Appendix A. Peer Review Chart Survey for Optometrists in Primary Care, Contact Lens, Pediatrics / Vision Therapy, and Myopia Control Clinics

Section 1. Chart Sample Identification

Please use this link for each of the charts you will be evaluating (3 for each provider).
The main quality assurance section will be counted for your score.
The MIPS section is for supplemental data as we evaluate how to improve clinical standards in our organization.

1. What is your full name?
2. What is the full name of the optometrist you are evaluating?
3. What is the assigned number of the chart you are evaluating (if not numbered, number in order received)?

Section 2. History (Yes or No Questions)

4. Was the patient's age documented on this exam (Date of birth does not count)?
5. Demographics: Were relevant demographic details documented for this chart?
   For example, including race or sex when relevant to the patient's clinical signs. (If not needed for the particular chart you are assessing, please select "yes".)
6. History of Present Illness (HPI): For complete eye exams, were at least 4 elements of HPI documented?
7. Was a Medical History appropriately reviewed and documented?
   Note: Collecting medical history with documentation of negative and positive disease processes is part of a comprehensive eye exam. This is different from a ROS (Review of Systems), which should be a review of **current symptoms** and not a reduplication of the problem list/medical history. ROS is no longer a necessary component for billing E/M visits, and thus is not a question for this year's chart review.
8. Personal, Family, Social History: Was at least ONE of the following documented/reviewed? (Family Ocular/Family Medical History Smoking status, Occupation or Grade level Hobbies, Reading or Electronic device/Screen usage Recreational drug usage, Alcohol consumption, Whether patient drives a motor vehicle)
9. Were medications documented/reviewed?
10. Were allergies documented/reviewed?

Section 3. Elements of Exam (Yes or No Questions)

11. Was visual acuity assessed and documented appropriately for each eye?
    (Note: Near VA may be checked during refraction and not documented in initial VA testing to receive credit. If non-verbal patient, give the point for VA as long as documented in chart that patient is non-verbal.)
12. Were appropriate entrance tests assessed (pupils and motility for all, and confrontation fields for comprehensive exams; non-verbal or intellectually-impaired patient charts should have documentation that patient unable to respond for appropriate sections)?
13. Was appropriate anterior segment exam documented?
14. Was appropriate posterior segment exam documented?
15. If refraction was performed, was visual acuity documented (Give point for non-verbal patients)? Yes or No or N/A
16. Was all personal identifying information (name, DOB, phone #, account #, etc) removed from this chart sample? (i.e. can you see any patient info, even through blacking out?)

Section 4. Compliance (Yes or No Questions)

17. Is it clear that the optometrist developed the assessment and plan? (Pay attention to clinical wording that indicates the provider has personally been involved in developing the assessment and plan.)
18. Is the chief complaint addressed in the assessment and plan?
19. Were all abnormal exam findings appropriately addressed in the assessment and plan?
20. Was a plan (further evaluation, management, treatment) recorded for each diagnosis?
21. Was the follow-up period noted (even if it's 12 months or 2 years)?
22. If a comprehensive eye exam, would a 92014 and 92015 be appropriately matched to the overall documentation for this exam?

For the questions below, all clinicians answered questions in Section 5 and 11.
Electronic survey design enabled providers to answer only the particular section relevant for the diagnosis of the chart being reviewed (For example, only Section 6 if a chart of a patient with Diabetes, or only Section 7 for a chart with a patient with a diagnosis of glaucoma).

Section 5. MIPS and Clinical Standards (Multiple Choice Question)
While there have been changes to the 2021 MIPS (Merit-Based Incentive Payment System) structure, we continue to assess the following quality of care measures this year. For this section, only answer the questions that apply to the diagnoses for this specific patient.

23. What is the primary diagnosis written at the top of the chart to evaluate? (Some chart samples may be missing 1 diagnosis and have 2 of the same diagnosis to compensate)

a. Primary Care: Diabetic Retinopathy
b. Primary Care: Cataracts
c. Primary Care: Glaucoma or Glaucoma Suspect
d. Contact Lens: Dry eye or Blepharitis
e. Contact Lens: Regular Astigmatism
f. Contact Lens: Progressive Myopia or Myopia
g. Pediatrics/VT/Vision Rehab: Convergence or Accommodative Dysfunction
h. Pediatrics/VT/Vision Rehab: Strabismus or Amblyopia
i. Pediatrics/VT/Vision Rehab/Myopia Control Clinic: Refractive Error
j. Low Vision: Age Related Macular Degeneration
k. Other: Evaluation/Management Sample

Section 6. Primary Care: Diabetes Standard of Care Questions (Yes or No Questions)

24. Measure 18: Documentation of presence or absence of macular edema and level of severity of retinopathy.
Did the optometrist document the presence or absence of macular edema AND level of severity of retinopathy?
25. Measure 117: Diabetic Patient Dilated Eye Exam (for patients 18-75 years old):
Was a dilated eye exam performed at this visit or documented within the last 12 months?
26. Measure 19 (High MIPS priority): Communication with the Physician Managing Diabetes Care about Diabetic Retinopathy (results of DFE reported to PCP regarding findings at least once a year). Was there documentation of communication with the PCP about the diabetic retinopathy, or were the results noted in the Problem List (i.e. "No retinopathy" noted in Problem List in EHR)?

Section 7. Primary Care: Glaucoma or Glaucoma Suspect Standard of Care Questions (Yes or No Questions)

24. Measure 141 (high MIPS priority): POAG/(glaucoma suspect management) for patients 18 years old and older--reduction of IOP by 15% OR documentation of plan of care. (For our purposes, glaucoma suspects have been included in this measure.)
Did the optometrist specify the target IOP and document the amount of reduction OR did the provider document a plan of care for POAG/glaucoma suspicion?
25. Did the optometrist document a plan for visual field testing and OCT testing as needed, or did they appropriately refer?
26. Did the optometrist document patient education about the importance of follow up to reduce risk of vision loss in their plan?

Section 8. Primary Care: Cataracts Standard of Care Questions (Yes or No Questions)

24. Did the optometrist document whether the cataracts were visually significant or impacting activities of daily living (ADLs)?
25. If BCVA was reduced to 20/40 or worse in either eye, did the optometrist document patient education on management options, including options for surgical consultation (or a reason for not doing so)?

26. Did the optometrist document the outcome of the patient education/discussion, ultimately whether the patient would be monitored or referred out for evaluation/consultation?

Section 9. Contact Lens: Standard of Care Questions (Yes or No Questions)
While not official PQRS questions, these questions are meant to help to improve CL provider documentation and quality of care. They will not count toward the official score.

24 Did the optometrist document at least 3 elements of contact lens hygiene (type of solution, average wear time, age of current lenses, age of CL case, etc)?
25. If prescribed, did the optometrist document any over-the-counter drugs or artificial tear supplements in the medication list (and not just in the assessment and plan)?
26. Did the optometrist address the pertinent (needs follow-up) ocular health findings that were found during the exam in their assessment and plan? (For example, if glaucoma suspect, were they scheduled for follow-up testing, or if retinal findings were found, was there an appropriate plan?)
27. Is the optometrist in compliance with the Final Amendment of the FTC Contact Lens Rule (ie. obtain and retain a signed confirmation from the patient that they received a copy of their contact lens prescription)?

Section 10. Measure 130: Documentation of Current Medications (Yes or No Question)
This measure was a high priority in the 2018 MIPS measures. While it is measured for patients 18 yo and older, all of our clinical providers will be reviewed for this standard of care, including for pediatric patients.

24. Measure 130: Documentation of current medications in medical record for patients 18 yo and older; must include all known prescriptions, over the counter medications, herbal remedies, vitamins, supplements, and must contain name, dosage, frequency, and route of administration

Section 11. Pediatric / Vision Therapy Standard of Care Questions (Yes or No Questions)

25. Was there documentation that the functional needs of the child (school performance, screen usage, IEP, etc) were asked in the history-taking?
26. Was patient education documented such that it was clear that the patient understood any risk to vision and was educated on the importance of follow-up?