VISION REHABILITATION

American Academy of Optometry
Phoenix, Arizona

October 2012

Presented by:
Richard Soden, OD, FAAO, CPC

I have no financial interests to disclose.

Initial Visit to Optometrist:

Initial E & M Visit (99000 code) or Appropriate 92000 (Medical)
Low Vision Examination (includes refraction)
Appropriate Special Procedures: VF, Extended Ophthalmoscopy, etc

Therapy Evaluation Visit – "Impaired Compensation Evaluation

Optometric Evaluation Visit to Access Rehabilitive Potential: E & M or 92000's

And (if needed and if appropriate) the following:

OT/PT Evaluation (if requested by OD/MD)
O & M Evaluation
Social Worker/Psychosocial Evaluation

What's done in this Visit?

a) Detailed Case History: Focuses on presenting problems of the patient (their limitations. It highlights the patient's limitations to perform necessary or valued activities. It begins to define the foundations upon which rehabilitation builds solutions to the presenting problems.

b) Functional Examination:

1) 12 Components of the Eye

2) Visual Impairments:
   a. Visual Acuity
   b. Contrast sensitivity
   c. Binocular Vision
   d. Confrontation Fields
   e. Glare Assessment

3) Visual Performance
   a. Reading
   b. Writing
   c. Face and object Identification
   d. Mobility

4) Orientation to time, place, etc
5) Assessment of Mood

c) Writing the "Treatment Plan"

Treatment Plan

Patient's Name: Date: _____

Date of Birth:

Chief Complaint:

Secondary Factors:

Level of Visual Impairment:

Best Corrected Acuity OD:
Best Corrected Acuity OS:

Visual Field Loss:

The patient is experiencing vision problems secondary to:

Disease: ICDA Codes:

Disease: ICDA Codes:

Is there a Restorative Component? _____ Yes _____ No

Patient's Ability to Comprehend (Cognitive Function):

_____ Adequate _____Inappropriate

Functional Ability for Rehabilitation:

_____ Adequate _____Inappropriate

The patient demonstrates the following symptoms. Related to their vision deficits that may impede basic activities of daily living and mobility - Check ALL that applies

__ Patient has a history of falls which may impair ADL performance and mobility
__ Patient suffers from diplopia, nystagmus or _____ which may impair His/her ability to read, write, or ambulate
__ Patient has problems with decreased visual scanning and search which may Impair ADL performance and mobility
__ Patient has restricted visual fields which may impair ADL performance and Mobility
__ Patient has limited useable remaining vision
__ Patient has a central scotoma which may impair ADL performance and mobility as well as the ability to read write and ambulate

The Above Checked Items may impair the following (check those that apply)

__ mobility/safe travel in the environment
__ managing personal finances
__ managing nutritional needs
__ managing ADL
__ community/work integration skills
__ managing health needs

Assessment and Plan: The patient will benefit from the following:

__ ADL training in: __ Optometric Office __ Rehab Office __ Both

__ Orientation and Mobility: Where: _____

__ Neuromuscular rehabilitation (eye-hand coordination, scanning, etc) in an Optometric Office

Plan of Care with Goals:

a) __ increase the patient's effective use of optical devices to read materials needed for daily living
b) __ increase the patient's ability to write legibly to complete communications such as answering mail
c) __ increase the patient's ability to complete financial transactions and manage financial affairs independently
d) __ Increase the patient's ability to complete self-care and homemaking activities with efficiency, independence and safety
e) __ Increase the patient's ability to engage in leisure & community activities
f) __ Other:

Appropriate ICDA Codes:
__99 __ 99 __99 __99 _99

Specific Rehabilitation Services to be Provided:

Duration of Program:
a) Estimate of time for completion: _____
b) Frequency of Services: _____
c) Re-evaluation Date: _____

Impressions/Recommendation:

- Prognosis for Training Success:
  - Excellent/Good/Fair/Poor
  - When Will Goals Be Met: __1 Month __ 2 Months __ 3 Months
  - Number of Visits Required: _____

Based upon the functional vision limitations and visual signs and symptoms, the patient's ocular diagnoses are inhibiting his/her personal independence and safety. I am recommending that this patient receive REHABILITATION FOR PATIENTS WITH VISUAL IMPAIRMENT.

_____O.D. Date: _____

Progress Note:

Name: _____ Date: _____

Initial Assessment: Diagnosis:

Best-Corrected Distance Visual Acuity: O.D. _____ O.S. _____

Diagnosis: _____ ICDA: _____
_____ ICDA: _____

Are You involved in or receiving any home health services? ____ Y ____ N

CPT: 97112: Neuromuscular re-education
97530: Improve functional performance
97533: Sensory Integration
97537:Community/work reintegration
97116: Gait Training
97532: Cognitive Skills
97535: ADL (meals,safety,adaptive equipment)

Session #:

1. Goal: CPT: UNITS:
Activity:

Low Vision Devices Used: _____

Other Considerations:
__ Lighting __ Field of View __ Working distance __Focusing Ability
__ Mobility __ Eccentric Viewing__ Care of device including changing battery

Success: Goal Achieved: __Yes __ No

2. Goal: CPT: UNITS:
Activity:

Low Vision Devices Used: _____
Other Considerations:
__ Lighting __ Field of View __ Working distance __Focusing Ability
__ Mobility __ Eccentric Viewing__ Care of device including changing battery

Success: Goal Achieved: __Yes __ No

3. Goal: CPT: UNITS:
Activity:

Low Vision Devices Used: _____
Other Considerations:
__ Lighting __ Field of View __ Working distance __Focusing Ability
__ Mobility __ Eccentric Viewing__ Care of device including changing battery

Success: Goal Achieved: __Yes __ No

4. Goal: CPT: UNITS:
Activity:

Low Vision Devices Used: _____
Other Considerations:
__ Lighting __ Field of View __ Working distance __Focusing Ability
__ Mobility __ Eccentric Viewing__ Care of device including changing battery

Success: Goal Achieved: __Yes __ No

_____O.D. Date: _____

Measurable Goals:

At the completion of the unit describing environmental visibility, the learner will modify his or her environment or will perform reading and other functions to a level that either maximizes his or her visual performance or to a level sufficient to meet the patient's daily living needs.

A. __ When asked, the patient will describe the effects of size, contrast, and illumination on environmental visibility to a level that demonstrates an adequate knowledge.

B. __ When asked, the patient will describe his or her best eye placement for eccentric viewing to a level that demonstrates adequate knowledge.

C. __ When presented with a stand magnifier to perform an activity of daily living, the patient will read labels, dial setting, medication bottles, etc. with 90% accuracy.

D. __ When presented with a stand magnifier, the patient will read and perform the activity of daily living with 90% accuracy

E. __ When presented with a head borne microscope, the patient will read and describe material with 90% accuracy.

F. __ When presented with a telescope, the patient will use it to view television and for other activities of daily living at a level sufficient to meet daily needs.

G. __ When presented with a standard signature guide and pencil, the patient will write his or her signature legibly with 90% accuracy.

H. __ When presented with a full page writing guide, the patient will write a one-page letter with 90% of the words legible.

I. __ When presented with a rotary dial telephone or a push bottom phone and 10 phone numbers, the patient will successfully contact 9.

J. __ When presented with a watch, the patient will consistently read the time and set it to within 5 minutes of the correct time.

K. __ When presented with a clock, the patient will consistently use all its functions to a level sufficient to meet his or her needs.

L. __ When presented with coins or bills, the patient will identify them correctly with 90% accuracy.

M. __ When presented with checks (regular or adaptive)O, the patient will write checks correctly with 90% accuracy.

N. __ When presented with an adaptive device, the patient will read and set a thermostat with 90% accuracy.

O. __ When presented with a regular or self-threading needs and the appropriate adaptive devices, the learner will thread the needle accurately

Progress Re-evaluation ___ or Final Discharge Summary:

Initial Goals: ___ ADL ___ Mobility ___ Neuromuscular

Extent to which each goal was met:

a) Increase the patient's effective use of optical devices to read materials needed for daily living

Goal met: ___ yes ___ no _____ Somewhat Comments:

b) Increase the patient's ability to write legibly to complete communications such as answering mail

Goal met: ___ yes ___ no _____ Somewhat Comments:

c) Increase the patient's ability to complete financial transactions and manage financial affairs independently

Goal met: ___ yes ___ no _____ Somewhat Comments:

d) Increase the patient's ability to complete self-care and homemaking activities with efficiency, independence and safety

Goal met: ___ yes ___ no _____ Somewhat Comments:

e) Increase the patient's ability to engage in leisure and community activities

Goal met: ___ yes ___ no _____ Somewhat Comments:

f) Other:

Goal met: ___ yes ___ no _____ Somewhat Comments:

Every 30 days, the above progress evaluation will be completed.

Summary: a) ___ Patient has reached his/her goals and rehabilitation is complete. The patient will be seen again in _____.

b) ___ Patient requires additional rehabilitation. _____ Additional sessions are needed. Next re-evaluation will be performed in _____ days

c) ___ Patient cannot tolerate Visual Rehabilitation and the program is terminated

Therapy Evaluation Visit
Impaired Compensation Evaluation

92000's or E & M's

Goals of This Visit:

1. To assess Optometric Rehabilitation Potential
2. To assess if the following are needed: OT, PT, O&M, and Social Worker/Psychological

Name of Patient: DOB: _____
Date of Exam: _____

Referred by:

Ocular Disease Causing Visual Impairment:

Past Medical History:

Past Surgical History:

Allergies:

Social History:

Who do you live with? __Lives Alone __ Married & lives with spouse
__ Live with Children __Other:

Are you able to take care of yourself?

What was the last grade you completed in school?

Do you smoke or drink?

Work history:

__ Currently Working __ Looking for Work __ Homemaker __Other:

Home Environment:

Adaptive Equipment Used:

Concerns about mobility including recent falls:

Visual Processing deficits noted:

__ Depth Perception Difficulties __ Visual-Motor Coordination
__ Figure Ground __ Pattern Recognition ___ None

Concerns about near vision:

Illumination Used:

Vocations/Hobbies:

Hearing Difficulties:

Current Reading Ability:

__ Uses Tape Recorder
__ Knows About Talking Books

Primary Goal:

Additional Goals:

VISUAL FINDINGS:

Acuity:	OD	OS	OU
Distance ( )	_____	_____	_____
Near ( )	_____	_____	_____

Visual Fields:

Contrast Sensitivity:

Tracking and Scanning:

Photosensitivity/Glare

Current Optical Devices:

Previous OT/PT

Cognitive Status:
____ Orientation to time and place
____ Attention
_____ Safety and judgment
_____ Memory
_____ Awareness
_____ Following Instructions

Difficulties with ADL's

Telling Time on Watch _____ Clock_____
Money Management ___
Community Skills ___
Medication Management ___
Dressing ___
Bathing ___
Grooming/Hygiene ___
Feeding ___
Mobility ___
- Negotiation Close Spaces ___
- Do you get around outdoors ___
- Loss of Balance ___
- Climbing Stairs ___
- Use of Transportation ___
  (Elevator,Train,Car)
- Street Crossings ___
- Negotiation in Stores ___
- Can you function at home? ___

- Do you drive? ___
- Do you use a cane? ___

Reading:
- Do you read print? ___
- Can you read:
  - Newspaper Headlines ___
  - Large Print ___
  - Textbooks ___
  - Newspaper ___
  - Magazines ___
  - Telephone Book ___
  - Your mail ___

Your bills ___
Price Tags ___
Medication bottles ___
Recipes ___
Other: ___

How much reading do you do? ____

What kind of light do you use for reading?

Do you want to read?

Writing:

Letters: ___
Lists ___
Phone Numbers ___
Name/Signature ___
Your checks ___
Other: ___

Telephone Use ___

Distance Vision:

Can you see faces? ___
Can you see street signs? ___
Can you go to the movies? ___
Can you see TV? ___

Can you operate?

The stove ___
The microwave ___
The calculator ___
The thermostat ___
The TV/VCR remote ___
The computer ___
Toaster/Blender/Coffee Pot ___

Can you identify?

Food in the refrigerator ___
Clothes in the closet ___
Food in cupboards ___
Colors ___

Cleaning Solutions ___
Medicines ___

Can you apply make-up? ___
Can you dress? ___
Can you groom/shave? ___
Can you pour liquids? ___
Can you clean your house? ___
Can you use your keys? ___
Can you change light bulbs? ___
Can you do home repairs? ___
Can you socialize with friends? ___
Can you play cards? ___

Clinical Observation Indicating Visual Impairment:

1. Near Visual Acuity: Ask the patient to read a line of standard or large print in a newspaper, magazine or book. The approximate size of the print is _____. The patient:

___ complains that the print looks fuzzy
___ complains of an inability to bring the print into focus
___ continuously adjusts the length of the page trying to bring it into focus
___ complains that the print is too small to read
___ brings the page of print in very close to try to read it
___ shifts the page of print to one side of midline to read it
___ views the print out of the corner of one eye or uses eccentric viewing
___ says it's impossible to read
___ Other:

2. Distance Visual Acuity: Ask the patient to look at a person across the room. The patient:

___ complains of an inability to recognize faces
___ use eccentric viewing to see faces
___ gets up and walks closer to see the person
___ states that his/her vision fluctuates too much
___ asks for additional light in order to see the person
___ says it's impossible to do
___ Other:

3. Contrast Sensitivity: Ask the patient to fill a clear glass with water from the tap or a pitcher to within ½ inch of the brim. The patient:

___ complains that they can't see the level of water as it rises up the glass
___ overfills the glass
___ uses the tip of a finger over the glass brim to determine water level
___ moves in very close to the glass to view the water level
___ tilts the glass back and forth to create movement to assess water level
___ Other:

4. Contrast Sensitivity: Ask the patient to fill a black cup with milk to within ½ inch of the brim and compare with his/her performance using the clear glass and water.

5. Mobility: Observe the patient ambulate in the office in an environment of low contrast (curb outside of the office, areas with poor illumination, furniture that does not contrast from surrounding features, door frames that do not contrast from the doors, etc). The patient:

___ hesitates when approaching curb or subtle changes in support surfaces
___ misses curb or does not see it until directly on top of it
___ bumps into or comes very close to low contrast obstacles
___ uses hands to guide around an obstacle
___ complains that he/she cannot recognize faces
___ asks for additional lights
___ is unable to accurately distinguish color of similar hues
___ is unable to complete to task
___ Other:

6. Visual Field Defect: Observe the patient ambulate through the office or outside of the office. The patient:

___ collides or comes very close to obstacles consistently on one side
___ stares straight ahead at the floor immediately in front of his/her or off to one side
___ stays very close to one side of the wall when ambulating
___ uses fingers to trail the wall to actually guide self
___ refuses to take lead when ambulating; prefers to walk behind others
___ appears anxious or uncertain
___ stops walking when approaching or passing by another person/object
___ complains of feeling off balance particularly to one side
___ fails to search the environment for information needed
___ Other:

Goals:

1.
2.
3.
4.
5.

Plan:

In Office (Optometric) Skills Taught to Patients Who Require Low Vision Rehabilitation

1. Safe operation of equipment _With Low Vision Devices
    a. Microwaves
    b. Thermostats, etc.
    c. Other:

2. Medication Management _ With Low Vision Devices

3. Home Finances

    1. Checkbook
    2. Bank Account
    3. Paying Bills
    4. Other:

4. Writing _With Low Vision Devices

    a. Guides
    b. Writing Implements

5. Telephone Dialing _ with Low Vision Devices

6. Money Identification - With Low Vision Devices

7. Personal Organization System for Mail
    -With Low Vision Devices

8. Orientation in Space _With Low Vision Devices

9. Spatial Relations _With Low Vision Devices

10. Lighting Management _With Low Vision Devices

11. Environmental modification _With Low Vision Devices

12. Eccentric Viewing Techniques _With Low Vision Devices

Patient Goals – Please Check the Appropriate Goals

Telephone Usage:

a) __ Finding a specific number in the phone book with low vision devices
b) __ Dialing a phone correctly with low vision devices or specialized phone dials
c) __ Correctly finding phone numbers in a telephone directory

CPT Codes: 97533 & 97535

Reading:

A) __ Correctly reading newspaper sized print for 15 minutes
B) __ Correctly seeing TV times/TV channels in a TV guide
C) __ Accurately reading bills with low vision devices

CPT: 97535

Money Management:

a) __ Paying rent or electrical bills on your own with prescribed low vision devices or check writing guides
b) __ Identifying coins and bills correctly with prescribed low vision devices
c) __ Sorting mail with low vision devices
d) __ Reading bill accurately with low vision devices
e) __ Accurately completing a check or money order

CPT: 97535 & 97537

Shopping:

a) __ Identifying food and cleaning products correctly with magnifiers
b) __ Reading price tags correctly with low vision devices
c) __ Correcting locating an object in an aisle
d) __ Writing a grocery list accurately

CPT: 97535 & 97537

Cooking/Eating/Meal Management/House Cleaning:

a) __ Safely seeing and setting the stove control settings (or the flame) with low vision devices
b) __ Correctly using a microwave to heat up a meal with low vision devices

c) __ Correcting seeing food on a plate
d) __ Pouring fluids accurately with low vision devices
e) __ Appropriately cleaning one's house or telling if one's house has been cleaned with low vision devices
f) __ Correctly identifying food labels with low vision devices
g) __ Correctly identifying panel ingredients on a food label
h) __ Accurately measuring ingredients
i) __ Accurately timing food and determining when it cooked
j) __ Reading food ingredients accurately with low vision devices

CPT 97535

Telling Time:

a) __Correctly setting watch with low vision devices
b) __ Correctly seeing a clock with low vision devices or eccentric viewing

CPT: 97533, 97535; 97537

Computer Usage:

a) __ Accessing the Internet with low vision devices or adaptive equipment
b) __ Correctly using word processing programs with low vision devices

CPT: 97535 & 97537

Watching TV:

a) __ Seeing the TV appropriately with telescopes
b) __ Accurately using the remote with low vision or adaptive equipment

CPT: 97535 & 97537

Grooming:

a) __ Appropriately applying make-up on yourself with low vision or adaptive equipment
b) __ Appropriately combing one's hair with low vision devices or adaptive equipment
c) __ Laundry preparation

CPT: 97535

Mobility:

a) __ Crossing street safely with specifically prescribed low vision devices or adaptive equipment
b) __ Appropriately traffic lights with specifically prescribed low vision devices or adaptive equipment
c) __ Identifying street sign accurately
d) __ Correcting seeing house/apartment numbers

e) __ Accurately seeing curbs/steps

CPT: 97535 & 97537

Hobbies:

a) __ Correctly threading a needle to sew with appropriately prescribed low vision devices or adaptive devices
b) __ Successful sewing/knitting with low vision devices or adaptive equipment
c) __ Accurately seeing photographs with low vision devices
d) __ Playing cards/bingo accurately with low vision devices
e) __ Appropriately doing crossword puzzles with low vision devices
f) __ Performing home repair activities with low vision devices

CPT: 97535 & 97537

Medication Bottles/Rx Management:

a) __ Correctly identifying labels on medication bottles
b) __ Correctly placing pills in a bill sorter/holder
c) __ Correctly filling an insulin syringe

CPT: 97535

Writing:

b) __ Correctly signing a check with low vision or check writing guides
c) __ Correctly addressing an envelope with low vision devices or writing guides

CPT: 97535 & 97537

Object Placement and Organization

CPT: 97535

CPT 97530 – Therapeutic activities direct (one to one) patient contact by the provider (use of dynamic activities to improve functional performance) each 15 minutes

a) hand/eye coordination
b) peripheral awareness
c) eccentric viewing
d) sensory integration
e) stroke issues and visual impairment

CPT 97535 – Self Care/home management (e.g. ADL and compensatory training, meal management, safety procedures and instruction in the use of adaptive equipment) direct (one-to-one) contact by the provider, each 15 minutes

a) Safety concerns
b) Medical Management
c) Grooming
d) Appliance Operation
e) Task lighting and contrast strategies
f) Object placement and organization
g) Grooming/hygiene
h) Integration of assistance technology for these tasks

CPT 97537 – Community/work reintegration training, transportation, money management, avocational activities and/or work environmental/modification analysis, work, task analysis. direct (one-to-one) contact by the provider, each 15 minutes

a) Education goals
b) Personal business management
c) Transportation options
d) Simulated work station
e) On site work station analysis/modification
f) Integration of assistive technology for these tasks

Visual Rehabilitation: A Model for Optometrists Using NY's Medicare Policy

Initial Visit to Optometrist:

E & M Visit (99000 code) or Appropriate 92000
Refraction/Low Vision Refraction
Appropriate Special Procedures: VF, Extended Ophthalmoscopy, etc

Therapy Evaluation Visit:

OT/PT Evaluation (if requested by OD/MD)
O & M Evaluation
Social Worker/Psychosocial Evaluation
Optometric Evaluation Visit to Access Rehabilitive Potential: E & M or 92000's

Therapy Sessions: (Generally 10 Maximum): 97112; 97116; 97530; 97532; 97533; 97535; 97537

- Optometrist Performs all of these sessions by billing Appropriate Rehab Codes
- Optometrist performs some of these sessions and refers to other disciplines for those services he/she cannot perform in the office (i.e. home teaching; Orientation and mobility, etc)
-Optometrist refers to patient out for ALL Rehabilitation (OT, PT, State or Non-Profit Agency, etc.)

Progress Evaluation:

Optometrist doing the Rehabilitation monitors his/her own using 92000 or 99000 (Every 30 days)
Optometrist who refers out sees the patient every 30 days and assesses progress Using 92000 or 99000 codes

Rehab Medicine:	Rehab for Patients With Visual Impairment:
Initial Diagnostic Test: Physician	Physician: OD/MD
Rehabilitive Plan: MD (including Physiatrist)	OD/MD
Rehab Teaching: Physiatrist, OT, PT, Speech	OD/MD. OT, PT, Speech, O&M, Rehab Teacher etc.
Progress Evaluation: MD (including Physiatrist)	OD/MD

Optometric Therapy Evaluation (Optometrist)

99000 0r 92000

Purpose:

-to diagnosis the patients vision disabilities and vision handicaps to determine the patient's visual capabilities

- To educate and counsel the patient and the family on the consequences of the patient's disease

-to determine the best ways to enhance the patient's remaining vision

-prescribe assistive devices and REHABILITATIVE training.

(Initial Evaluation diagnosed visual system disorders and visual impairments)

Vision disorders: Diagnoses such as cataract, macular degeneration, injury

Visual Impairments: Disorders lead to visual impairments defined as abnormalities in visual functioning. They are classified by performance on visual function tests such as visual acuity, contrast sensitivity; glare sensitivity; color vision etc.

Visual Disabilities: visual impairments lead to vision disabilities as defined as limitations imposed by visual impairments on a person's ability to perform activities that are important to the person. They include loss of ability to drive, read, and watch TV. Goal of rehabilitation is to restore function b y enhancing impaired vision and teaching the patient how to compensate for the disabling effects of the visual impairment.

Optometric Therapy Evaluation:

A. Case History:

1. Chief Complaint
2. Functional History:

    a. Communication
    b. Eating
    c. Grooming and Self Care
    d. Dressing
    e. Mobility
    f. Driving
    g. Ability to Read

3. Past History:
    a. Nature of the problem
    b. Duration of the problem
    c. Evolution of the problem
    d. Coping mechanisms

e. Past attempts at rehabilitation
f. Other:

3. Social history:

a. Impact of the problem on independence and self-reliance
b. Impact of the problem on family life
c. Impact of the problem at work or in school
d. Use of support systems and community resources

4. Systems Review: (Consider limitations, endurance, pain, self-administration of medication, etc)

B. Examination:

a) 12 Components of the Eye

b) Visual Impairments:
f. Visual Acuity
g. Contrast sensitivity
h. Binocular Vision
i. Confrontation Fields
j. Glare Assessment

d) Visual Performance
a. Reading
b. Writing
c. Face and object Identification
d. Mobility

e) Orientation to time, place, etc
f) Assessment of Mood

C. Level of Medical Decision Making

b) Number of possible diagnosis and management options
a. Prescription of assistance devices
b. Development of the rehabilitative plan
c. Referrals to other professions
c) Complexity of the case and review of test results
d) Range of co-morbities and risks of complications that may interfere with the rehabilitative plan (suicide, poor self-care for a diabetic etc.) or risk of complications from therapy (psychological disturbances, loss of independence, etc

Straightforward Medical Decision: (minimal number of diagnosis and treatment options; minimal or no complex data to interpret; minimal or no risk; no co-morbidities_

a. Routine low vision patient who needs simple near and distance aids and simple training in their use.
b. He/She has no functional problems beyond the use of the devices;
c. He/She is copying well with the loss and has no co-morbidities

Low Complexity: (limited number of diagnosis or treatment options, limited amount of data to interpret; low risk of complications, minimal co-morbities to be managed)

a. Low vision patient whose chief complaints are problems with reading, writing, seeing TV, seeing faces.
b. Problems cannot be ameliorated with simple optical devices
c. Patient has cataracts which are reducing his contrast; Good health for rehab

Moderate Complexity: (multiple diagnosis or treatment options, moderate amount of data to interpret; moderate amount of risk of complications, and moderate complicated co-mortifies to be managed)

a. Low Vision patient with a three year history of optic atrophy secondary to trauma. He/She sees double occasionally, cannot see the Blackboard in school cannot see street signs. Difficult mobility
b. Can use a biotic for driving; reduced contrast, visual field losses
c. Good health for rehab

High Complexity: (many possible diagnosis of disabilities or treatment options, extensive complex tests results to interpret; high risk of complications, and highly complex co-morbities to be managed)

a. Adult onset diabetes treated with extensive laser. One eye has finger Counting and the other is at risk to a RD; the patient has kidney Disease, CHF

B The patient is wheel-chair bound and cannot work\ She lives alone and Perform activities of daily living including seeing her medication Bottles and monitoring her blood sugar.

c. Questionable health for rehab

EMPIRE MEDICARE SERVICES
LOCAL MEDICAL REVIEW POLICY

Contractor Name

Empire Medicare Services

Contractor Number

New York-00803
New Jersey-00805

Contractor Type

Carrier

LMRP Database ID Number

New York-L11902
New Jersey-L5269

LMRP Title

REHABILITATION FOR PATIENTS WITH VISUAL IMPAIRMENT

Contractor's Policy Number

New York- PM001E01
New Jersey-Y-12C

AMA CPT Copyright Statement

CMS National Coverage Policy

- Title XVIII of the Social Security Act, Section 1862 (a)(7)
  This section excludes routine physical examinations.
- Title XVIII of the Social Security Act, Section 1862 (a)(1)(A)
  This section allows coverage and payment for only those services considered medically reasonable and necessary.
- Title XVIII of the Social Security Act, Section 1833 (e)
  This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

- CMS Program Memorandum AB-00-39
  This memorandum provides instructions for reporting correct units of service pertaining to outpatient rehabilitation therapy.
- CMS Program Memorandum AB-02-078
  This memorandum provides coverage instructions regarding rehabilitation services for vision impairment.
- Medicare Carrier's Manual, Section 2215
  This section defines services furnished by physical or occupational therapist in independent practice.

Primary Geographic Jurisdiction

Downstate New York excluding Queens
New Jersey

Oversight Region

02

CMS Consortium

Northeast

DMERC Region LMRP Covers

N/A

Original Policy Effective Date

New York-03/27/2003
New Jersey-11/01/1998

Entire Policy Ending Date

N/A

Revision Effective Date

10/01/2003

Revision Ending Date

N/A

LMRP Abstract

Low vision services use aids and education to minimize vision related disability when no restorative process, such as correction of refractive error, corneal transplantation, or cataract surgery, is possible. The purpose of rehabilitate therapy is to maximize the use of residual vision and provide patients with many practical adaptations for activities of daily living (ADL).

A Medicare beneficiary with vision loss may be eligible for rehabilitation services designed to improve functioning and performance of ADL, including self-care and home management skills. Evaluation of the patient's level of functioning in ADL is critical and should be performed by an occupational or physical therapist. Physical therapy and occupational therapy assistants cannot perform such evaluations.

Vision impairment ranging from low vision to total blindness may result from a primary eye diagnosis, such as macular degeneration, retinitis pigmentosa, glaucoma, or as a condition secondary to another primary diagnosis, such as diabetes mellitus or acquired immune deficiency syndrome (AIDS).

Indications and Limitations of Coverage and/or Medical Necessity

Coverage of low vision rehabilitation services is considered reasonable and necessary only for patients with a clear medical need. Such indications are as follows:

- Patients must have at least a moderate or severe visual impairment not correctable by conventional refractive means; and
- Patients must have a clear potential for significant improvement in function following rehabilitation within a reasonable period of time.

In accordance with established conditions, all rehabilitative services to beneficiaries with a primary vision impairment diagnosis must be provided pursuant to a written treatment plan established by a Medicare Physician (M.D., D.O., or Optometrist) and implemented by approved Medicare providers (physical or occupational therapists), and or incident to physician services. The treatment plan should include:

- an initial assessment which documents the level of visual impairment;
- a plan of care identifying specific goals to be fulfilled during rehabilitation;
- definition of specific rehabilitative services to be provided during the course of rehabilitation; and
- a reasonable estimate of when the goals will be reached and the frequency at which the services will be provided.

Rehabilitation program/services for beneficiaries with vision impairment may include the following examples of Medicare covered therapeutic services:

- mobility;
- ADL; and
- Other rehabilitation goals that are medically necessary.

The levels of vision impairment are described as:

Levels of Vision Impairment	Description
Moderate visual impairment	Best corrected visual acuity is less than 20/60 in the better eye (including 20/70 to 20/160)
Severe visual impairment (legal blindness)	Best corrected visual acuity is less than 20/160 including 20/200 to 20/400); or visual field diameter is 20 degrees or less (largest field diameter for Goldmann isopter III4e, 1/100 white test object or equivalent) in the better eye.
Profound visual impairment (moderate blindness)	Best corrected visual acuity is less than 20/400, or visual field is 10 degrees or less.
Near-total visual impairment (severe blindness)	Best corrected visual acuity is less than 20/1000, or visual field is 5 degrees or less
Total visual impairment (total blindness)	No light perception

Most rehabilitation is short-term and intensive, and sessions are generally conducted over ten (10) encounters in a 90-day period of time with intervals appropriate to the patient's rehabilitative needs. Patients usually receive therapy 1-2 times a week, and not less frequently than once every two weeks. The sessions are generally 30-60 minutes in duration. If additional sessions are necessary, medical record documentation must indicate the need for the additional sessions. Periodic follow-up and evaluation verification should be documented by the physician during the course of the rehabilitation.

The program of rehabilitation will be judged to have been completed when the treatment goals have been attained. Any subsequent services would be regarded as maintenance at a level functional ability.

Patients may require additional therapy if there has been a significant change in their visual status so that they require additional training to manage with a decreased level of function.

Services may be provided by a physician as defined in §1861 (r)(1) and (4) of the Social Security Act, a qualified occupational therapist, or a qualified physical therapist. Orientation and Mobility Specialists, Low Vision Therapists and Rehabilitation Teachers may also provide this type of therapy "incident to" a physician’s service. Services

furnished by an employee of the physician may only be done under the physician's direct personal supervision and must meet other "incident to" requirements provided in §2050 of the Medicare Carriers Manual. Direct supervision means that a physician must be in the immediate vicinity of the rehabilitation program, and immediately available or accessible for consultation or emergency. It does not require that the physician be physically present in the room itself. Certified occupational therapy and physical therapy assistants must perform under the appropriate level of supervision as with other therapy services.

"Incident to" services are **integral** but **incidental** to the physician's services. Measurement of a visual acuity or blood pressure, or recording a visual field or an electrocardiogram are skills easily taught to a technician and are considered an integral but incidental part of the physician's service. On the other hand, knowledge of optics and the teaching ability necessary to design, execute, and adjust a low vision rehabilitation plan requires extended formal education and clinical experience. Therapeutic services and treatment planning services are not incidental to low vision rehabilitation; they are the determinants of success. Furthermore, these services are not well known or understood by most health care providers, and should not be performed without proper training.

A technician, for example, a certified ophthalmic assistant (COA) or a certified ophthalmic technician (COT) may collect data "incident to" physician's service as part of the low vision evaluation or progress assessment, which are evaluation and management services. However, only a physician, occupational or physical therapist, or a professional possessing a certification in low vision training, or whose state practice license specifically identifies low vision rehabilitation as a service they may provide, may serve "incident to" a physician in the provision of visual rehabilitation. Visual rehabilitation services are primarily implemented by an occupational therapist rather than a physical therapist. However, a physical therapist may become an integral provider when an occupational therapist is not locally available.

Effective for dates of service January 1, 2000, optometrists may refer patients for visual outpatient rehabilitation services as well as establish and review the plan of treatment.

The physician, therapist or other treating professional is required to have direct one-on-one patient contact when therapeutic procedures are billed.

CPT/HCPCS Section

Physical Medicine and Rehabilitation

Benefit Category

Outpatient Physical Therapy Services
Outpatient Occupational Therapy Services

Coverage Topics

Physical, Occupational, and Speech Therapy

CPT/HCPCS Codes

97001	Physical therapy evaluation
97002	Physical therapy re-evaluation
97003	Occupational therapy evaluation
97004	Occupational therapy re-evaluation
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception
97116	gait training (includes stair climbing)
97530	Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97532	Development of cognitive skills to improve attention, memory, problem solving, (include compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes
97535	Self care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) direct one on one contact by provider, each 15 minutes
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis), direct one on one contact by provider, each 15 minutes
GO	Service delivered under an outpatient occupational therapy

(Modifier)	plan of care
GP (Modifier)	Service delivered under an outpatient physical therapy plan of care

Not Otherwise Classified (NOC)

N/A

ICD-9-CM Codes that Support Medical Necessity

TRUNCATED DIAGNOSIS CODES ARE NOT ACCEPTABLE.

ICD-9-CM code listings may cover a range and include truncated codes. It is the provider's responsibility to avoid truncated codes by selecting a code(s) carried out to the highest level of specificity and selected from the ICD-9-CM book appropriate to the year in which the service was performed.

It is not enough to link the procedure code to a correct, payable ICD-9-CM code. The diagnosis or clinical signs/symptoms must be present for the procedure to be paid.

Further, these ICD-9-CM codes can be used only with the conditions listed in the Indications and Limitations sections of this policy.

368.41	Scotoma involving central area
368.45	Generalized contraction or constriction
368.46	Homonymous bilateral field defects
368.47	Heteronymous bilateral field defects
369.01	Better eye: total vision impairment; lesser eye: total vision impairment
369.03	Better eye: near-total vision impairment; lesser eye: total vision impairment
369.04	Better eye: near-total vision impairment; lesser eye: near-total vision impairment
369.06	Better eye: profound vision impairment; lesser eye: total vision impairment
369.07	Better eye: profound vision impairment; lesser eye: near-

	total vision impairment
369.08	Better eye: profound vision impairment; lesser eye: profound vision impairment
369.12	Better eye: severe vision impairment; lesser eye: total vision impairment
369.13	Better eye: severe vision impairment; lesser eye: near-total vision impairment
369.14	Better eye: severe vision impairment; lesser eye: profound vision impairment lesser eye: blind, not further specified
369.16	Better eye: moderate vision impairment; lesser eye: total vision impairment
369.17	Better eye: moderate vision impairment; lesser eye: near-total vision impairment
369.18	Better eye: moderate vision impairment; lesser eye: profound vision impairment
369.22	Better eye: severe impairment; lesser eye; severe impairment
369.24	Better eye: moderate vision impairment; lesser eye: severe vision impairment
369.25	Better eye: moderate vision impairment; lesser eye: moderate vision impairment

Diagnoses that Support Medical Necessity

N/A

ICD-9-CM Codes that DO NOT Support Medical Necessity

- Use of any ICD-9-CM code not listed in the "ICD-9-CM Codes that Support Medical Necessity" section of this policy will be denied

Diagnoses that DO NOT Support Medical Necessity

N/A

Reasons for Denials

1. A claim submitted without a valid ICD-9-CM code will be returned as an incomplete claim under 1833(e).

2. A claim submitted without one of the ICD-9-CM codes listed in the "ICD-9-CM Codes that Support Medical Necessity" section of this policy will be denied under 1862 (a)(1)(A).

3. A claim for services rendered in any place of service other than those indicated as payable in the "Coding Guidelines" section of this policy will be denied.

4. Any claim submitted without the name and UPIN of the referring/ordering physician will be returned as an incomplete claim under 1833 (e).

5. The provision of conventional refraction aids and the immediate instruction in their use are not covered, unless related to the treatment following cataract surgery.

6. Services for a patient who cannot adhere to a rehabilitation treatment plan, has poor rehabilitative potential, is unable to cooperate in the program, or where no clear goals are definable, will not be covered.

7. "Maintenance", where a patient has reached a steady state in his or her rehabilitation and is seen at intervals to maintain that state, is a non-covered service.

8. Claims for services submitted without a GO (alpha-O) or GP modifier may be returned without processing.

Noncovered ICD-9-CM Codes

N/A

Noncovered Diagnoses

N/A

Coding Guidelines

1. The guidelines of the Correct Coding Initiative supersede all coding instructions in this policy.

2. Payable places of service (POS) are office (11), home (12), and custodial care facility (33), and independent clinic (49*). Use place of service mobile (15) if service is provided outdoors, unrelated to one of the places listed above (ex., walking along the street).
   *Place of service code effective 10/01/2003.

3. The ordering/referring physician's name and UPIN are entered in Items 17 and 17A, respectively on the CMS-1500 form, or in the appropriate electronic fields listed below. If the performing physician is also the ordering physician, that

physician must enter his/her name and UPIN in Items 17 and 17A, or in the equivalent electronic fields shown below:

Format	**Item 17 (Name)**	**Item 17A (UPIN)**
NSF (1.04, 2.00)	EA0.22, positions 120-139 (Last Name) EA0.23, positions 140-151 (First Name) EA0.24, position 152 (Middle Initial)	EA0.20, positions 80-94
NSF (3.01)	EA0.24, positions 120-139 (Last Name) EA0.25, positions 140-151 (First Name) EA0.26, position 152 (Middle Initial)	EA0.20, positions 80-94
ANSI X12 (30.32)	2-250.B-NM103/04/05 or 2-420.A-NM103/04/05	2-250.B-NM109 or 2-420.A-NM109
ANSI X12 (30.51)	2-250.B-NM103/04/05 or 2-500.A-NM103/04/05	2-250.B-NM109 or 2-500.A-NM109
ANSI X12 (40.10 HIPAA version)	2-250-NM103/04/05 or 2-500-NM103/04/05	2-271-REF02 or 2-525-REF02

4. When an independent physical or occupational therapist submits claims, the date that patient was last seen and the UPIN of patient's attending physician must be entered in Item 19 of the CMS-1500 form or equivalent electronic fields as shown above.

5. All services should be coded with either modifier GO (alpha-O) or GP, (provider under an outpatient occupational or physical therapy plan of care, respectively). As the majority of these services are expected to be part of an occupational plan of care, it is anticipated that the GO modifier will be used almost exclusively. The modifier must be used whether the service is provided by a therapist, a physician or incident to a physician's service.

Documentation Requirements

- Each claim must be submitted with ICD-9-CM codes that reflect the condition of the patient, and indicate the reason(s) for which the service was performed. Claims submitted without ICD-9-CM codes will be returned.
- Written documentation by the provider conducting the sessions should include:
    1. initial assessment;
    2. plan of care with specific goals;
    3. progress notes describing the content and number of time units for each session; and
    4. discharge summary that documents the extent to which each goal in the plan of care was achieved, reviewed and signed by the physician.
- Patients receiving services from physical or occupational therapists in private practice require reviews (dated and signed) of the treatment plan by the attending physician at least every 30 days, or any time the plan is changed (Refer to Medicare Carriers Manual, Section 2215E. 2).
- Documentation must be available to Medicare upon request.

Utilization Guidelines

Evaluation, therapeutic planning and execution of the treatment plan should not exceed ten (10) encounters in a 90-day period. Encounters are not expected to exceed 1-2 times per week, and should be no less frequent than once every two weeks. Sessions occurring less than biweekly may be considered maintenance therapy and denied. Sessions are generally expected to last 30-60 minutes.

Other Comments

- For services that exceed the accepted standard of medical practice and may be deemed not medically necessary, the provider/supplier must provide the patient with an acceptable advance notice of Medicare's possible denial of payment. An advance beneficiary notice (ABN) should be signed when a provider/supplier does not want to accept financial responsibility for the service.
- Reimbursement for therapy services provided to patients for treatment of visual impairments will be included in the annual therapy caps.

Sources of Information and Basis for Decision

1. The American Academy of Ophthalmology Rehabilitation: The Management of Adult Patients with Low Vision. Prepared by the American Academy of Ophthalmology Quality of Care Committee. 1994.
2. Beaver, Kathleen A. "Overview of Technology for Low Vision. The American Journal of Occupational Therapy, October. 1995: pp 913-921.

3. Colenbrander, August. "Basic Concepts and Terms for Low Vision Rehabilitation." The American Journal of Occupational Therapy, October. 1995: pp 865-869.

4. Lampert, Jessica. "Functional Considerations in Evaluation and Treatment of the Client with Low Vision." The American Journal of Occupational Therapy, October. 1995: pp 885-890.

5. Massof, Robert W. "A Systems Model for Low Vision Rehabilitation." Optometry and Vision Science, Vol. 72, No. 10, pp 725-736.

6. Raasch, Thomas W. "Evaluating the Value of Low-Vision Services." Journal of the American Optometric Association, May. 1997: pp 287-294.

7. A conference was held in New York, NY on December 5, 2002 to discuss issues and advise the Carriers on concerns related to this policy among number of practitioners representing NYS Optometric Society; Lighthouse International, The Jewish Guild for the Blind, NYS Occupational Therapy Association, NYS Physical Therapy Association, The NYS Commission for the Blind and Visually Handicapped, NYS Society of PM&R, and the New York State Medicare Carriers (GHI, HealthNow, Inc. and Empire New York).

8. American Optometric Association. "Optometric Clinical Practice Guideline: Care of the Patient with Low Vision", 1997, 2000.

9. American Academy of Ophthalmology. "Preferred Practice Pattern: Vision Rehabilitation for Adults", February 2001.

10. The American Occupational Therapy Association, Inc. "Occupational Therapy Practice Guidelines for Adults with Low Vision." 1998.

11. Stelmack JA, Stelmack TR, Massof RW. "Measuring low-vision rehabilitation outcomes with the NEI VFQ-25" Invest Ophthalmol Vis Sci 2002 Sep;43(9):2859-68

12. Solicited opinion, Robert Massof, PhD, Director, Lions Vision Research and Rehabilitation Center, Wilmer Ophthalmological Institute, Johns Hopkins University School of Medicine, Baltimore, MD December 30, 2002.

13. Other Medicare Part B Carriers' Local Medical Review Policies (LMRPs):
    a. BCBS of Kansas;
    b. Wisconsin Physicians Service Insurance Corporation (Illinois and Michigan)

Advisory Committee Meeting Notes

New York-10/09/2002
New Jersey-10/16/2002

Start Date of Comment Period

New York-10/09/2002
New Jersey-10/16/2002

End Date of Comment Period

New York-11/22/2002
New Jersey-11/29/2002

Start Date of Notice Period

11/26/2003

Revision History

New York

Revision Number	Revision History Explanation
1	• Updated Coding Guideline #2 to add place of service code 49 (independent clinic) .

New Jersey

Revision Number	Revision History Explanation
Y-12C	• Updated Coding Guideline #2 to add place of service code 49 (independent clinic) .
Y-12B	• Policy becomes effective 03/27/2003. • Policy revised to add following information from Program Memorandum AB-02-078: • Added ICD-9-CM codes 368.41 and 368.45; • Added "profound", "near-total', and "total" levels of visual impairment. • Policy revised to add CPT codes 97001, 97002, 97003, 97004, 975332, and 97533, and modifiers GO and GP. • Policy revised to add POS eligible for reimbursement. • Policy revised to add paper and electronic claims reporting instructions.

	• Removed maximum numbers of session assigned to "moderate" and "severe" levels of impairment found in both "Indications and Limitations" and "Utilization Guidelines" sections of the policy. • Frequency increased to 10 sessions in a 90-day period in the "Indication and Limitations" section. • Incorporated additional information from BCBS of Kansas's LMRP "Low Vision Services," New York State Carrier-sponsored conference of low-vision providers, and Occupational Therapy Association. • Policy revised to provide updated utilization guidelines and providers of the services.
Y-12A	• Policy revised to add clarifying statement based upon Program Memorandum AB-00-39.

Disclaimer Specialty Name

This policy does not reflect the sole opinion of the contractor or contractor medical director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from