C&P Optometry workgroup meeting minutes 11/28/2012

The meeting was led by Makesha Sink and Brian LeStrange. We appreciate everyone who participated on the call. Please remember that the opinions and comments given during the conference calls are to be taken as such, and are not necessarily absolute rules that need to be followed in all instances. Hopefully, these calls, the views expressed, and any subsequently generated meeting minutes are helpful to all members of our working group as we seek to provide the veterans we serve with the very best Compensation & Pension eye examinations.

1. Directive on ACE "Acceptable Clinical Evidence" – Impact on C & P Eye Exams

    - This is a directive officially giving permission to complete a C&P evaluation without a scheduled appointment if there is enough clinical evidence from case review to make a decision/opinion. This can include a phone interview with the veteran if necessary to clarify information. Although there are likely not many cases where this will apply for eye exams, there are patients that are routinely seen in our eye clinics that file claims and their usual exam information may suffice to complete the claim. Be sure you have all the information requested on the DBQ form or it may get returned to you to complete an examination. The facility director should work to create a workload credit for these instances when the ACE process is used.

2. Visual Field Testing and the DBQ Eye (Group discussion – when done/not done/concerns)

    - Formal visual field testing is not required for every C&P or IDES examination/claim

    - Although it is a good idea to perform a confrontation visual field on all patients in order to complete the DBQ section III.10, a Goldmann or acceptable alternative (Humphrey kinetic) is only necessary if a visual field defect is suspected based on the exam or for conditions which typically cause field defects (glaucoma, neurological, etc).

    - The C&P raters use the visual field calculator to determine if there is a visual field defect present. This "calculator" can be viewed through the VA optometry Intranet website administrative page if you want to know how it works. http://vaww1.va.gov/OPTOMETRY/Administrative_Page.asp

    - Humphrey automated kinetic fields limit the ability to determine a central scotoma but there are manual kinetic options on the Humphrey that can be used to determine any scotoma, whether central or peripheral.

    - As a general recommendation - a visual field defect should only be marked "yes" on the DBQ if it relates to the claimed condition on the 2507. If a field defect is found during the exam which relates to an unclaimed condition, it can be reported in the "remarks" section at the bottom of the DBQ.

- Per our previous survey – about 40-50% of C&P optometry providers are using the Automated Humphrey kinetic field, the remainder are using Goldmann or another source to assess visual field loss.

- It is important to keep in mind that the C&P reviewers are not medical providers and are basing their decision solely on what is reported to them. They may ask for visual fields or clarifications that do not make sense to us clinically and we have to keep open communication with them and let them know clinically if conditions exist, if field defects exist, or if visual field testing is needed for a certain diagnoses.

- It is good to use the remarks section on the DBQ to provide extra information to the raters that is not in the DBQ template

3. Shift to generic C&P/IDES requests ("bilateral eye", "eye disability")

    - Veteran service representatives write the claims and the 2507, and will often use generic terms like "eye condition" "eye issue" "loss of vision" when they see anything in the veteran's record, veteran's report, or history that refers to eyes. We still have to perform the exam. It is a good idea to write what the claimed condition is in quotes and then to separately document what the veteran reports as the condition.

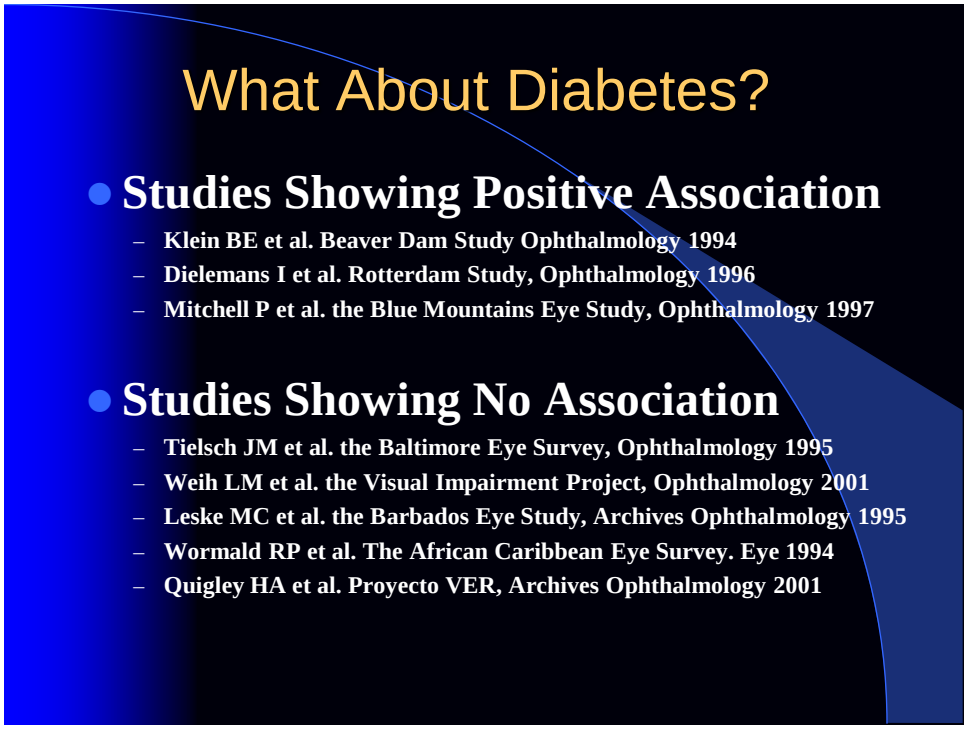
4. DBQ Eye (Group discussion – Recommended improvements/"Santa Wish List")

    - Dr. LeStrange had made contact with an individual at DMA that is willing to get our input when it comes time to update or change the eye DBQ format. This gives us an opportunity to gather recommendations and work through John Townsend and the central office to pass along changes that we may like to see. We will work over the next few months to create a survey specific to this topic and to gather everyone's feedback to be able to potentially make the form more provider-friendly; keeping in mind we cannot please everyone!

5. Glaucoma secondary to diabetes

    - In every case, we as the providers must use our clinical decision to make a judgment on each claim. As most literature suggests, in order for the glaucoma to be secondary to diabetes, it has to be secondary to vascular compromise from diabetes. So, neovascular glaucoma from proliferative diabetic retinopathy would certainly qualify. There can be an argument for low tension glaucoma in a patient with retinopathy secondary to vascular compromise. Whatever you decide/opine, you should be able to use literature to back your decision in case a clarification or appeal ensues.

- Olga Whitman provided the following slide with some references to support a decision of glaucoma associated with diabetes or not. You can use this if so desired.



- Brian LeStrange has offered this statement as well that he has used for the past few months:

  Based on the following consensus statement from the World Glaucoma Association, it is less likely as not that the veteran's glaucoma is caused by or aggravated by his diabetes:

  > " Diabetes was routinely assumed to be a risk factor for primary open angle glaucoma (POAG) until the last 15 years, when it failed to show an association with POAG in several population-based studies and clinical trials. There is reason to believe that the past association between diabetes and glaucoma may have been partly derived from ascertainment bias because diabetes patients might have more eye examinations (glaucoma more likely to be discovered). At the present moment, the relationship between diabetes and the risk of glaucoma development and progression remains unclear."

6. Other topics. Dr. Sink has researched the topics below and provided the hard evidence in the highlighted areas and listed where it was found. Use it as you wish!

   1. A question came up regarding if the DBQ had to be used and several providers on the call stated that they had their own templates that they use. I researched on the Office

of Disability and Medical Assessment (DMA) website and found the following statement under the DBQ information section.

"Compensation and Pension clinics may receive a DBQ request by regional offices in addition to or instead of examination worksheets/templates as part of the disability examination process. If this is the case, the DBQ should be completed during scheduled disability examinations."

So according to this statement – we should all be using the "DBQ eye conditions" template for C&P exams and the "eye examination" template for IDES if it is listed as the ***requested exam*** on the 2507. If you desire to use additional templates or exam reports they can be submitted in addition to the DBQ. The DMA website address is as follows if you desire further information.
http://vaww.demo.va.gov/DBQWorkshop2011.asp

2. Discussing results of the C&P exam to the veteran/service member.

I researched the CPEP performance support training system.
http://vaww.mam.lrn.va.gov/cpep/

The following is listed as what the "wrap-up" of the exam should entail:

> **"Wrap-up**
> *The Exam*
>
> 1. Ask the veteran if he/she has any questions.
> 2. If the veteran asks what the outcome of the claim will be:
>   - Explain that this is not a decision that the clinician makes
>   - Inform the veteran that your role is to perform the examination
>   - Explain that VBA will determine the final rating, and the decision will be sent to them.
>
> **DO NOT** respond by speculating on a claim outcome"

Another DMA reference lists the following about discussion of C&P exam results:
http://vaww.demo.va.gov/dbqscripts.asp#s1

> "At the time a DBQ is completed, all clinicians should discuss the examination results with the Veteran. Openly discussing the findings with the Veteran provides a partnership in the process and demonstrates respect, empathy and support for Veterans. Any discussion related to Veterans disability criteria or compensation awards must be deferred to VBA. The following are examples of suggested scripts when using IHD DBQs. However, similar language may be used for other DBQs."
>
> (Sample discussion scripts are listed on the website below this statement.)

3. Do the Humphrey kinetic field results have to be transferred to the Goldmann chart to be turned in?
    - http://vaww1.va.gov/OPTOMETRY/docs/FL06-021.doc
    - in the link above – it states: "To be accepted, the results must be reported on standard Goldmann charts." Some in the field report that they are turning in the Humphrey printout without problems, others say they request the results transferred onto Goldmann charts.

Our goal is to meet again in January 2013. If you have any agenda items, questions, comments, please let Brian and Makesha know (e-mails below). Also, this, future, and previous C&P workgroup meeting minutes are posted on the C&P workgroup page of the NAVAO website www.navao.org for NAVAO members.

Happy Holidays to you all!

Makesha.sink@va.gov
Brian.LeStrange@va.gov