

American Board of Ophthalmology

Guide to the Office Record Review (ORR)

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Overview

The Office Record Review (ORR) satisfies the Practice Performance Assessment component of the Board's Maintenance of Certification (MOC) process and is mandatory for all who seek certificate renewal. The ORR is an online self-review of clinical practice in which a diplomate reviews 15 of his/her current patient charts. The ORR consists of 41 ophthalmic diagnoses with specific criteria (ORR modules), for example:

Myopia: a new adult patient 18 years or older who presents with myopia, seen by you at least once in the past 12 months.

ORR module content encompasses practice patterns related to the specific diagnosis. Self-review of patient charts via ORR modules is meant to assess the quality of practice through verification of the documentation of appropriate measurements, diagnosis, management, treatment, and follow-up. The ORR is available to eligible diplomates online, on-demand via the ABO web site: www.abop.org. This guide is designed as preparation for registration and participation in the online ORR program.

Guiding Principles

Purpose: The purpose of the Office Record Review process is to sample patient records of Maintenance of Certification examinees to assess their conformance to certain standards of practice and to contribute to the enhanced quality of ophthalmic practice.

Confidentiality: All patient records will remain in the control of the physician. Pooled data from the ORR process may be used for sharing certain information relating to trends in practice or health care. No data will be made public in any way that would compare one physician, or group of physicians, to others.

Review Method: Recognizing the importance of the patient record in the provision of continuing quality ophthalmic care, the American Board of Ophthalmology recommends that the patient record contain certain information critical to quality ophthalmic care. Although ORR module responses will be reviewed according to standards of the Board, the presence or absence of a specific item(s) in a module does not imply that any one item or group of items is a standard of care. Information sought by the ORR process represents data points determined by consensus to be of interest and possible relevance to the nature and quality of the practice of ophthalmology.

Documentation Principle: The ORR is based on the general premise that there are certain items that must be documented in the patient record to confirm both that the events occurred and that they have been appropriately recorded to be effectively utilized in future patient care. Thus, in the absence of an indication in the record, the presumption is that the events did not occur.

Evolutionary Change: While the ORR modules and process will be open and disseminated to MOC candidates, they are subject to change, consistent with a principle of continuous improvement to both process and content matters.

Accessing the ORR

The ORR is administered online, on-demand via the examinee's MOC status page which is accessed on the ABO web site: www.abop.org. If you are eligible for the ORR, you will click on the "Office Record Review (ORR)" link on your MOC status page to begin the registration process. The fee for the ORR is \$775. Upon registration approval, you will be presented with a link to the ORR administration homepage*. Once on the ORR homepage, you will opt to Create a New ORR and will proceed to the selection of three modules.

**Please Note: The ABO partners with Castle Worldwide, Inc. to provide online delivery of and technical assistance for the ORR.*

Selecting ORR Modules and Corresponding Patient Records

There are 41 ORR modules offered. Currently available modules and their required criteria are listed on pages 4-5. The online ORR program will require you to select three modules. When selecting your three ORR modules, keep in mind that you must assign five of your patient records for each that meet the module's criteria, including the timeframe requirements, and all records must be patients for whom you have direct patient care responsibility* on a continuing basis. The ABO encourages diplomates to select consecutive records in order to obtain an accurate snapshot of practice patterns.

**Please note that direct patient care is required. If you are in a group-partnership or teaching position, exclusive care of the patient is not mandatory for selection of patient charts for the ORR, but you must be actively involved in the patient's care.*

Assigning Patient Records for Review

The Board requires some basic, non-identifying information about the patient records to be used, including year of birth, initial visit date and most recent visit date. The online ORR program will guide you through entering the required information. Once the patient information is entered, you will be prompted to begin reviewing the 15 patient records.

Tip: The Board recommends selection of the three ORR modules and the five patient records prior to registering for the ORR. Because the criteria for each module is specific, it is important to identify the availability of the correct number of patients (5) for each module. Entering the information about the patient charts you will use can be time-consuming when dealing with multiple sources of information. The Board recommends writing down the requested information about each chart prior to entering the information into the online ORR program. To aid you in this process the Board created an ORR Patient Assignment Worksheet, which can be found on page 6.

Reviewing Your Records

Based on the information in each patient record, you complete the 15 ORR modules by indicating if the information requested is recorded, not recorded or not applicable. A good method for determining if information is recorded or not is to view the records from another ophthalmologist's perspective – can another ophthalmologist determine specific information about the patient from what is recorded in the chart?

For example, the patient record documents that the patient “has no history of systemic disease.” The ORR module asks if “History of heart disease” is recorded or not. While the patient record does not specifically state “heart disease,” heart disease is a systemic disease and, therefore, the answer is recorded.

Once the ORR is complete, you will receive instant feedback on responses and overall performance. The ORR Score Report now includes detailed explanations and identifies unrecorded items, which are indicated as essential or non-essential. Where applicable, ORR modules also include quality measures identified by the American Medical Association (AMA)-convened Physician Consortium for Performance Improvement, and these measures are highlighted in the ORR Score Report.

ORR Timeframe

ORR must be completed once during the MOC cycle. Ultimately, diplomates will complete the ORR in years 3-4 of each ten-year cycle; however, while the Board transitions to maintenance of certification, the timeframe requirements are slightly different for each group of diplomates. Diplomates can determine when they are eligible for ORR by reviewing the Timeframe Chart on the ABO web site.

The ORR must be completed within 30 days of starting the actual review of patient charts. The start date of the 30-day window is the day you finish submitting the required information on all 15 charts you will review. Once started, you can access and re-access the ORR during the 30-day timeframe via the MOC status page. You must use the patient charts submitted during registration; no substitutions are allowed. Additionally, the ORR is administered during a calendar year. **Any ORR that an examinee registers for in a particular year must be completed by December 31 of that same year.** For example, if you register for ORR on December 15,

2010, that ORR must be complete by December 31, 2010. If you do not complete the ORR by December 31 of the year you registered for it, you will forfeit the ORR, which means that you must reregister and pay (with applicable penalty) for the ORR in the next year.

ORR Technical Assistance

The online ORR program will offer a browser test page to test internet browser capability (standard Internet Explorer or Netscape), as well as a telephone number and email to request technical assistance.

ORR Module Criteria

GENERAL OPHTHALMOLOGY

Myopia: A new patient 18 years or older who presents with myopia, seen by you at least once in the past 12 months.

Presbyopia: A new patient who presents with presbyopia, seen by you at least once in the past 12 months.

Presumed Acute Bacterial Conjunctivitis: A patient with acute ocular inflammation that primarily affects the conjunctiva, seen by you at least once in the past 12 months.

Dry Eyes: A patient complains of ocular irritation, tearing, or contact lens intolerance; patient with ocular surface disease and no other cause; or patient with poor blink, seen by you at least once in the past 12 months.

Macular Degeneration: A new patient 50 years or older who presents with age-related macular degeneration seen by you at least once within the past 12 months.

Corneal Ulcer/Bacterial Keratitis: A patient with acute infectious disease of the cornea, seen by you at least once in the past 24 months.

PEDIATRICS

Amblyopia: A child presenting prior to the age of eight years followed by you for at least two years and seen by you at least once in the past 18 months.

Comprehensive Childhood Exam: A new patient between age three and six years old brought in for general eye examination, seen by you at least once in the past 12 months.

Esotropia: A child under the age of 10 years old who presents with esotropia and who has at least two follow-up visits in the past 18 months.

GLAUCOMA

Advanced/Uncontrolled Primary Open Angle Glaucoma: The patient must be 18 years or older and can either be referred or be your primary patient. You must have managed this patient for a minimum of two years, and examined this patient at least once in the past 12 months. The patient's glaucoma must fit into the following status:

- At some point in your management of the patient at least one therapeutic adjustment was required.
- Disc damage C/D > 0.7. Visual field loss inside the central 10 degrees or any field loss in both the superior and inferior fields.

Subacute or Chronic Angle-Closure Glaucoma: A patient with any form of angle-closure with or without a history of an acute attack. The patient was followed by you for a minimum of six months and seen by you at least once in the past 24 months; with or without angle, disc and or visual field injury secondary to angle-closure.

Open Angle Glaucoma Suspect: The patient must be 18 years or older with suspicion of open-angle glaucoma on the basis of elevated intraocular pressures (IOP), or suspicious disc or field, followed by you for a minimum of two years, and seen by you at least once in the past 12 months.

Stable Primary Open Angle Glaucoma: The patient must be 18 years or older and the patient's care must have been initiated and followed by you for a minimum of two years, and seen by you at least once in the past 12 months. The patient's glaucoma must fit into the following status:

- Stable, mild to moderate disc and/or visual field damage (no more than nasal step or arcuate scotoma in one hemisphere).
- Therapeutic adjustments may have been made, but none within the past year.

Laser Trabeculoplasty (Surgical Management): An adult patient on whom you have performed laser trabeculoplasty (argon, diode, or Nd:YAG) and followed for at least six months, seen by you at least once in the past 12 months.

CATARACT

Cataract (Surgical Management): Patient must be 18 years or older with cataract who has had cataract extraction by you on one or both eyes, seen by you at least once in the past 12 months, and followed by you for at least one month.

Cataract (Observational Management): Patient must be 18 years or older with cataract who has not yet had cataract extraction on either eye, seen by you at least once in the past 12 months.

YAG Laser Capsulotomy (Surgical Management): An adult pseudophakic patient 18 years or older, on whom cataract surgery had been performed, has decreased vision, was examined by you in the last year, and had YAG laser posterior capsulotomy performed.

Refractive Surgery: Patient evaluated for refractive surgery, seen by you at least once in the past 24 months.

RETINA

Recurrent Active Iritis: A patient with a history of iritis, who is seen by you at least once with active anterior uveitis in the past 12 months.

Diabetic Retinopathy: Patient must be 18 years or older with diabetic retinopathy followed by you for at least three years and seen by you at least once in the past 12 months.

Retinal Detachment: A new or established patient who presents with rhegmatogenous retinal detachment who develops an initial or new recurrent retinal detachment seen by you at least once in the past 12 months.

Central Retinal Vein Occlusion: Patient complains of sudden painless decrease in visual acuity; retinal hemorrhages and retinal microangiopathy, a darkened tortuous venous tree, disc swelling, macular edema, and retinal exudes may be present to a variable degree; seen by you at least once in the past 24 months.

Rhegmatogenous Retinal Detachment Suspect: A patient who experiences acute onset of “flashes” or “floaters” (less than 1 week duration), seen by you at least once in the past 18 months.

OCULOPLASTICS

Ptosis (Observational Management): A patient 18 years or older presenting with blepharoptosis, seen by you at least once in the past 24 months.

Thyroid Ophthalmopathy: A patient with thyroid-associated ophthalmopathy, dysthyroid ophthalmopathy, thyroid eye disease, thyrotoxic exophthalmos, thyroid ophthalmopathy, Hashimoto disease or Graves disease; seen by you at least once in the past 24 months.

Blowout Fracture of the Orbit: Patient presents with blunt trauma to the orbit, seen by you at least once in the past 24 months.

Epiphora and Presumed Nasolacrimal Duct Obstruction: A patient 18 years or older complains of tearing or discharge seen by you at least once in the past 12 months.

Lower Eyelid Ectropion/Entropion (Surgical Management): A patient 18 years or older with lower eyelid ectropion/entropion, operated on by you in the past 24 months, and had at least one short-term (within 14 days post-op) and one long-term (90 days or longer) follow-up examination.

Adult Acquired Blepharoptosis (Surgical Management): A patient 18 years or older with acquired blepharoptosis, operated on by you in the past 24 months, and had at least one short-term (within 14 days post-op) and one long-term (90 days or longer) follow-up examination.

PATHOLOGY & ONCOLOGY

Metastatic Disease to the Eye: A patient who complains of an acute onset of new vision symptoms or is referred for evaluation of a mass in the eye seen by you at least once in the past 48 months.

Retinoblastoma: A child presenting prior to the age of seven years and examined by you at least once in the past 48 months for retinoblastoma in one or both eyes.

Choroidal Melanoma: A patient with a history of suspected intraocular nevus or melanoma, seen by you at least once in the past 24 months.

Pathology Modules: These modules were developed for Ophthalmic Pathologists only.

Ophthalmic Pathologist: Basal Cell Carcinoma: A specimen with pathologic diagnosis of basal cell carcinoma processed and diagnosed by you in the past 18 months.

Ophthalmic Pathologist: Enucleation Specimen with Choroidal Malignant Melanoma: A specimen with pathologic diagnosis of choroidal malignant melanoma processed and diagnosed by you in the past 18 months.

Ophthalmic Pathologist: Corneal Infection: A pathologic corneal specimen with suspected infection/inflammation processed and diagnosed by you in the past 18 months.

NEURO-OPHTHALMOLOGY

Initial Optic Neuritis: A patient who presents with optic neuritis, seen by you at least once in the past 24 months.

Idiopathic Intracranial Hypertension: A patient who presented with papilledema, increased intracranial pressure and no mass lesion on neuroimaging, and seen by you at least once in the past 24 months.

Sixth Nerve Palsy: A patient 18 years or older presents with onset of diplopia of less than three months duration due to sixth nerve palsy, seen by you at least once in the past 48 months.

Anterior Ischemic Optic Neuropathy: A patient presents with the first symptomatic acute onset of monocular visual loss and disc edema, seen by you at least once in the past 24 months.

Third Nerve Palsy: A patient 18 years or older presents with a third nerve palsy initially seen by you within the past 48 months.

Temporal Artery Biopsy (Surgical Management): A patient who has undergone temporal artery biopsy to diagnose possible temporal arteritis (giant cell arteritis), within the past 48 months.

Visit the ABO web site to view the content of all ORR modules: www.abop.org

ORR Patient Assignment Worksheet

The Board requires some basic, non-identifying information about the patient records you will review for the ORR, including year of birth, initial visit date and most recent visit date. The Board recommends selection of the three ORR modules and the five patient records prior to registering for the ORR. Because the criteria for each module are specific, it is important to identify the availability of the correct number of patients (5) for each module. Entering the information about the patient charts you will use can be time-consuming when dealing with multiple sources of information. The Board recommends writing down the requested information about each chart prior to entering the information into the ORR system. To aid you in this process the Board created this ORR Patient Assignment Worksheet.

This worksheet is intended to help you identify appropriate patient records and aid you in entering the required information into the ORR system only. This is not a registration form for the ORR; the ABO does not collect this worksheet. This worksheet is for your use only.

In the section labeled record number/unique record identifier, please use your internal chart referencing number; this identifier is for your use in identifying the patient records you will use for the review.

Directions: Use the chart below to record the requested information about the patient charts you will use for the ORR. You can then work off of this worksheet when entering the patient information into the ORR system (rather than entering the information from multiple sources, i.e. patient charts).

Module #	Patient #	Sex (M/F)	Record Number/ Unique Record Identifier	Patient meets category definition.	Patient meets timeframe requirement.	I have direct patient care responsibility for this patient.	Patient's Year of Birth	Initial Visit Date	Most-recent Visit Date
	1								
	2								
	3								
	4								
	5								
	1								
	2								
	3								
	4								
	5								
	1								
	2								
	3								
	4								
	5								