

Ohio DDD Internal Medicine

Consultative Examination Guidelines

Part VII: Ophthalmological/Optometric Consultative Examinations (including Perimetry)

General Examination/Report Requirements

Introduction and Required Components

Make sure the report - through its thoroughness and presentation and interpretation of evidence - demonstrates that a genuine effort has been made to identify all ophthalmological/optometric diagnoses and probable diagnoses, as well as formulate a carefully thought-out assessment of current functional status ("Medical Source Statement") with respect to visual acuity and visual fields.

Make sure that the report documents the positive elements of the medical history and physical examination, as well as the negative elements. This is crucial because DDD cannot accept that an element of the history or physical examination was negative or normal unless it was explicitly stated to be negative or normal.

Make sure that all of the following requirements are met and documented in the report narrative using appropriate headings:

- A. Identify the Claimant
- B. List All Ophthalmological/Optometric Complaints
- C. Elaborate on Each Ophthalmological/Optometric Complaint in the History of Present Illness
- D. Document Pertinent Elements of Medical, Family and Social Histories and Medications
- E. In Children, Obtain Specific Age-Appropriate Information
- F. Conduct an Ophthalmological/Optometric Review of Systems
- G. Describe Claimant's General Appearance and Presentation
- H. Examine the Head
- I. Measure Uncorrected Visual Acuities
- J. Examine the Pupils, Extraocular Muscles and External Eye
- K. Test Visual Fields by Confrontation
- L. Measure Intraocular Pressures
- M. Perform Dilated Funduscopic Examination
- N. Measure Corrected Visual Acuities, Distance and Reading
- O. Measure Perimetry in One of Two Ways
- P. In Children, Perform Age-Appropriate Vision Assessment
- Q. Comment on Validity of Acuities and Perimetry
- R. Review Medical Records from DDD

- S. List Ophthalmological/Optometric Diagnostic Impressions
- T. Provide a Functional Statement ("Medical Source Statement") of Claimant's Ability to See
- U. Specifically State If Claimant Meets Legal Criteria for Statutory Blindness
- V. 1151 Form
- W. Proofread
- X. Signature

What If a Report is Inadequate?

If a report contains errors, DDD will need you to prepare an addendum that contains corrections or clarifying information. *Note: You are not paid for drafting addenda.*

If a report is missing important historical information or elements of the physical examination, DDD will need you to prepare an addendum and, in some cases, will require you to reexamine the claimant in your office at your own expense.

DDD understands that in some cases a claimant may be uncooperative. Document this in your report.

Thoroughness and Time Spent During History and Physical

DDD does not want you to rush through these important examinations, which are distinct from your regular examinations in the course of medical practice. Sometimes a consultative examination is the only medical evidence DDD will receive, making it vital to the determination process.

You need not create a therapeutic relationship during a consultative examination, but do allow enough time so that some degree of rapport can be developed between examiner and examinee. Allow ample time for the claimant to state all of his or her ophthalmological/optometric complaints and symptoms and to answer all of the questions with minimal interruptions from the examiner. This may take about an hour, but SSA requires that the history and physical (not including the writing and dictating of the report) must take 30 minutes or more.

Avoid excessively brief examinations. Important elements of the history or physical could be omitted during a cursory history and physical, which could result in the consultant having to complete a request for a clarifying addendum or even reexamine the claimant at the consultant's own expense. SSA requires that all claimant complaints be investigated, and one of the most common complaints is that an examination was too brief.

Who Is Permitted to Perform Various Parts of the Examination?

DDD realizes that a physician is not needed to weigh, measure height, take blood pressure and pulse, or even measure visual acuity; however, SSA has published criteria that specify who can and who cannot do various aspects of the history, physical examination and ancillary testing.

The Green Book states: "The medical source chosen may use support staff to help perform the consultative examination. Any such support staff (e.g., X-ray technician, nurse, etc.) must meet appropriate licensing or certification requirements of the State."

DDD has no problem with some elements of the examination or testing performed by appropriate support staff, which would include licensed and certified physician extenders like ophthalmology technicians. Except for these "substitutions," DDD expects that the physician personally perform all of the following:

- Take the history
- Examine the claimant
- Interpret the perimetry results

Professionalism and Complaints

DDD follows a formal procedure when a complaint is received. Common complaints in the past, in addition to allegations of an excessively brief examination encounter, have included that the consultant:

- Was rude
- Asked questions too quickly
- Did not give the claimant enough time to answer the questions
- Was rough when testing range of motion
- Had a poor bedside manner
- Told the claimant he/she was not disabled
- Told the claimant to go get a job

If any complaint is received, DDD will write you, request a written response to the claimant's allegations, and evaluate your response.

If a consultant receives multiple complaints, DDD will investigate and may cease to do business with that consultant.

You must be sincere and professional in all of your encounters with claimants.

Routine Review of Consultative Examination Quality

A statistical sample of reports is reviewed weekly by DDD's Chief Medical Consultant. When a report is found to be unsatisfactory, a letter is sent to the consultant, who must then submit a clarifying addendum. DDD monitors reports that deviate from SSA and DDD standards; however, most consultants regularly meet or exceed examination/report standards. When DDD does find poor quality reports, with no improvement in response to constructive criticism, the agency may cease to do business with a consultant.

Definite and Probable Diagnoses: Dealing with Uncertainty

The primary reason DDD needs your services through a consultative examination is that the agency has received little or no medical evidence from a claimant's treating sources. This is usually because the treating sources have not responded to medical records requests or the claimant does not have a treating source. As a result, when you see a claimant, you may not have other medical data that would assist you in definitively diagnosing any impairments or conditions he or she may have.

Because of the lack of medical testing and other data, you may not have enough information to make one or more definitive diagnoses on the basis of a one-time history and physical examination. It is acceptable to mention probable diagnoses.

Voucher Information

Read all of the voucher information so that you complete what is requested. On some occasions, there are special instructions about specific elements of the history or physical upon which DDD would like you to focus and comment.

Conducting Tests that Have Not Been Ordered

If perimetry is not ordered on the voucher, do not perform perimetry.

In the past, some consultants - on their own - have decided that an unordered test would be helpful and have gone on to perform the test. **This must not be done.** Payment will not be rendered for testing that is not preapproved and ordered on the voucher.

How to Add a Test

If you do think it would be beneficial to add a test, call DDD to discuss it. Sometimes, the agency will approve the added test. In this case, you will be paid for it, but **only** if you follow proper procedures and get approval in advance.

Non-English-Speaking Claimants

For non-English-speaking claimants, the history must be obtained from family members present during the exam or from an interpreter contracted by DDD. Report communication difficulties whether due to:

- Language barrier
- Difficulty hearing
- Difficulty speaking
- Difficulty seeing
- Cognitive impairment
- Mental illness
- Other

Specific Examination/Report Requirements

Enter the information on the appropriate forms provided with the voucher. Forms include:

- Ophthalmological Consultative Examination Form (Appendix A)
- Ophthalmological Consultative Examination Without Perimetric Fields Form (Appendix B)
- Ophthalmological Consultative Examination: Children Up to Five Years of Age (Appendix C)

These forms must be typed or legibly handwritten.

Identify the Claimant

Compare the claimant's countenance with a valid photo identification card.

List All Ophthalmological/Optometric Complaints

- Give claimant ample time to name complaints.
- Instead of asking, "Why can't you work?" be general and ask, "What sorts of physical problems and symptoms do you have?"
- Report from whom you obtained the medical history.
- Record whether you believe the claimant or other informant was reliable in presenting the history.

Elaborate on Each Ophthalmological/Optometric Complaint in the History of Present Illness

- Elaborate fully on each symptom and specific illness stated as a chief complaint.
- Record when each major symptom and each eye disorder began.
- Explain how each eye disorder was diagnosed.
- Describe the severity of each symptom and/or specific eye disorder onset and how the severity has changed or progressed.
- Document the eye treatments, surgeries or procedures that have been done and how successful they have been.

Document Pertinent Elements of Medical, Family and Social Histories and Medications

- List significant traumas, especially head, brain and eye trauma.
- List eye surgeries and significant procedures.
- List significant infections such as meningitis, encephalitis, demyelinating diseases and stroke.
- If present, list family histories of:
 - » Visual impairments
 - » Eye diseases
 - » Genetic syndromes
 - » Hearing impairments
 - » Neurological or neurodegenerative diseases
- List whether the following have been used and the extent of use (i.e., pack years, etc.):
 - » Tobacco (smoking)
 - » Tobacco (smokeless)
 - » Alcohol
 - » Illicit drugs

In Children, Obtain Specific Age-Appropriate Information

Important historical information in children includes the following:

- » Birth history and developmental milestones
- » Details of any developmental delays
- » Presence of any known genetic defects or congenital anomalies or syndromes
- » For children under 5, preschool and daycare behavior and ability to see
- » For school age children, school behavior and ability to see
- » History of any therapies (physical, occupational, speech)
- » Prescription for or use of glasses, contacts, low-vision devices or helps and any improvements noted
- » Enrollment in a school for the visually impaired or school for the blind

- » Independent educational plans (IEPs) or "504s" used in the school setting
- » Other accommodations used in the school setting
- » Attendance or residence in highly structured or highly supportive environments, institutions or settings and any improvements noted

Describe Claimant's General Appearance and Presentation

- Describe the salient features of your first impression of the claimant.
- Assess the claimant's ability to maneuver in the office and hallways and comment on whether this is consistent with measured acuities and visual fields and physical findings.

Examine the Head

- Report any syndromic features such as facial dysmorphism, skeletal anomalies or congenital anomalies.
- Document any evidence of head or eye trauma or brain surgeries.

Measure Uncorrected Visual Acuities

- Visual acuity should be measured using Snellen methodology or any other comparable testing methodology.

Examine the Pupils, Extraocular Muscles and External Eye

- Note the presence of and details about any cataracts or other causes of clouding of the media, as well as signs of uveitis.

Test Visual Fields by Confrontation

- This is important to assess the validity of perimetry.

Measure Intraocular Pressures

Perform Dilated Funduscopy Examination

- Document any physical findings that could account for losses of visual acuity or visual field abnormalities. This includes:
 - » C/D ratios and any changes of glaucoma
 - » Optic pallor or atrophy
 - » Macular abnormalities
 - » Presence of macular edema or proliferative diabetic retinopathy

Measure Corrected Visual Acuities (Distance and Reading)

- Visual acuity should be measured using Snellen methodology or any other comparable testing methodology.
- Refraction is used to determine best corrected vision.
- If a claimant has telescopic lenses, these should NOT be used to determine best corrected distance acuities.

Measure Perimetry in One of Two Ways

- Perimetry can be measured by using:
 1. Goldmann perimetry OR
 2. Automated static threshold perimetry with, for example, a Humphrey Field Analyzer 30-2 and an SSA Test Kinetic
- For static threshold perimetry, the perimeter must satisfy all of the following:
 1. Use optical projection to generate the test stimuli.
 2. Have an internal normative database for automatically comparing your performance with that of the general population.
 3. Have a statistical analysis package that is able to calculate visual field indices, particularly mean deviation.
 4. Demonstrate the ability to correctly detect visual field loss and correctly identify normal visual fields.
 5. Demonstrate good test-retest reliability.
 6. Have undergone clinical validation studies by three or more independent laboratories with results published in peer-reviewed ophthalmic journals.
- Other static perimetry requirements include:
 1. The test must use a white size III Goldmann stimulus and a 31.5 apostilb (10 cd/m²) white background. The intensity of the stimulus must be 4e. The stimuli locations must be no more than 6 degrees apart horizontally or vertically. Measurements must be reported on standard charts and include a description of the size and intensity of the test stimulus.
 2. In automated static threshold perimetry, the intensity of the stimulus varies. The intensity of the stimulus is expressed in decibels (dB). DDD needs to determine the dB level that corresponds to a 4e intensity for the particular perimeter being used. DDD will use the dB printout to determine which points would be seen at a 4e intensity level. For example, in Humphrey Field

Analyzers, a 10 dB stimulus is equivalent to a 4e stimulus. A dB level that is higher than 10 represents a dimmer stimulus, while a dB level that is lower than 10 represents a brighter stimulus. Therefore, for tests performed on Humphrey Field Analyzers, any point seen at 10 dB or higher is a point that would be seen with a 4e stimulus.

- In kinetic perimetry, the following is a requirement:

1. The kinetic test must use a white III4e stimulus projected on a white 31.5 apostilb (10 cd/m²) background.

In Children, Perform Age-Appropriate Vision Assessment

- The Landolt C Test or the Tumbling E Test can be used to evaluate young children who are unable to participate in testing using Snellen methodology. These alternate methods for measuring visual acuity should be performed by specialists with expertise in assessment of childhood vision.
- If formal testing is not possible, fixation and visual-following behavior can be used.

Comment on Validity of Acuities and Perimetry

If not valid, explain why not.

Review Medical Records from DDD

- If DDD has medical records on the claimant, the agency will send you some of the most pertinent records.
- Incorporate these results, if pertinent, in your ophthalmological/optometric diagnostic impressions (*see List Otolaryngological Diagnostic Impressions*) and your functional assessment (*see Provide a Functional Statement ("Medical Source Statement") of the Claimant's Ability to See*).

List Ophthalmological/Optometric Diagnostic Impressions

- This is a key element of the consultative examination and report.
- Include both confirmed diagnoses plus "probable" diagnoses.

Provide a Functional Statement ("Medical Source Statement") of Claimant's Ability to See

- This is an "educated estimate" of ability to physically function in the workplace for eight hours per day, five days per week.
- Important functionalities to consider include:
 - » Commercial driving
 - » Working at heights
 - » Working on dangerous machines
 - » Reading normal size print
 - » Reading large size print
- DDD realizes that you do not have the availability of every useful test to help you; that is why it is described as an "educated estimate."
- Use all of the data you do have, including the history, examination results, any X-rays or other tests done in your office (if applicable) and any medical records received from DDD.
- Do a reasonable and realistic assessment of function based on everything you know and have discovered about the claimant's vision.

Specifically State if Claimant Meets Legal Criteria for Statutory Blindness

- Statutory blindness is blindness as defined in sections 216(i)(1) and 1614(a)(2) of the Social Security Act (the Act). The Act defines blindness as visual acuity of 20/200 or less* in the better eye with the use of a correcting lens. The best-corrected visual acuity for distance in the better eye is used to determine if this definition is met. The Act also provides that an eye that has a visual field limitation such that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered as having visual acuity of 20/200 or less*.

**Most test charts that use Snellen methodology do not have lines that measure visual acuity between 20/100 and 20/200. Newer test charts, such as the Bailey-Lovie or the Early Treatment Diabetic Retinopathy Study (ETDRS), do have lines that measure visual acuity between 20/100 and 20/200. If the visual acuity is measured with one of these newer charts, and none of the letters on the 20/100 line can be read, this will be considered equivalent to a Snellen visual acuity of 20/200 or less (and therefore the determination of statutory blindness is appropriate).*

- Example: if the best-corrected visual acuity for distance in the better eye is determined to be 20/160 using an ETDRS chart, this is statutory blindness. Regardless of the type of test chart used, the finding of statutory blindness is not correct if the claimant can read at least one letter on the 20/100 line. For example, if the best-corrected visual acuity for distance in the better eye is determined to be 20/125+1 using an ETDRS chart, this is not statutory blindness because one letter on the 20/100 line was read.

1151 Form

- For some appeals, an administrative law judge will request an *1151 Form (Part II - Appendix D)*, which should be included in your packet. If it is requested on the voucher but not in the packet, *contact DDD*.
- You are not expected to fill out the portions not related to otolaryngological issues; you must complete the relevant part of page 4, the question about noise exposure on page 5 and sign the form.
- An extra fee is paid for completion of a requested *1151 Form*. The form is self-explanatory.
- The same principles stated under *Provide a Functional Statement ("Medical Source Statement") of the Claimant's Ability to See* should be used in completing the 1151. A copy of an 1151 Form can be found in Appendix D.

Proofread

Signature

Sign the report personally. Stamps, electronic signatures or signatures by persons other than the consultative physician are not permitted.

Part VII Appendices

- A. Ophthalmological Consultative Examination Form
- B. Ophthalmological Consultative Examination Without Perimetric Fields Form
- C. Ophthalmological Consultative Examination: Children Up to Five Years of Age
- D. 1151 Form (see Part II - Appendix D)

**OPPORTUNITIES FOR OHIOANS WITH DISABILITIES
DIVISION OF DISABILITY DETERMINATION**

Claimant: _____ A/N Case: _____

OPHTHALMOLOGICAL/OPTOMETRIC CONSULTATIVE EXAMINATION

History

Give ocular history, including any eye injury or surgery (state type and date).

R _____

L _____

Examination

Refract and give claimant's best corrected distance and near vision.

Visual Acuity - Snellen notations (20 feet for distance).

- If claimant is unable to read the largest letter on the Snellen Chart from any distance, but can count fingers, report "Count Fingers" (C.F.) at the determined distance.
- If the claimant is unable to count fingers, report "Hand Movements" (H.M.) at the determined distance.
- If the claimant is unable to see "Hand Movements," report "Light Perception" (L.P.) or "No Light Perception" (No L.P.).

Distance: Report in Snellen

Without glasses: R _____ L _____

With best correction R _____ L _____

Reading: Report in Snellen, Jaeger or Point Print

Without glasses: R _____ L _____

With best Correction R _____ at _____ inches L _____ at _____ inches

Visual acuity as given is ___ is not ___ consistent with findings. If not, explain:

Refraction Record:

OD: Sphere _____ Cylinder _____ Axis _____ Add _____

OS: Sphere _____ Cylinder _____ Axis _____ Add _____

Muscle Function:

Normal _____ Abnormal _____

Intraocular Pressure:

R _____ L _____

Describe abnormalities of extra-ocular muscles, external portion of eye, media and fundi:

Visual Field

Plot fields on all claimants using either the Goldmann Perimeter OR you may use the Humphrey Field Analyzer II (providing both the Central 30-2 Threshold Test AND the “SSA Test Kinetic”).

- The target/stimulus must be a size III at 4e intensity.
- All fields are to be performed **without** glasses. (If contact lenses are worn or special perimetric lenses, this is acceptable.)
- Please submit your field maps with this report.
- **It is important to obtain valid perimetric fields. It may be necessary to repeat field testing to be sure it is accurate and consistent with the findings on your exam.**

Indicate Plotted Field OS:	Indicate Plotted Field OD:
Without glasses	Without glasses
With contacts or perimetric lenses	With contacts
Target/Stimulus Size III intensity 4e	Target/Stimulus Size III intensity 4e
Other (specify):	Other (specify):

Indicate if you feel the claimant cooperated with the field testing in terms of fixation:

Cooperation: Good _____ Fair _____ Poor _____

Fixation: Good _____ Fair _____ Poor _____

Visual fields plotted are NORMAL _____ ABNORMAL _____

Visual fields plotted ARE _____ ARE NOT _____ consistent with findings.

If not consistent, even after repeating the perimetric fields, perform confrontation fields and comment on the claimant's ability to move about within the office.

Diagnosis

Ocular pathology primarily responsible for impaired vision:

R _____ L _____

Secondary pathological condition, if any:

R _____ L _____

Remarks:

In the space below, explain how the visual impairment, if any, affects this individual's ability to perform work-related activities (driving, reading, working at heights or other hazardous situations):

Doctor's Printed Name

Doctor's Signature

Name of Facility

Date

**OPPORTUNITIES FOR OHIOANS WITH DISABILITIES
DIVISION OF DISABILITY DETERMINATION**

Claimant: _____ A/N Case: _____

**OPHTHALMOLOGICAL/OPTOMETRIC CONSULTATIVE EXAMINATION
WITHOUT PERIMETRIC FIELDS**

History

Give ocular history, including any eye injury or surgery (state type and date).

R _____

L _____

Examination

Refract and give claimant's best corrected distance and near vision.

Visual Acuity - Snellen notations (20 feet for distance).

- If claimant is unable to read the largest letter on the Snellen Chart from any distance, but can count fingers, report "Count Fingers" (C.F.) at the determined distance.
- If the claimant is unable to count fingers, report "Hand Movements" (H.M.) at the determined distance.
- If the claimant is unable to see "Hand Movements," report "Light Perception" (L.P.) or "No Light Perception" (No L.P.).

Distance: Report in Snellen

Without glasses: R _____ L _____

With best correction R _____ L _____

Reading: Report in Snellen, Jaeger or Point Print

Without glasses: R _____ L _____

With best Correction R _____ at _____ inches L _____ at _____ inches

Visual acuity as given is ___ is not ___ consistent with findings. If not, explain:

Refraction Record:

OD: Sphere _____ Cylinder _____ Axis _____ Add _____

OS: Sphere _____ Cylinder _____ Axis _____ Add _____

Muscle Function:

Normal _____ Abnormal _____

Intraocular Pressure:

R _____ L _____

Describe abnormalities of extra-ocular muscles, external portion of eye, media and fundi:

Confrontation Field

Perform confrontation fields *without glasses*. (If contact lenses are worn, this is acceptable.)
Results of confrontation fields.

Visual fields by confrontation ARE _____ ARE NOT _____ consistent with findings.

If confrontation fields are not consistent, please explain and describe claimant's ability to move about within the office.

Diagnosis

Ocular pathology primarily responsible for impaired vision:

R _____ L _____

Secondary pathological condition, if any:

R _____ L _____

Remarks:

In the space below, explain how the visual impairment, if any, affects this individual's ability to perform work-related activities (driving, reading, working at heights or other hazzardous situations):

Doctor's Printed Name

Doctor's Signature

Name of Facility

Date

**OPPORTUNITIES FOR OHIOANS WITH DISABILITIES
DIVISION OF DISABILITY DETERMINATION**

Claimant: _____ A/N Case: _____

**OPHTHALMOLOGICAL/OPTOMETRIC CONSULTATIVE EXAMINATION
Children Up to Five (5) Years of Age**

Please describe the patient's ability to fixate: _____

Can patient perceive light? Hand movements? Does patient follow objects? Accept offered objects? Recognize familiar persons? If possible, measure visual acuity with and without correction.

Do pupils respond to light? Accommodation?

Describe the external eye, media, fundi in detail so that an independent objective estimate of visual efficiency may be made. Please describe ocular pathology.

Is nystagmus present? _____

Are random or wandering movements noted? _____

If cooperation permits, please give refraction and corrected visual acuity with Landolt C, Tumbling E, picture or similar chart.

Diagnosis: _____

Remarks: _____

Please explain how the visual impairment, if one is present, affects the child's ability to perform age-appropriate activities: _____

Doctor's Printed Name

Doctor's Signature

Facility Name

Date