Care standards: Eye exam

Comprehensive eye exams are critical, not only to correct and preserve vision, but also for the early detection of disease. To support our commitment to quality care for all patients, we have developed care standards for eye health examination. These guidelines reflect our focus on early detection and prevention.

The following 17 elements are required for all comprehensive eye health examinations:

Element 1: Reason for visit

What is expected: The patient should be directly questioned as to why they presented for the encounter. The patient should be asked about issues with their eyes and vision or other problems that may be related to the visual system. The answers to these questions should be documented in the medical record.

Key points

Care standards for eye exams include 17 required elements that reflect our focus on early detection and prevention

Element 2: Review of systems

What is expected: Each of the following systems should be queried and the patient's response recorded. For all positive responses, additional questioning may be indicated.

- Cardiovascular
- Constitutional
- Endocrine
- Gastrointestinal
- Head
- Hematologic/Lymphatic
- Immunologic
- Integumentary
- Musculoskeletal
- Neurological
- Psychiatric
- Respiratory

Element 3: Medications and allergies

What is expected: Medication name and dosage for all drugs or supplements the patient is taking should be recorded. If no medication, this should be indicated on the chart as none and not left blank. For allergies related to medications, the name should be listed as well as the adverse effect the member experienced. If the patient experiences environmental or food allergies, these should be noted as well. If no allergies are reported, the chart should indicate this.

Element 4: Ocular history; family history; orientation, mood and affect

What is expected: A detailed list of the patient's previous eye problems and procedures should be listed. The family history should query medical problems including diabetes, hypertension, thyroid problems and cancer in addition to eye problems such as cataracts, glaucoma, and macular degeneration. The patients should be asked if they know the day, date and their current location. The clinician should note the validity and assess whether the patient's mood or affect is normal or abnormal.

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Element 5: Entering visual acuity at distance and near

What is expected: A measurement of visual acuity both uncorrected and with the patient's habitual correction should be performed at both distance and near.

Element 6: Entering tests, including vital signs and external examination

What is expected: Measurement of the following:

- Height*
- Weight*
- Body mass index*
- Blood pressure for patients age 13 and older*
- Pulse*
- Testing of pupil response
  - Direct
  - Consensual
  - Swinging flashlights
- Extra ocular muscle testing
- Cover test
- Visual field
  - Confrontation or
  - Automated test

*Measurements for these items are highly recommended, but are not required.

Element 7: Refraction

What is expected: The refraction is the subjective test that allows for the patient's visual perception of the physical refractive error. Auto-refraction, by itself, is not an acceptable measurement.

Element 8: Near point testing

What is expected: Testing may include measurements of accommodation and/or convergence as well as additional testing as determined by the provider (e.g. evaluation of saccadic eye movements).

Element 9: Current optical prescriptions

What is expected: The current glasses prescription should be recorded in the refractive testing area.

Element 10: Corneal curvature

What is expected: The measurement should be recorded in the refractive testing area when indicated.

Element 11: Biomicroscopy

What is expected: Use of the slit lamp biomicroscope to inspect all anterior segment eye structures including the lids and lashes, tear film, cornea, anterior chamber, angle grade, iris and lens. The documentation must be individualized based on the findings of the examination. Cloned language in electronic health records should be carefully reviewed and revised to be consistent with the rest of the documentation in the record.

Element 12: Intraocular Pressure

What is expected: The type of instrument used as well as the time of measurement should be included with the numerical finding.

Element 13: Optic nerve head evaluation

What is expected: The optic nerve must be visualized, and details recorded at each visit. The details of the evaluation of the Optic nerve should include all aspects of the nerve itself, including cup to disc ratio, disc margin, disc size, color, thickness and vessel caliber. The exam may be performed with a minimum of a fundus lens, or a direct ophthalmoscope, indirect ophthalmoscope or photographically.

Element 14: Dilated fundus examination

What is expected: A thorough inspection of the optic nerve, macula, vascular tree and retinal surface with a fundus lens and biomicroscope, a binocular indirect ophthalmoscope and/or a wide-angle retinal imaging system. Document the method of examination. Although retinal imaging is acceptable in some cases, it is not a substitute for a binocular physical retina examination. All providers must be licensed and capable to dilate the pupil and perform the physical retina examination.

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Element 15: Diagnosis

What is expected: These can be a refractive diagnosis such as Myopia, Astigmatism, Emmetropia, Hyperopia, or Presbyopia or medical eye diagnoses such as Cataract, Corneal Dystrophy, Choroidal Nevus or Glaucoma. Pertinent medical diagnoses such as diabetes should also be listed.

Element 16: Assessment, management and treatment plan

What is expected: In this section, the provider should summarize the overall examination, and clarify the points that need to be managed. The treatment/management plan should spell out the steps to be taken to address the chief concerns identified in the clinical findings. In healthy patients, this can be as simple as, "Normal Exam, return in 1 year for re-examination." For a patient with refractive error, the verbiage can include the diagnosis and be stated as "Myopia, order glasses to be used for distance only, return in 1 year." For patients with pathology, this section should be more specific and address patient education, glasses, contact lenses, low-vision aids, medications prescribed with directions for use, referrals, recommended testing, time frames and follow-up schedules. Other clinicians, reviewers, and any party evaluating this clinical encounter will look to this section to determine the important clinical points of the case and identify the plan of action and recommended follow-up.

Element 17: Legible records

What is expected: Records that are easily deciphered, following a consistent examination sequence, that are complete and document all findings, clinical decisions and any continuity of care recommendations. If using electronic medical records, it is important to review any "pre-populated" and/or "cloned" default data for accuracy, attest to the doctor personally reviewing history and medications and review all recorded data to ensure it reflects the examination findings and recommendations. A signature is required on all charts, if electronic it needs to be time and date stamped.

Additional Information

You can find additional information about our care standards in your Network Administration Guide.