient is under consolidated billing where the facility is responsible for paying for much of that patient's care. There are exceptions that include physician professional services. The nursing facility is NOT RESPONSIBLE for your professional fees during this period. This means that while the optometrist can bill for services provided during this 100 day period, you will be paid the Facility fees rate rather than the Non-facility fee rate. Again this only applies when that patient is under Consolidated Billing Part A Medicare.

However, if the optometrist performs any procedure while seeing a Consolidated Billing Part A Medicare patient, you can only be paid for the Professional Component of that procedure. The nursing facility is responsible for the technical component of that procedure. For example, when performing and billing for fundus photography the code would be 92250-26 for the professional component and 92250-TC for the technical component.

Another important consideration necessary when billing Medicare for services provided to any patient in a facility is the place of service code (POS) for that particular patient. Any patient under Consolidated Billing Part A Medicare, the POS should be Skilled Nursing Facility – 31. However, when seeing a patient in a nursing facility who is not under Consolidated Billing Part A Medicare the POS should be Nursing Facility – 32. And patients seen in Adult Congregate Living Facilities –Domicillary, Rest Home, Custodial Care – the POS is typically Custodial Care Facility – 33.

From the CMS website covering this topic:

In the Balanced Budget Act of 1997, Congress mandated that payment for the majority of services provided to beneficiaries in a Medicare covered SNF stay be included in a bundled prospective payment made through the Part A Medicare Administrative Contractor (MAC) to the SNF. These bundled services had to be billed by the SNF to the Part A MAC in a consolidated bill. No longer would entities that provided these services to beneficiaries in a SNF stay be able to bill separately for those services. Medicare beneficiaries can either be in a Part A covered SNF stay which includes medical services as well as room and board, or they can be in a Part B non-covered SNF stay in which the Part A benefits are exhausted, but certain medical services are still covered though room and board is not.

The consolidated billing requirement confers on the SNF the billing responsibility for the entire package of care that residents receive during a covered Part A SNF stay and physical, occupational, and speech therapy services received during a non-covered stay. Exception: There are a limited number of services specifically excluded from consolidated billing, and therefore, separately payable.

For Medicare beneficiaries in a covered Part A stay, these separately payable services include:

- physician's professional services;
- certain dialysis-related services, including covered ambulance transportation to obtain the dialysis services;
- certain ambulance services, including ambulance services that transport the beneficiary to the SNF initially, ambulance services that transport the beneficiary from the SNF at the end of the stay (other than in situations involving transfer to another SNF), and roundtrip ambulance services furnished during the stay that transport the beneficiary offsite temporarily in order to receive dialysis, or to receive certain types of intensive or emergency outpatient hospital services;
- erythropoietin for certain dialysis patients;
- certain chemotherapy drugs;
- certain chemotherapy administration services;
- radioisotope services; and
- customized prosthetic devices.

For Medicare beneficiaries in a non-covered stay, only therapy services are subject to consolidated billing. All other covered SNF services for these beneficiaries can be separately billed to and paid by the Medicare contractor.

https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html

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 payers can be extremely helpful. 51

Compliance and Nursing Home Visits

It is of the upmost importance that optometrist and other consultants in nursing facilities pay close attention to documentation and compliance issues. Completely and thoroughly document the visit, including very specific reasons for the for the visit, the reason a patient was referred for care and, when possible, an accurate chief complaint obtained from the patient. CMS and regional contractors pay particular attention to this type of patient care due to a long history of abusive visit practices and ―gang visits‖. Nursing facility patients are a ―captive audience‖. CMS understands that while there is a real medical need for this population to receive care, that abuse can and does exist. Pay particular attention to Section IV C of the manual discussing the strong recommendation and, with some carriers, requirement of obtaining an order to see any nursing facility patient. This order should be signed and dated by the attending physician and detail the specific reason(s) for the request to have the patient seen for eye care. In a recent Medicare Court of Appeals decision regarding this topic, the courts made is clear that the rules of a carrier need to be followed and that the provider documentation is vital to establishing the medical necessity for the care. 52

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XV. APPENDIX

Appendix A: General Public Fact Sheet Optometry and Nursing Homes
Appendix B: Fact Sheet for Nursing Home Administrators Appendix
Appendix C: Examples of Care Plans Involving Vision

APPENDIX A
FACTS ABOUT OPTOMETRIC NURSING HOME CARE (General Public)

Doctors of Optometry (optometrist, optometric physician, O.D.) are educated and trained in regionally and nationally accredited schools and colleges and are licensed by state boards to provide vision and eye health care.

Doctors of Optometry examine, diagnose, treat and manage disorders of the visual system, the eye, and associated structures as well as diagnose related systemic conditions. They provide services to residents of nursing facilities to improve their quality of eye and vision care, to increase their quality of life, and to assist them in attaining, maintaining, and enhancing their functional capacity.

Eye disease and vision disorders increase with age. One-fourth to one-half of nursing home residents has vision impairment. Primary causes of vision loss include cataracts, age-related macular degeneration, glaucoma, and diabetic retinopathy.

Doctors of Optometry provide treatment for residents with glaucoma, cataract, diabetic complications, stroke sequella, and other conditions that may affect the eye and vision system. They also co-manage resident care with attending physicians and other specialists.

Doctors of Optometry provide vision services to residents with healthy eyes as well as to residents who have eye disease that result in low vision.

Doctors of Optometry are vital members of the rehabilitation team. When vision conditions are properly diagnosed and managed, the resident's rehabilitation program will be more effective. This can aid in helping prevent and guard against fall prevention which is a major area of concern amongst long term care facilities.

Nursing facilities are regulated by the federal government and must comply with Medicare Requirements for Long Term Care Facilities. Under these regulations, the facilities must provide the necessary care for residents to maintain their highest practical level of function and independence. Nursing facilities are required to assist residents in obtaining eye care as needed.

Doctors of Optometry provide the expertise to assist nursing homes in maintaining compliance with these regulations. Nursing facilities must meet and comply with both federal and state regulations to receive payment from both Medicare and Medicaid. 2

APPENDIX B
FACTS ABOUT OPTOMETRIC NURSING FACILITY CARE FOR NURSING HOME ADMINISTRATORS

Doctors of Optometry (optometrist, optometric physician, O.D.) are educated and trained in regionally and nationally accredited schools and colleges and are licensed by state boards to provide vision and eye health care.

Doctors of Optometry examine, diagnose, treat and manage disorders of the visual system, the eye, and associated structures as well as diagnose related systemic conditions. They provide services to residents of nursing facilities to improve their quality of eye and vision care, to increase their quality of life, and to assist them in attaining, maintaining, and enhancing their functional capacity.

Optometrists provide more than two-thirds of the primary eye care services in the United States. They are more widely distributed geographically than other eye care providers and are readily accessible for the delivery of eye and vision care services.

Eye disease and vision disorders increase with age. One-fourth to one-half of nursing home residents has vision impairment. Primary causes of vision loss include cataracts, age-related macular degeneration, glaucoma, and diabetic retinopathy. In addition, potentially blinding conditions such as glaucoma or diabetic retinopathy may cause no symptoms until they are far advanced and the ocular damage is irreparable.

The Geriatric community needs a much more detailed and closer observation of their health compared to the younger population. As such it is recommended that eye health evaluation be maintained at much closer intervals. From age 18 to 60 exams every two years is acceptable per the American optometric association guidelines, however 61 and older need to be examined more frequently due to higher risk

factors such as system disease and increased amount of medications. Seeing these patients more frequently will ensure the early detention is maintained and the likelihood of problems arising unnoticed is at a minimum.

Doctors of Optometry provide treatment for residents with glaucoma, cataract, diabetic complications, stroke sequella, and other conditions that may affect the eye and vision system. They also co-manage resident care with attending physicians and other specialists.

Doctors of Optometry can assist health care planning teams in determining the visual needs and abilities of residents. When vision conditions are properly diagnosed and managed, the resident's rehabilitation program may be more effective. Impaired vision has been shown to be associated with decreased transfer ability, decreased self-care, and falls.

Doctors of Optometry provide vision services to residents with healthy eyes as well as to residents who have eye disease that result in low vision. Services may include provision of spectacles, medication management, specialized optical devices, and training for visual impairment.

Optometric care can be delivered within the facility through a large array of portable and handheld equipment removing the burden of transportation of the resident to a doctor's office. The use of portable equipment allows flexibility in space requirements within the facility.

Doctors of Optometry are independent health care providers whose services are covered under Medicare Part B, Medicaid, and many other forms of insurance. Optometric services are not bundled with payments to the nursing facility.

Appendix C: Examples of Care Plans Involving Vision

DEPARTMENT OF HEALTH AND HUMAN SERVICES DEPARTMENTAL APPEALS BOARD DECISION OF MEDICARE APPEALS COUNCIL

In the case of: Claim for: Lance E. Daniel, O.D. Supplementary Medical Insurance Benefits (Part B)(Appellant) **** **** (Beneficiary) (HIC Number) Pinnacle Business Solutions **** (Contractor) (ALJ Appeal Number) The Administrative Law Judge (ALJ) issued a decision dated January 22, 2009, which concerned an overpayment resulting from denial of coverage for multiple claims for physician services involving eye examinations and testing of nursing home residents. The ALJ determined that the appellant was required and failed to provide an attending physician's order for each visit with a resident and facility nursing notes documenting medical necessity for the services. The ALJ also rejected the appellant's challenges to the statistical sampling process used and determined that the appellant was liable for the services which were not covered. The appellant has asked the Medicare Appeals Council to review this action. The Council reviews the ALJ's decision de novo. 42 C.F.R. § 405.1108(a). The Council will limit its review of the ALJ's action to the exceptions raised by the party in the request forreview, unless the appellant is an unrepresented beneficiary.42 C.F.R. § 405.1112(c). As set forth below, the Council reverses as to 19 of the 63 claims at issue, while 44 claims continue to be denied. The contractor will need to recalculate the overpayment amount to account for the percentage of the sample cases now determined to be covered. 8 DISCUSSION At issue on appeal are 63 claims each representing a single visit by the appellant with a beneficiary between January 1, 2003 and December 1, 2004. The beneficiaries were all residents of nursing facilities and their examinations were performed in a licensed mobile unit operated by the appellant. The claims were among those included in a statistical sampling review resulting an overpayment finding. The ALJ determined that none of the claims was covered and that the statistical sampling process used a reliable methodology, and found the appellant liable for the overpayment. ALJ Decision at 6-8. In requesting Council review, the appellant argues that: documentation based on the absence of nursing facility records and attending physician orders while failing to issue requested subpoenas to allow the appellant to obtain access to the confidential records. where the appellant himself was a "treating physician" entitled to deference in evaluating medical necessity. Furthermore, beneficiaries have a right to optometric services "when presenting complaints or other symptoms

ofconcern" regardless of their living situation. pplemental documentation which contained additional physician orders and nursing facility records that the appellant was able to obtain which he admitted into the record, even though the ALJ found good cause to admit the supplemental documentation into the record. the underlying data is flawed. Request for Review, Attachment B (RR) at 1-2. Below, we first consider what the applicable legal standards require as documentation of medical necessity for the provisions of services by optometrists to nursing facility residents. Next, we apply those standards de novo to the documentation in the record for the 63 claims. We then address the appellant's 3 9 assertions that he was entitled to issuance of subpoenas and that the extrapolation was improper. 1. The correct legal standard for documentation of optometric physician services to nursing facility residents requires referral/order from attending physician and evidence of need for nonroutine examination or tests. Medicare Part B pays for physicians' services, including iagnosis and consultation, when provided by a "doctor of optometry" acting within the scope of his license. 1 42 C.F.R. §410.20(a) and (b)(4). Covered services by doctors of optometry are limited to those authorized in the relevant state and listed in section 1861(s) of the Act and section 410.10 of the regulations. 42 C.F.R. § 410.22. Section 415.102 provides, in relevant part, that physicians may be paid on a fee schedule basis for services furnished to beneficiaries in providers(which would include nursing facilities) so long as the services are "personally furnished for an individual beneficiary by a physician," "contribute directly to the diagnosis or treatmentof an individual beneficiary," and "ordinarily require performance by a physician." 42 C.F.R. § 415.102 (a). Furthermore, the Medicare Benefit Policy Manual (MBPM), Chapter 250 states that physicians' services are covered under Part B,when provided to a nursing facility resident, even though the patient has Part A coverage for the facility stay. The ALJ concluded that the appellant failed to provide the requisite documentation to support any of the challenged claims. ALJ Decision at 6. The ALJ decision rests on the following two legal conclusions: diagnostic tests based on a signed prescription with a diagnosis, there must be an order from the attending physician in order for an outside physician to render services to a resident in a nursing home." nursing notes alone although the appellant argues that it does [sic]." 1 It is not disputed that the services at issue were provided within the scopeof the appellant's license, which appears consistent with the version of therules of the Arkansas State Board of Optometry in the record. Ex. D at 65;Ex. E at 151-82. 10 4 ALJ Decision at 6 (citations omitted). The only authorities cited for these legal assertions are the Medicare Program Integrity Manual (MPIM), Chapter 13, Section 13.5.1 and a December 2000 contractor newsletter. 2 The MPIM section discusses what a local coverage determination should contain, which may include a description of circumstances under which services will be considered reasonable and necessary (absent a statutory exception from the reasonable and necessary requirement). Nothing in the section provides any information as to whether an outside physician requires an order from an attending physician to treat a nursing home resident or whether nursing notes are required to establish medical necessity for diagnostic tests. The requirement that an optometric physician providing services to nursing home residents must do so pursuant to an order from the residents' attending physician, on which the ALJ relied to deny all the claims across the board, is derived from the local contractor newsletter article published in December 2000. The article requires that, when requested to document "the medical necessity of a nursing home visit performed by someone other than the attending physician," a provider is requested to submit a signed, dated written request for the specialist visit (and nursing notes if the reason for the visit is not clear in the physician's order) along with the specialist's own documentation of the services performed. Ex. E, at 138. (Medicare News, MCB2000-06, December 2000). The rationale for this requirement is to ensure that services of optometrists (along with other healthcare providers such as podiatrists or clinical social workers) are "a reaction to a stated or suspected problem, not in response to routine screening practices." Id. 2 ALJ quoted and cited numerous other statutory and regulatory provisions inthe legal framework section of his decision, but nowhere explained the relevance of most of them to the dispute before him. He cited 42 C.F.R. § 424.24 in setting out requirements for medical and other services furnished by providers under Part B. ALJ Decision at 5. Section 424.24 addresses certification requirements. Physicians are to play "a major role in determining utilization of health services furnished by providers" and, to that end, must order tests and treatments and certify medical necessity. 42 C.F.R. § 424.10(a). Coverage of Part B provider services requires a certification of medical

necessity by a physician. 42 C.F.R. § 424.24(b)(g). Physicians who furnish items or services under Medicare, including "doctors of optometry" acting within the scope of their licenses, however, are considered "suppliers" and not "providers of service." Sections 1861(d),1861(r), and 1861(u) of the Act. The regulatory provision for physiciancertification of the medical necessity of services furnished by a providerunder Part B does not apply to services furnished by a doctor of optometry orother specialty physician services. 11 The article's concern reflects Medicare's restrictions on routine testing in general and on eye care in particular. Thus, section 411.15 of the Medicare regulations excludes from coverage routine physical checkups including examinations not performed to treat or diagnose specific illness, symptoms, complaints or injuries in general. 42 C.F.R. § 411.15(a).Furthermore, in particular, coverage is excluded for eyeglasses or contact lenses (except prostheses for those lacking a lens either congenitally or post-surgically and one pair after a cataract surgery) and eye examinations "for the purpose of prescribing, fitting or changing eyeglasses or contact lenses for refractive error only" and any refractive procedures even "in connection with otherwise covered diagnosis or treatment of illness or injury." 42 C.F.R. § 411.15(b) and (c). 3 The requirement for an order from the attending physician, who is required to be familiar with the resident's overall plan of care, also ensures that the services are not duplicative and do not conflict with other medical conditions of the resident or services already being provided. The article goes further, however, to state that the premise that medical necessity requires a showing of "an identifiable relationship" between a nursing home resident's attending physician and any other Part B provider furnishing services "constitutes no more or no less than the requirements found in" 42 C.F.R. § 483.40. This assertion is legally incorrect. The cited provision requires that "a facility must ensure that themedical care of each resident is supervised by a physician and that physician visits must take into account the resident's total program of care, including medication and treatments."(Emphasis added.) On its face, the requirement is placed on the nursing home to obtain physician supervision for the medical care it provides and to inform physicians of the total plan of care. Similarly, section 483.20(d), also cited in the article, lays out the requirements for the facility to develop a 3 Similarly, the Medicare Benefit Policy Manual (MBPM) makes clear that Medicare does not cover "[r]outine physical checkups; eyeglasses, contacts,and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses; eye refractions by whatever practitioner and for whatever purpose performed . . ." among other routine services, including any "examinations performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury . . . ." MBPM, Ch. 16, § 90 (Rev. 1,10-1-03). On the other hand, these exclusions "do not apply to physicians'services (and services incident to a physicians' service) performed inconjunction with an eye disease, as for example, glaucoma or cataracts . . .." Id. 6 12 comprehensive care plan based on a comprehensive assessment of all the resident's medical, nursing, mental and psychosocial needs. The facility must include the attending physician in the development of the care plan, along with the nurse caring forthe resident, and representatives of other disciplines as needed, but the responsibility to develop, review and carry out the care plan lies with the facility. 42 C.F.R. § 483.20.Nothing in the cited regulations creates a requirement for any particular "relationship" between a resident's attending physician and other Part B providers from whom the facility may obtain services to implement the plan of care and the physician's orders. In September 27, 2004, the contractor issued an online provider information notice entitled "Podiatrists and Optometrists Billing for Nursing Facility Assessments." Ex. E, at 139. This notice indicated that optometrists could not bill as physicians for purposes of reviewing comprehensive assessments and careplans for nursing facilities, because areas of the total care are outside the scope of their licenses. Id. Instead,optometrists may bill for consultation visits "when the primary care physician has ordered . . . optometry services," in which case the documentation must include a signed order from the attending physician. Id. No mention is made in this later document of any requirement that the optometrist not only obtain an attending physician's order and document that the services are medically necessary and otherwise covered under Medicare(i.e., not routine screening examinations or excluded eye care), but also that the optometrist must obtain nursing notes from the facility showing the reason for the visit. We conclude that the ALJ could, and we do, properly defer to the contractor's requirement, repeated in two communications from the contractor of which the appellant had constructive notice under 42 C.F.R. § 411.406(e), that an attending physician's

order must be produced. 4 It is further clear that the appellant 4 Unfortunately, it is not clear to what the ALJ was in fact deferring. He included a list of local coverage determinations supposedly "[s]pecific to the instant case" which he asserts that he "considered and gave substantial deference to," but which appear completely irrelevant, dealing with evaluation of veins and arteries in the extremities, pulmonary function, and nerve conduction studies, while providing no reference to any policy dealing with services of doctors of optometry or services by external physicians to nursing home residents. ALJ Decision at 5-6. In our de novo review, however, we have considered both the 2000 and 2004 contractor communications and give substantial (though not complete) deference to them, as explained in the text. 13 bears the burden of documenting that the services provided were reasonable and necessary to diagnose or treat specific complaints or illnesses presented by the individual patients and not merely screening, routine examinations, or related to eye refractions or the provision of glasses or contacts. We do not, however, agree with the ALJ that the only potential documentation adequate to establish medical necessity would benursing notes maintained by the nursing facility. 5 The ALJ gave as an alternative basis for denying the claims that the medical documentation was inadequate to show medical necessity. ALJ Decision at 6. We agree with the ALJ that the appellant was required to document why an individual beneficiary required the eye examinations and diagnostic tests which he performed. The ALJ failed, however, to discuss any of the specific medical documentation on which the appellant relied. Instead, the ALJ simply repeated that the documentation was inadequate because there were "no nursing notes or attending physician orders to show that the residents needed eye services." Id. This assertion is not an independent basis for his non-coverage conclusions and is, in any case, an inaccurate description of the record since physician orders do appear in many of the beneficiary exhibits and some contain nursing notes. We therefore next review the medical documentation de novo to determine whether it is adequate to show that the services provided were reasonable and necessary. 2. Evaluation of medical necessity documentation in individual claims The Council has reviewed the recording of the ALJ hearing, the exhibits and declarations, and the entire record on appeal. In each case, our review included the appellant's supplemental beneficiary statement (prepared at the request of the ALJ at the hearing), the individual beneficiary medical exhibits (Exhibit 2 in each file), the index of documentation prepared by the appellant as revised exhibit H, and the supplemental documentation for each beneficiary submitted as exhibit J. 5 Notably, the ALJ did not actually hold that that nursing notes were requiredbut rather that nursing notes alone were insufficient. ALJ Decision at 6 (language quoted supra). He proceeded, nevertheless, to treat the absence ofnursing notes as fatal to coverage. 14 As discussed above, optometric services must be based on a specific problem or complaint relating to an eye disease, such as cataracts or glaucoma; general screening examinations or services related to visual acuity or need for eyeglasses are excluded from coverage. It is not sufficient to merely list diagnoses, such as depression, dementia, or hypertension that may relate to the reasons for the beneficiary's nursing home placement, without an indication that some complaint or symptom occurred which was related in time and reason to the optometric services provided on the dates at issue. Therefore, we deny claims where the presenting complaint is loss of visual acuity or inadequate glasses. Attending physician orders that either do not mention optometrics ervices at all or that are undated or dated months before or after the dates of service cannot provide evidence of medical necessity for these services. See, e.g., File of M.M., Ex. 2. In addition, many cases involve only a complaint of watery eyes or dry eyes with evidence that the resident was already being treated with eye lubricants and no evidence of any recent exacerbation or new development. In addition, general statements by the facility, even if signed by the medical director, that Dr. Daniel provided services to residents over the course of three years that were done "for the benefit of residents" do not establish a physician's order for or a need by a particular resident to receive an examination or services on at particular date. See, e.g., File of W.F., Ex. 2. While, as stated above, we will accept documentation other than nursing notes to show the precipitating need for optometric services, the documentation must demonstrate a reason that an examination was needed when performed. Furthermore, where nursing facility records were provided in the supplemental exhibits, they often consisted of admission assessments or medication records lacking any information about specific complaints or symptoms relevant to eye disease or merely mentioning that the beneficiary wears glasses.

Based on our review of the entire clinical records provided by the appellant, we reach the following conclusions as to thedocumentation of medical necessity: The following beneficiaries' claims remain denied because no attending physician's order for optometry services was produced:*** C.; L.C.; *** C.; J.D.; D.D.; A.D.; B.D.; M.E.; D.E.; M.E.;W.F.; G.G.; C.G.; J.G.; S.H.; J.K.; L.L.; S.L.; C.M.; L.M.; 15 J.P.; B.R.; *** R.; *** R.; D.S.; R.S.; F.V.; *** W.; M.W.;B.W.; and V.Z. (31 claims total). The following beneficiaries' claims remain denied because, although an attending physician's order was produced, neither nursing notes nor other clinical documentation indicates that the beneficiary was seen for any specific complaint other than routine examination, or else the only complaint, diagnosis and/or treatment related to refractive measurements or need for eyeglasses or contacts: T.A..; C.A.; G.A.; T.B.; D.B.; V.B.;E.B.; O.B.; H.F.; I.M.; M.M.; G.P.; and L.S. (13 claims total). The following beneficiaries' claims are covered because their files contain both attending physician's orders and adequate documentation that the services provided were medically necessary and not merely routine examinations or provision of excluded eye care services: R.A. (glaucoma diagnosis); J.B.(blurred vision; medication for blepharitis); I.B. (dry age-related macular degeneration (ARMD) with blepharitis, sicca, and suspected glaucoma); M.B. (post-corneal transplant, medication for blepharitis, cataract evaluation); C.B. (cataracts); L.B.(blurred vision; levator disinsertion evaluation); V.H. (blurred vision; moderate cataracts and ARMD); L.H. (eye discharge; trichiasis, monitor other conditions); *** H.(blurred vision; severe ARMD); *** H. (blurred vision; moderate cataracts); A.K. (eye pain; cataracts and blepharitis); R.M.(inflammatory glaucoma, medication for blepharitis); W.M.(blurred vision; glaucoma); L.N. (eye pain; blepharitis, ARMD, optic nerve atrophy); B.P. (crusted lids; medication for glaucoma, cataract); E.P. (blurred vision; cataracts, opticatrophy); C.S. (blurred vision; cataracts, ARMC, optic atrophy); J.W.(blurred vision and watery eyes; cataracts, sicca); and *** W. (eye pain and inflammation; medication for blepharitis). In summary, 19 claims are covered, while 44 claims continue tobe denied. Attached to this decision is an annotated list of beneficiaries with the outcome as to each claim. 3. We deny the subpoena request. Before the ALJ and again before the Council, the appellant sought issuance of subpoenas in order to compel nursing facilities to provide documentation of the medical necessity of his services. RR at 2. The ALJ failed to rule on the subpoena request. We deny the subpoena request. Since we have found that the appellant had notice (either actual or constructive) of 16 the contractor's requirement to document orders from the attending physician when seeing nursing facility residents, the appellant should have already had such orders in his records. Since we have not required that medical necessity be documented by facility nursing notes, and since the appellant was obliged to be able to document the medical necessity of any services he provided, the appellant should not have required retrospective access to nursing facility records to obtain such documentation. We therefore conclude that the appellant has failed to demonstrate that subpoenas are necessary. 4. We reject appellant's argument on statistical sampling and extrapolation. The percentage of sample claims from the two-year period which were determined to be not covered by Medicare was the basis for an extrapolation for a total overpayment. The ALJ found that the appellant was provided with all materials concerning the sampling methodology and concluded that the process was "sufficiently reliable to withstand scrutiny under a due process analysis." ALJ Decision at 7. On appeal to the Council, the appellant argues that the extrapolation of the reviewed claims was "conducted by applying the erroneous standard of presenting an attending physician's order" and that the "calculation is flawed in its reliance upon data based on this erroneous threshold requirement." RR at 2. This argument fails to identify any deficiency in the statistical sampling methodology. Instead, the appellant essentially takes the position that, if the individual sample claims were wrongly denied, then the extrapolation is flawed. This argument provides no basis to find the statistical sampling process or the extrapolation methods improper. Furthermore, we have already rejected the appellant's argument that attending physician referrals were unnecessary. As to those 19 claims which we have found had physician orders and were otherwise covered, however, we agree that the corresponding amount of the overpayment that reflected the noncoverage of those cases must be adjusted. The requirement to adjust the overpayment accordingly is a proper application of, not a rejection of, the extrapolation method used here. We note that we do not address liability since the appellant did not challenge that aspect of the ALJ Decision on appeal. 17 DECISION It is the decision of the Medicare

Appeals Council that the 19 claims identified above are covered, while the remaining 44 are not. The overpayment amount should be adjusted accordingly. MEDICARE APPEALS COUNCIL /s/ Leslie A. Sussan, Member Departmental Appeals Board /s/ Clausen Krzywicki Administrative Appeals Judge Date: December 3, 2009 18

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[i] National Institute on Aging, National Institutes of Health "U.S. Population Age 65 and Over." 2005.

[ii] Presentation, American Academy of Optometry "Aging and Vision" Rosenbloom, A. by permission, 2006

[iii] Annals of Long Term Care, "Preventing Falls in Nursing Homes," Kamel HK, 2012

[iv] Academic Medicine, "Bringing Interdisciplinary and Multicultural Team Building to Health Care Education: The Downstate Team-Building Initiative," Hope JM, Lugassy D, Meyer R, et al., 80(1), 2005

[v] Optometry, "Alzeimer's Disease: Visual System Review", Valenti DA, 81(1): 12-21, 2010