

VHA PROSTHETIC CLINICAL MANAGEMENT PROGRAM CLINICAL PRACTICE RECOMMENDATIONS

PRESCRIPTION AND PROVISION OF OPTICAL LOW-VISION DEVICES TO AID IN OVERCOMING VISUAL IMPAIRMENT

I. PURPOSE

The purpose of these clinical practice recommendations is to assist practitioners in clinical decision-making and delivery of services, to standardize and improve the quality of patient care, and to promote cost-effective prescribing.

II. BACKGROUND

The Under Secretary for Health directed Veterans Health Administration (VHA) Prosthetic and Sensory Aids Service Strategic Healthcare Group to establish a Prosthetic Clinical Management Program (PCMP). The objectives are to coordinate the development of clinical practice recommendations for prosthetic prescription practices and contracting opportunities to assure technology uniformity and ease of access to prosthetic prescriptions and patient care that will lead to valid outcome measures and analysis for research purposes.

A work group with input from selected clinicians, blind rehabilitation specialists, prosthetic experts, and consumer representatives from the Blinded Veterans Association (BVA) convened to develop clinical practice recommendations for the prescription, use, training and issuance of Optical Low-Vision Devices (OLVDs) to assist veterans with legal blindness and visual impairment. OLVDs can be categorized as near, intermediate and distance devices; sunwear; emerging technology; lighting devices; reading stands; magnifying mirrors; optical character readers (OCR), etc. (Attachment A).

VA Blind Rehabilitation Centers, Blind Rehabilitation Outpatient Specialist (BROS), and Visual Impairment Services Team (VIST) programs were developed to care for veterans that meet the criteria for legal blindness. There will be occasions when veterans with significant visual impairment, including those that are not legally blind, may have need for and could benefit from some items categorized as Aids for the Blind, including OLVDs. Those eye care practitioners that serve the abovementioned veterans in a variety of clinical settings may prescribe appropriate Aids for the Blind OLVDs as indicated. When the veteran is visually-impaired but not legally blind, the Prosthetics order should be processed through an appropriate eye care

practitioner, not through VIST or BROS. There must be documentation about the justification for and evidence of appropriate patient training in use of OLVDs to meet VHA outcome measures (Attachment B).

III. MEDICAL CRITERIA

The following criteria must be met for visually-impaired veterans to be prescribed appropriate OLVDs to aid in improving or maintaining independence in essential activities of daily living:

- A. The veteran must be determined by an eye care practitioner (optometrist or ophthalmologist) to be legally blind or have significant visual impairment that may benefit from OLVDs. For purposes of this Clinical Practice Recommendation, "significant" visual impairment is defined in the American Optometric Association, Optometric Clinical Practice Guideline, Care of the Patient with Low Vision, and American Academy of Ophthalmology, Preferred Practice Patterns: Vision Rehabilitation for Adults.
- B. In general, the veteran's vision should be stable or not require any immediate invasive medical treatment. However, visually-impaired veterans may be prescribed and issued prosthetic OLVDs during periods of visual instability or as a result of extended or delayed treatment processes (e.g., waiting for possible eye surgery) so they may accomplish essential functional tasks such as the ability to independently manage their medical or other necessary healthcare therapies.
- C. An increasing number of veterans suffer age-related losses in both vision and hearing. To aid in successful rehabilitation, prior evaluation by Audiology with dispensing of hearing aids is preferred before enrollment in a visual rehabilitation program. On occasion, over-the-counter Amplification/Listening Devices may be needed to assist uncorrected hearing-impaired veterans during the visual rehabilitation process; however, these veterans should ultimately be referred to Audiology for more in-depth evaluation to reduce the impact of dual sensory impairment.
- D. A comprehensive low-vision examination by an eye care practitioner that allows for evaluation of the full range of OLVDs, meeting the nationally published standard of care, must be available to veterans with significant visual impairment.
- E. An abbreviated low-vision examination with or without the need for additional training session(s) must be performed by an eye care practitioner for those veterans with near-normal vision or mild visual impairment.

- F. The veteran has a stated goal(s) that requires the use of OLVDs.
- G. The veteran expresses an interest in using OLVDs to accomplish the goal(s).
- H. The veteran demonstrates the ability to independently and safely use the OLVDs to effectively meet the stated goal(s).
- I. Prior to prescription of an OLVD, the practitioner should evaluate appropriate devices to help the veteran accomplish the stated goal(s), including conventional optical devices, closed circuit televisions (CCTV) and non-optical devices.
- J. The OLVD must prove to be the most efficient and effective means of utilizing the veteran's remaining vision to accomplish the stated goal(s).

IV. CLINICAL PRACTICE RECOMMENDATIONS FOR EVALUATION/ TRAINING IN THE USE OF OLVDs

- A. Coordination of care for legally blind veterans is the primary responsibility of the Visual Impairment Services Team (VIST) Coordinator. The VIST Coordinator, with appropriate training and competencies, serves as the local resource on visual impairment issues, benefits, and services. All significantly visually-impaired veterans should be referred to the Visual Impairment Services Team.
- B. Basic low-vision care should be offered in primary eye care clinics on a just-in-time basis for those veterans with near-normal vision or moderate visual impairment. This entails an abbreviated low-vision exam with or without the need for additional training sessions. Priority referral to the eye clinic should be available to patients through primary care providers who determine or suspect that the veteran has vision loss.
- C. Intermediate or advanced low-vision care should be offered in clinics staffed by a low vision eye care practitioner and low-vision rehabilitation multidisciplinary or interdisciplinary staff member(s) respectively. A comprehensive low-vision eye examination that meets the nationally published standards of care should initiate the assessment and plan. The low-vision examination will evaluate the veteran's ability to benefit from a full range of OLVDs.
- D. Training in the use of OLVDs is essential and may be offered through outpatient or inpatient VHA programs, including Visual Impairment Center to Optimize Remaining Sight (VICTORS), BROS, VHA low-vision clinics,

Blind Rehabilitation Centers (BRC), Visual Impairment Services Outpatient Rehabilitation (VISOR), general Eye Clinics of Optometry or Ophthalmology, and appropriate local or state non-VHA agencies. The VIST Coordinator should aid the veteran in timely referral to the appropriate resource for the level of care that would best serve the needs of the veteran.

- E. Training in use of OLVDs should be provided by specialists with appropriate competencies in the least restrictive environment available. The training may be done by optometrists, ophthalmologists, blind rehabilitation specialists, low-vision therapists, occupational therapists with training as a low-vision therapist/visual skills instructor, optometry technicians or ophthalmology technicians.
- F. The clinic in which the provider offers care for the visually-impaired veteran should have documented evidence of an ongoing program of quality assurance in order to maintain the highest level of care.
- G. Appropriate documentation must appear in the medical record that clearly identifies the training provided and the veteran's ability to achieve the stated goal(s).
- H. Correction of refractive error, accomplished through examination by a VA or VA contract optometrist or ophthalmologist, must precede prescription of OLVDs. OLVDs must be evaluated in conjunction with conventional eyeglasses (e.g. microscopic spectacles) that may also help achieve the stated goal(s). Considerations for OLVDs should include ergonomics, comfort, health status, and patient preferences in addition to performance level in determination of efficiency and effectiveness.
- I. When the veteran's goals necessitate prosthetics devices for distance, and/or intermediate, and/or near vision related tasks, prescription of more than one OLVD and/or Emerging Technology OLVD within the same type or category may be justified.
- J. When the veteran presents with vocational, educational, and/or avocational goals, which demand multiple working distances, and/or portability, that cannot be adequately accomplished with a standard OLVD, then the appropriate Emerging Technology OLVD alternative may be evaluated. These alternatives include but are not limited to, portable flat screens with hand-held cameras and head mounted screen displays with cameras.
- K. When the primary goal of the veteran involves volume reading or other visual tasks that cannot be adequately accomplished by using standard

OLVDs, the OCR and/or other Emerging Technology Prosthetics devices may be evaluated.

- L. Visually-impaired veterans with a demonstrated need for standard OLVDs, Emerging Technology Prosthetics devices, and an OCR may be prescribed all of these devices.
- M. OLVDs must be prescribed by and/or their provision coordinated with a VA or VA contract doctor of optometry or ophthalmology.
- N. A veteran denied an OLVD may appeal the decision through the appellate rights process. The veteran submits a Notice of Disagreement to the local program who then develops a Statement of the Case before the claim is sent to VACO.

V. PRESCRIPTION AND PROVISION OF OLVDs

- A. OLVDs must be prescribed by and/or their provision coordinated with a VA or VA contract doctor of optometry or ophthalmology. Each prescribing VA eye care practitioner must have clinical privileges to ensure appropriate services and prescriptions for visually-impaired veterans. VA contract eye care practitioners must be privileged when providing care at the VA medical facility or possess appropriate credentials for care contracted off-station.
- B. In coordination with a VA or VA contract optometrist or ophthalmologist, appropriately credentialed and clinically trained low vision and blind rehabilitation specialists (e.g., low-vision therapist, BROS) may recommend prescription of and provide selected OLVDs to meet the veteran's immediate needs until such time as a comprehensive low-vision examination can be completed by a VA or VA contract optometrist or ophthalmologist.
- C. The temporary provision of selected OLVDs does not substitute for or obviate the need to refer visually impaired veterans to a VA or VA contract optometrist or ophthalmologist for a comprehensive low-vision examination.
- D. Prescription of OLVDs should adhere to VHA policies and procedures as well as Medicare guidelines for documentation of examination, treatment, outcomes, billing procedures, and prescription of prosthetic devices. To receive prescriptive prosthetic devices to aid in overcoming visual impairment, the

veteran must be an eligible beneficiary and the prosthetic equipment must be medically necessary. Proper documentation must include the medical justification for and evidence of appropriate patient training in use of OLVDs. VHA outcome measures are included to aid the clinician in determination of successful outcome of prescription of OLVDs. (Attachment B)

- E. Blind Rehabilitation Centers: Blind Rehabilitation Specialists with appropriate competencies may recommend prosthetic devices for veterans participating in a Blind Rehabilitation Center. The VA staff optometrist or ophthalmologist for the Blind Rehabilitation Center is responsible for documentation of medical necessity and prescription of all prosthetic OLVDs for veterans enrolled in the Blind Rehabilitation Center. The Prosthetics Activity at the medical center at which the BRC is located will furnish all prescribed devices upon completion of training.
- F. Blind Rehabilitation Outpatient Specialist (BROS): The prescription of any adaptive aids or appliances will follow the same guidelines used by Blind Rehabilitation Specialists at the BRC with which the BROS is affiliated.
- G. Replacement OLVDs must be prescribed by and/or their provision coordinated with the optometrist or ophthalmologist at the home VA medical facility of veterans who have previously participated in BROS, BRC, VICTORS, VISOR, or other special rehabilitation programs. The VIST Coordinator should facilitate replacement of devices by sending an electronic consult to the appropriate VA or VA contract optometrist or ophthalmologist with specific information on the condition of the device and necessity of replacement or re-evaluation of the veteran.

VI. HOME SET-UP OF EQUIPMENT

Some types of electronic equipment may require assistance for set-up in the veteran's home. The prescribing VA or VA contract optometrist or ophthalmologist, as well as VIST and BRCs are encouraged to work with the Prosthetics Activity and all available resources to ensure that equipment is properly issued, set-up, and maintained in the veteran's home environment. This may be accomplished through BROS or a home visit by a BRC instructor if the veteran lives in close proximity to a BRC. In other cases, the prescribing VA or VA contract optometrist or ophthalmologist, and VIST or BRC may need to work with the local Prosthetic Activity to identify a vendor or third party assistance with home

set-up of special electronic equipment. The cost of set-up and delivery should be arranged and funded by the local VA Prosthetics Activity.

VII. REFERENCES


- A. Optometric Clinical Practice Guideline, Care of the Patient with Low Vision, American Optometric Association.
<http://www.aoanet.org/eweb/Documents/14.pdf>
- B. Preferred Practice Patterns: Vision Rehabilitation for Adults, American Academy of Ophthalmology.
- C. World Health Organization, The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM).
- D. The American Medical Association: Cocchiarella L, Anderson G, eds. Guides to the Evaluation of Permanent Impairment. 5th ed. Chicago: American Medical Association Press, 2001.
- E. The International Society for Low Vision Research and Rehabilitation: Colenbrander A. Guide for the Evaluation of Visual Impairment. San Francisco: Pacific Vision Foundation, 1999.
- F. Social Security Administration, <http://www.ssa.gov>
- G. Aids For The Blind, VHA Handbook 1173.5, September 23, 2002.
- H. Study on Coverage of Outpatient Vision Services Furnished by Vision Rehabilitation Professionals Under Part B (Section 645 of the Conference Agreement and Section 446 of the Senate Bill).
- I. Department of Veterans Affairs VHA HANDBOOK 1173.2, Veterans Health Administration Transmittal Sheet, Washington, DC 20420 November 3, 2000
FURNISHING PROSTHETIC APPLIANCES AND SERVICES

J. Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP)

K. Maintaining Billable Provider Credential Information in the Veteran Health Information System and Technology Architecture (VISTA) New Person File, VHA Directive 2002-056, September 23, 2002.

L. VHA Prosthetic Clinical Management Program Clinical Practice Recommendations for Prescription of Closed Circuit Televisions (CCTVs) and other Electronic Optical Enhancement Devices (EOEDs), August 9, 2002.

APPROVED/DISAPPROVED:


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ATTACHMENT A

TYPES OF OPTICAL LOW VISION DEVICES, VISUAL IMPAIRMENT PROSTHETICS AND THEIR RECOMMENDED USE

The purpose of the devices listed by type or category is to enhance the visually impaired veterans' abilities to:

A. NEAR

Read fluently or perform near spotting tasks:

1. Microscopic Spectacles
2. Closed Circuit Televisions (CCTVs)
3. Pocket Magnifiers
4. Stand Magnifiers

B. INTERMEDIATE

Perform practical tasks at arm's length, such as, writing, card playing, reading music,

basic home maintenance tasks, etc.:

1. Optivisors
2. Magnifying Lamps
3. Single Vision Only Spectacles
4. Loupes
5. Telemicroscopes

C. DISTANCE

Perform distance-short term spotting, and distance long-term viewing:

1. Hand-held Monocular Telescopes
2. Spectacle Mounted Telescopes

D. SUNWEAR/TINTS/FILTERS

Adapt to varying lighting conditions by improving contrast sensitivity and ameliorating glare issues.

E. EMERGING TECHNOLOGY

Accomplish vocational, educational, and/or avocational related goals, which demand multiple working distances and/or portability:

1. Electronic Optical Enhancement Devices (EOEDs)
2. Multi-Distance Auto-focus Devices
3. Night Vision Enhancement Devices

F. OTHER AIDS FOR THE BLIND

Improve quality of life, safety, mobility, with appropriate assistive and/or adaptive devices:

- Lighting Devices
- Reading Stands
- Magnifying Mirrors
- Optical Character Readers

ATTACHMENT B

VHA OUTCOME MEASURES

At the conclusion of training, the veteran will show improvement in and development of skills and capabilities needed for personal independence, and successful integration into the community and family environment, which may lead to improved quality of life. VHA outcomes measures for Prosthetics devices may include the following areas, as applicable:

1. Orientation and mobility
2. Living skills
3. Communication skills
4. Activities of daily living (ADL)
5. Independent living
6. Manual skills
7. Visual skills
8. Computer access training skills
9. Physical conditioning
10. Recreation
11. Adjustment to blindness and/or significant visual impairment
12. Group meetings/social interactions

NOTE: The VHA Outcome Measures are arrived at through both objective and subjective means. Current research dictates the particular measurement tools or measures utilized.

ATTACHMENT C

VHA Prosthetic Clinical Management Program Clinical Practice
Recommendations for Prescription of Closed Circuit Televisions (CCTVs) and
other Electronic Optical enhancement Devices (EOEDs), August 9, 2002.



CCTV and EOED
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