



PRESIDENT'S DESK

Happy New Year ALLDocs Members!



Kerry Gelb, OD
President

It was best stated in the Cooper Vision Practice Survival Guide:

“The eye care practices that come out of this pandemic the best will be the ones that took advantage of every opportunity and prepared for the reopening of their business, including potential changes to what that future might look like.”

Innovative ways of doing business have been implemented rapidly this year with a new focus on E-commerce. ALLDocs practices have always been diverse and included subscription models, retailing OTC products, Myopia Management, Low Vision, Vision Therapy, specialty contacts and ocular aesthetics even before the pandemic.

To our benefit, there is great opportunity for us still. It has been reported that **20.9% of Contact Lenses in America are Sold Online.** (Q42019 Vision Council Report)



That means **79.1%** are sold in doctors' offices and retail stores. Also, according to the CDC, **61 million adults** in the United States are at high risk for serious vision loss, but only half visited an eye doctor in the past 12 months.

ALLDocs members have always been ahead of the curve and nimble when it comes to business practices. We have certainly shared our ideas this year, together we are stronger. Never before have we been more creative and collaborative.



Alfonso Cerullo
General Manager
Lenscrafters

Congratulations again to Alfonso Cerullo. Mr. Cerullo spoke to our membership in Utah this September at our annual meeting. As of December 2020, he is now officially in the role of General Manager of LensCrafters. We look forward to collaborating with him to continue to build the strongest brand in the optical industry.

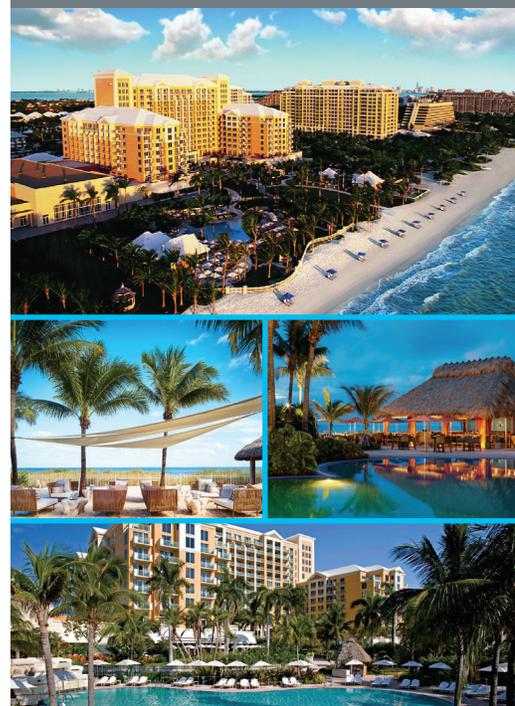
Luxottica unveiled a new headquarters and showroom (a 50,000- square foot building at 1 West 37th street) in New York City this May. The ALLDocs Board plans to work closely with the new leadership.



GALLERY



2021 Annual Meeting
The Ritz-Carlton Key Biscayne, Miami
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Optometry & Social Work: The Next Big Partnership



Throughout the country, healthcare institutions are increasingly focusing their attention on providing holistic, collaborative care to optimize patient outcomes. Even during the COVID-19 pandemic, optometrists are being asked to make concerted efforts to increase collaboration with other healthcare professions to effectively implement a patient-centered approach. Social work is one profession that can be an important partner to optometry, especially throughout the vision rehabilitation process.¹

What Is Social Work?

The National Association of Social Workers has defined the practice of social work as applying “social work values, principles, and techniques to helping people obtain tangible services; counseling and psychotherapy with individuals, families, and groups; helping communities or groups provide or improve social and health services; and participating in legislative processes.”² Patients who stand to benefit from vision rehabilitation may also benefit from the expertise of social workers.¹

Social workers may assist optometrists patients with many different services, including but not limited to:

- Assistance with disability advocacy
- Resolution of transportation needs for medical appointments
- Follow-up with medical advice
- Medication management and assistance programs
- Connection to diabetic resources
- Mental health resources
- Self-care education

A Collaborative Approach

Reduced vision among adults has been shown to result in social isolation and depression in many patients.³ Early in the vision rehabilitation process, optometrists should add screening questions to a patient history intake to facilitate conversations during exam room consultations. See the Table below for a few sample questions to consider asking your patients. These additional questions can help identify potential behavioral or mental health concerns or the need for other health professionals, like social workers, that go beyond eye care.

Table: Samples Questions to Consider During Patient History Intakes

“In addition to the services you received today, do you have any other life issues or concerns for which you might need some assistance?”

“Have you frequently been feeling nervous, stressed, depressed, or anxious over the past several days or weeks?”

Do you have any difficulties that would prevent you from successfully completing your eye treatment plan?”

If the answer to any of the additional screening questions is “yes,” this should trigger optometrists to ask if patients would be interested in talking with a social worker. If patients are concerned about making it to their appointments, social workers can help coordinate transportation. Social workers can also help patients deal with a wide variety of issues, such as anxiety and depression or family issues.

When considering a partnership with social work, optometrists should think about hiring a social worker on a contractual basis or having readily available referrals to private, community-based, or organizational social workers. Optometrists are in a unique position to lead by example through the vision rehabilitation process, and a partnership with social work can further improve the well-being of patients.

SOURCES

1. Hinkley S. Optometry and social work. American Optometric Association. July 29, 2019. Available at: <https://www.aoa.org/news/clinical-eye-care/optometry-and-social-work>.
2. National Association of Social Workers. Practice. August 18, 2020. Available at: <https://www.socialworkers.org/Practice>.
3. Department of Health and Human Services. Office of Minority Health Resource Center. Improving the nation's vision health: a coordinated public health approach. 2007. Available at: https://minorityhealth.hhs.gov/Assets/pdf/Checked/FINAL_Improving_the_Nations_Vision_Health.pdf.



Visual Deficits & Dysfunction After Traumatic Brain Injury



More than two-thirds of patients who suffer a traumatic brain injury (TBI) report problems with their vision after their TBI, but the prevalence of underlying visual dysfunction symptoms varies substantially. In a systematic review and meta-analysis published in *Optometry and Vision Science*, investigators sought to determine the prevalence of accommodative dysfunction, convergence insufficiency, visual field loss, and visual acuity loss in TBI patients without concomitant eye injuries. After reviewing 22 relevant publications that reported on these domains, random-effects models revealed the following combined prevalence estimates in people with TBI:

- Accommodative dysfunction: 43%
- Convergence insufficiency: 36%
- Visual field loss: 18%
- Visual acuity loss: 0%

In meta-regression and subgroup analyses, visual field loss was significantly more prevalent in moderate to severe TBI than in mild TBI (40% vs 7%, respectively). Based on the findings, the authors recommended future longitudinal studies be conducted with more rigorous and uniform methodology to better understand the short- and long-term effects of TBI on the vision system.

SOURCES

Merezhinskaya N, Mallia RK, Park D, Bryden DW, Mathur K, Barker FM. Visual deficits and dysfunctions associated with traumatic brain injury: a systematic review and meta-analysis. *Optom Vis Sci*. 2019;96(8):542-555. Available at: https://journals.lww.com/optvissci/Fulltext/2019/08000/Visual_Deficits_and_Dysfunctions_Associated_with_2.aspx.



Investigating Communication on Healthy Contact Lens Behaviors



Approximately 45 million Americans wear contact lenses, but many of these people may be at increased risk for complications stemming from improper wear and care behaviors.¹ Microbial keratitis is one of the most serious complications that can result from contact lens wear as it can sometimes result in reduced vision or blindness.²

New Research

A recent study published in the *Morbidity and Mortality Weekly Report* sought to better understand and assess contact lens education from providers to patients. Two surveys were administered, the first of which assessed the experiences of contact lens wearers based on receipt of 9 recommendations from eye care providers during their most recent appointment (Table). The second survey evaluated provider-reported practices for communicating contact lens wear and care recommendations to their patients.¹

and older recalled never being informed about lens wear and care recommendations. Fewer than half (48%) remembered hearing their provider recommend not sleeping in lenses at their last visit, and only about 20% recalled being told to avoid topping off their contact lens solution.

However, the majority of eye care providers reported sharing recommendations “always” or “most of the time” at initial visits, regular checkups, and complication-related visits. Of the 9 recommendations for safe contact lens wear and care, eye care providers most often encouraged complying with the recommended lens replacement schedules, not sleeping in lenses, and not topping off solutions at regular checkups. Eye care providers also reported sharing these messages more frequently at initial visits and complication-related visits than at regular checkups.

Important Implications

The observed discrepancy in provider-patient communication is important because the gap between what providers say and what patients hear might be a factor in the large number of contact lens wearers reporting behaviors that put them at risk for a contact lens-related eye infections.^{3 4} The study team notes that eye care providers play an important role in the health of their contact lens-wearing patients and can share health communication messages to help educate their patients about healthy wear and care habits.

Findings from the study can assist in the development of health communication messages to encourage eye care providers to communicate more effectively with patients. To alleviate time constraints of a typical visit, eye care providers can also distribute educational materials, like CDC’s tear off pads, for their patients to take home.

SOURCES

1. Konne NM, Collier SA, Spangler J, Cope JR. Healthy contact lens behaviors communicated by eye care providers and recalled by patients—United States, 2018. *MMWR Morb Mortal Wkly Rep.* 2019;68:693–697. Available at: <https://www.cdc.gov/mmwr/volumes/68/wr/mm6832a2.htm>.
2. Dart JK, Radford CF, Minassian D, Verma S, Stapleton F. Risk factors for microbial keratitis with contemporary contact lenses: a case-control study. *Ophthalmology.* 2008;115:1647–54, 1654.e1–3.
3. Cope JR, Collier SA, Nethercut H, Jones JM, Yates K, Yoder JS. Risk behaviors for contact lens-related eye infections among adults and adolescents—United States, 2016. *MMWR Morb Mortal Wkly Rep.* 2017;66:841–845.
4. Cope JR, Collier SA, Rao MM, et al. Contact lens wearer demographics and risk behaviors for contact lens-related eye infections—United States, 2014. *MMWR Morb Mortal Wkly Rep.* 2015;64:865–870.



Study: “Time Is Vision” After a Stroke



When patients suffer a stroke that causes vision loss, treatment options are lacking to improve or regain vision. However, a study from University of Rochester researchers suggests early vision training interventions may be of help. The study compared patients who were evaluated and treated more than 6-months after their stroke with early subacute stroke patients. The researchers trained both groups of patients using a computer-based device that served as a form of physical therapy for the visual system.

According to the results, survivors of occipital strokes appeared to retain some visual capabilities immediately after the stroke, but these abilities diminished and eventually disappeared permanently after 6 months. By capitalizing on the initial preserved vision, early eye training interventions may help stroke patients recover more of their vision loss than if training is administered after 6 months. The investigators added that a key finding of their analysis was that an occipital stroke that damages the visual cortex causes gradual degeneration of visual structures all the way back to the eyes.

SOURCES

Saionz EL, Tadin D, Melnick MD, Huxlin KR. Functional preservation and enhanced capacity for visual restoration in subacute occipital stroke. *Brain.* 2020;143(6):1857–1872.

Table: Samples Questions to Consider to During Patient History Intakes

1	Avoid sleeping overnight or napping in lenses
2	Wash and dry hands before inserting or removing lenses
3	Replace lenses as often as recommended
4	Replace lens case at least once every 3 months
5	Avoid storing lenses in water
6	Avoid rinsing lenses in water
7	Avoid topping off solution
8	Avoid swimming in lenses
9	Avoid showering in lenses

Key Findings

According to the study, about 30% of contact lens wearers aged 18 years



A Q&A on Liability Insurance



Optometrists are often challenged by understanding the nuances between general and professional liability insurance as well as liability limits. The American Optometric Association (AOA) provides information to help optometrists navigate these complicated issues. Below are some frequently asked questions and answers regarding liability insurance.

What is the difference between general and professional liability insurance?

General liability insurance offers protection against physical injury to people or damage to property that can arise from your daily operations as an optometrist. Professional liability insurance—also referred to as malpractice insurance—is different in that it covers negligence relating to the professional services or treatment that is provided to patients.

Of note, many doctors carry both types of coverage for a variety of reasons, with one of the most common being that a place of employment requires it. However, in most cases, the onus is on the provider to determine if they wish to carry both general and professional liability coverage.¹

What determining factors go into a malpractice insurance quote?

Several factors can play a role in quotes that are given for malpractice insurance and prices can vary accordingly. The amount you pay for a policy will be determined by factors like new-doctor discounts, coverage levels, and stipulations from the county and state in which you practice.¹

What are liability limits?

The level of malpractice insurance coverage is commonly represented by two figures. The first represents the maximum dollar amount that the insurance company will pay per claim during the policy year. The second is the maximum dollar amount an insurance company will pay for all claims during a policy year.¹

How are shared limits and separate limits different for professional liability coverage?

With shared limits, you and your company share the limits of liability, meaning you would both draw on the amount of whatever your shared limit is per occurrence; this is often done with no extra charges. With separate limits, your corporation has an additional limit of liability, which is the same amount as yours but separate. Separate limits increase premium amounts.¹

What are common pitfalls to look for when reviewing a policy?

Some malpractice insurance policies contain exclusions that can be left open to interpretation. For example, a policy may have surgical exclusions that are unclear when purchasing a policy. In addition, some policies may not cover every procedure that is part of your state's defined scope of practice.¹ Experts recommend carefully reading the fine print of all policies before making a purchase.

Protect Your Practice

The AOA and other groups offer helpful services to guide decision making when shopping for general and professional liability insurance, such as complimentary quotes and policy reviews.² You and your organization should work together to identify the insurance needs to ensure the best decision is made.

SOURCES

1. American Optometric Association. The liability lowdown. July 2, 2019. Available at: <https://www.aoa.org/news/practice-management/frequently-asked-questions-about-liability-insurance>.
2. American Optometric Association. Professional liability, business owners & cyber liability insurance. August 18, 2020. Available at: <https://www.aoa.org/practice/professional-protection/business-and-liability-insurance>.



Corneal Transplantation Risks With Guttata



The relative risk for corneal transplantation after phacoemulsification was 68.2 times higher for patients with corneal guttata than that for those without it, according to new data from a registry-based cohort study. The analysis included 276,362 patients with cataracts and 2,091 patients who underwent corneal transplantation due to endothelial failure. In patients with corneal guttata, investigators observed an incidence rate of corneal transplantation after phacoemulsification of 88 per 10,000 person-years.

According to findings, the annual incidence rate was highest the first year after phacoemulsification and decreased with time. Cataract surgery in these patients was associated with corneal transplantation, with an adjusted relative risk of 68.2. The study team noted that the incidence rate of corneal transplantation among patients without corneal guttata was 1.4 per 10,000 person years.

SOURCES

- Viberg A, Samolov B, Claesson Armitage M, et al. Incidence of corneal transplantation after phacoemulsification in patients with corneal guttata: a registry-based cohort study. *J Cat Refract Surg.* 2020;46(7):961-966.



Modifier 25: Examining Appropriate Use



In 2015, the Office of the Inspector General (OIG) issued a report for the United States Department of Health and Human Services that sought to determine the extent to which ophthalmology services are vulnerable to fraud, waste, and/or abuse. Overall, the OIG report found that most eye care physicians did not exhibit questionable billing practices.¹ However, the report did provide data indicating that certain optometrists are billing claims with Modifier 24 and Modifier 25 at a higher rate than other eye care providers.¹

Continued Scrutiny

In 2020, appropriate use of Modifier 25 was again under scrutiny by auditors and the OIG. In fact, a recent OIG settlement with an ophthalmology practice notes that allegations on the practice improperly used the Modifier 25 billing code to charge Medicare and Medicaid for exams that were not separately billable from other procedures performed on the same day. The settlement also states that allegations of certain Medicare and Medicaid billings during the same period included charges for exams at higher levels than appropriate. It is important to note that the claims settled by this agreement are allegations only, and there has been no determination of liability.²

Call to Action

A key takeaway from this settlement is the importance of all optometrists understanding the appropriate use of Modifier 25. The following are some helpful points for clinicians to keep in

mind:²

- Modifier 25 is defined as “a significant evaluation and management (E/M) service by same physician on date of global procedure.” Simply put, if E/M services are provided that exceed what is normally involved in preparing patients for a procedure and the standard follow-up services directly following a procedure, then an E/M service should be reported along with Modifier 25
- Many elements of an E/M service are included as a standard part of performing surgical services. However, additional E/M services may be necessary when performing surgical services. For example, patients presenting for treatment of glaucoma may have a foreign body identified. In such cases, the evaluation for glaucoma and the foreign body removal would be reported. As a result, E/M would be reported with Modifier 25

Optometrists should recognize that Modifier 25 should only be used when reporting E/M services, and any documentation needs to reflect the necessity of the E/M service. Optometrists should be aware that an E/M service provided on the day of procedure with a global fee period will only be reimbursed if the physician indicates that the service is for a significant, separately identifiable E/M service that goes above and beyond the usual pre- and postoperative work of the procedure.²

SOURCES

1. Office of Inspector General. Questionable billing for Medicare ophthalmology services. September 2015. Available at: <https://oig.hhs.gov/oei/reports/oei-04-12-00280.pdf>.
2. American Optometric Association. Appropriate use of modifier 25. August 12, 2020. Available at: <https://www.aoa.org/news/practice-management/billing-and-coding/appropriate-use-of-modifier-25>



Topical Corticosteroids: Are They Safe in Pregnancy?



Treatment for allergic conjunctivitis is not essential in pregnant women because it is rarely a vision-threatening disease, but many of these patients would like relief from their symptoms. A Japanese study team has determined that using ophthalmic corticosteroids during the first trimester of pregnancy was not associated with any adverse effects on the baby, including congenital anomalies, preterm birth, low birth weight, and composite outcome.

For the study, researchers compared 898 pregnant women who received topical ophthalmic corticosteroids with mothers not prescribed steroids in the first trimester. Rates of congenital anomalies, preterm birth, low birth weight, and the composite outcome of all three were comparably low between recipients and non-recipients of topical ophthalmic corticosteroids (all less than 12%, respectively).

Propensity scores with known confounders were then calculated, including disorders during pregnancy, other chronic comorbidities, and use of antihistamines. No significant associations were seen between corticosteroid eye drop use and an increase in any of these adverse outcomes.

SOURCES

- Hasimoto Y, Michihata N, Yamana H, et al. Ophthalmic corticosteroids in pregnant women with allergic conjunctivitis and adverse neonatal outcomes: propensity score analyses. *Am J Ophthalmol.* 2020 Jul 16 [Epub ahead of print].

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*Based on lens movement, centration and rotation at initial fitting.
Reference: 1. In a study where n=78 eyes; Alcon data on file, 2020.

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GALLERY

Troubles With Eye Drop Instillation



Many people who use eye drops won't have problems using them, but a new study shows that a majority of patients may not be self-administering them correctly. The study, which consisted of 6,758 older patients who used drops for at least 1 month, found that only 3% of participants properly followed all the recommended steps. In addition, while 98% of patients could get the drops into their eyes, 14% had to make more than one attempt to do so. The most common mistakes patients made were:

- Not performing nasolacrimal occlusion for at least 1 minute after drop instillation: **95%**
- Failing to close the eye post-drop: **68%**
- Touching the bottle to their eye or eyelid: **41%**

Importantly, 20% of ophthalmic suspensions were not shaken before use. Furthermore, 40% of patients reported at least one problem with eye drop instillation, and only about half of the sample recalled having any education in eye drop instillation technique. The authors suggested community pharmacists take a more proactive role in detecting and resolving these issues.

SOURCES

Mehuys E, C Delaey C, T Christiaens T, et al. Eye drop administration technique and problems reported by eye drop users. Eye. 2019 Nov 5 [Epub ahead of print].

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