



PRESIDENT'S DESK

Lots of Great Events Happening in 2026!



Hoping your 2026 is off to a great start. This year is particularly special for our organization as ALLDOCS celebrates 40 years. The upcoming meeting will mark our 40-year anniversary and tenure. Please watch for announcements regarding registration. Quebec City will serve as a fantastic venue to commemorate this momentous occasion, and we look forward to welcoming more of our Canadian members.



In other meeting news, the dates for our popular Managers Meeting have been announced: June 14-16, 2026, in Clearwater, Florida. It is advisable to register your key staff members soon, as space is limited. We have an exciting lineup of speakers, topics, and activities planned for this in-demand event. Registration is now open. For any questions, please contact Tara O'Grady at: tara@alldocsod.com.

THANK YOU FOR BEING A PART OF ALLDOCS



GALLERY



2026 Annual Meeting

Le Château Frontenac

QUÉBEC CITY, CANADA

Aug. 30-Sept. 04, 2026



Strategies for Managing Medicare Advantage Records Requests

Receiving a records request related to the Medicare Advantage Risk Adjustment Data Validation (RADV) program can feel daunting, but optometrists can take a strategic approach to minimize disruption and protect their time. These requests are not audits in the traditional sense. Instead, they are part of a routine process used by insurance plans to validate diagnoses and secure appropriate reimbursement from Medicare.¹

Stay Calm and Take Action

When a request comes in, the first step is to stay calm. “Sometimes when a practice gets this kind of request, the initial thought is panic,” said Steve Eiss, OD, chair of the American Optometric Association’s (AOA) Third Party Center Committee in a recent press release.¹ “But this is nothing that they’re being scrutinized for. [Insurance plans] are looking for diagnoses and data points to submit to Medicare for higher reimbursement.”¹

Once the request arrives—often via mail from a third-party vendor—optometrists should take immediate action. Call the number listed and ask for a deadline extension. Most vendors are willing to accommodate this, giving your team more time to gather and organize the necessary documentation without compromising patient care.¹

Negotiate Scope and Ask for Reimbursement

The next step for optometrists is to negotiate the scope of the request. Ask to reduce the number of records required. Fewer records mean less staff time and lower operational strain.¹ The AOA notes that insurers are often flexible, especially when practices engage professionally and promptly.¹

Importantly, optometrists should ask for reimbursement. Since these requests benefit the insurer financially, it is reasonable to seek compensation for time and effort. While there are no formal guidelines for reimbursement rates, some practices have received up to \$50 per record. Discussing reimbursement often leads to a reduction in the number of records requested, making the process more manageable.¹



Before submitting any records, try to secure an agreement on reimbursement terms. This ensures the practice is compensated fairly and avoids delays or disputes after submission. According to the AOA, insurers are generally cooperative and willing to work with practices that engage proactively.

Do Not Ignore Requests

Ignoring records requests is not recommended. Participating in RADV audits can support the role of optometry in the broader healthcare system and ensures continued inclusion in Medicare Advantage programs. The AOA offers resources to help practices navigate these requests, including the guide “Risk Adjustment Audits/Records Requests—How To Respond.”² For questions about reimbursement, members can contact stopplanabuses@aoa.org.²

Optometrists can take control of Medicare Advantage records requests by negotiating deadlines, reducing workload, and seeking fair compensation. With the right approach, these audits become manageable tasks rather than disruptive burdens, allowing practices to stay focused on delivering quality patient care while advocating for their time and value.¹

SOURCES

1. American Optometric Association. Take a strategic approach to Medicare Advantage records requests. Published May 21, 2025. Accessed October 12, 2025. <https://www.aoa.org/news/practice-management/perfect-your-practice/take-a-strategic-approach-to-medicare-advantage-records-requests>.
2. American Optometric Association. AOA Practice Success. Risk Adjustment Audits/Records Requests—How To Respond. <https://www.aoa.org/AOA/Documents/Practice%20Management/AOA%20MORE/Risk%20Adjustment%20Audits.pdf>

Gout May Accelerate AMD Progression



A multicenter study has found a strong correlation between gout and increased risk of developing age-related macular degeneration (AMD). The analysis compared over 23,000 patients with idiopathic gout who had a prescription for a uric acid-lowering agent (gout cohort) with a control group of nearly 1.8 million patients without a gout diagnosis. Patients with gout were more than twice as likely to develop dry AMD, advanced dry AMD, wet AMD, and require anti-VEGF therapy when compared with a healthy control group. The study also showed that gout was associated with a higher risk for macular hemorrhage and faster progression from early to advanced AMD stages.

Investigators noted in vitro studies suggest uric acid-lowering therapies may help reduce retinal toxicity and promote recovery. While antioxidant-rich diets may help prevent gout flares, their combined efficacy in AMD remains unclear. The study results highlight the importance of monitoring ocular health in patients with gout and exploring anti-inflammatory strategies to mitigate AMD risk. as:

SOURCE

Alshaikhslama AM, Alsoudi AF, Wai KM, et al. Gout and risk of age-related macular degeneration. *Retina*. 2025. Jul 3 [Epub ahead of print].

Keratoconus: Practical Guidance for Managing the Newly Diagnosed

A keratoconus diagnosis can feel overwhelming for patients, making early communication critical. Anecdotal evidence suggests clear, relatable explanations and structured education can improve understanding and long-term outcomes.¹ It is important to start by explaining the condition with relatable analogies, such as comparing the cornea to a camera lens, where keratoconus distorts curvature like a weak spot on a ball. Next, review tomography and aberrometry results using simple explanations and visual simulations. This approach can validate symptoms, help patients understand their condition, and set clear expectations for care.¹

Review Risk Factors

Newly diagnosed patients with keratoconus often ask if they will go blind, if it is genetic, and if they can stop it from progressing. Untreated keratoconus can severely impair vision, but progression can be slowed with lenses or surgery. Genetics are complex—there is no single “keratoconus gene,” but 36 DNA markers exist. It is important to screen family members, especially children and those with Down syndrome.² Patients should be instructed to avoid eye rubbing and manage associated conditions like allergies, asthma, and apnea for better outcomes.³

The “Keratoconus 1-2-3” Framework

One of the simplest ways to educate patients is to introduce them to the concept of “Keratoconus 1, 2, 3.” This approach can be easily remembered by patients:¹

1. **Stabilize:** Corneal crosslinking (CXL) stabilizes the cornea and is the single most important advancement in keratoconus; it is the keystone for modern management
2. **Contour:** Various techniques are available to optimize corneal shape and improve visual potential when contact lenses are not worn
3. **Improve vision:** Contact lenses are the cornerstone of achieving optimal visual outcomes in keratoconus. These include custom soft, hybrid, piggyback or scleral lenses

Introducing all three concepts can ensure you have a well-informed patient who is aware of and encouraged to consider multiple treatment options.¹

Practical Considerations

When managing patients, stabilizing keratoconus is the top priority, with CXL



proven to be highly effective. Recent FDA trial data show CXL halts progression, with most patients maintaining vision over 10 years.⁴ In addition, it is important to consider other factors like age, timing, and setting expectations:

- **Age:** Patients younger than 20 years of age require immediate CXL referral. Patients aged 20 to 40 years need close monitoring every 3 months
- **Timing:** Do not delay care. Optometrists should start with whichever option is available. Reinforce to patients that seeing well with lenses does not mean keratoconus has stopped
- **Set realistic expectations:** Contouring procedures improve outcomes but rarely achieve perfect 20/20 vision.

Key Takeaways

To effectively manage keratoconus, it is critical to establish clear communication, schedule next steps, and maintain close follow-up. Investing in diagnostic tools like corneal tomography and building referral networks with surgeons and contact lens specialists can help. The goal should be to ensure patients leave with confidence in their care plan.

SOURCES:

1. Gelles JD. My patient has keratoconus... now what? Rev Optometry. Published November 15, 2025. <https://www.reviewofoptometry.com/article/my-patient-has-keratoconus-now-what>.
2. Hardcastle AJ, Liskova P, Bykhovskaya Y, et al. A multi-ethnic genome-wide association study implicates collagen matrix integrity and cell differentiation pathways in keratoconus. Commun Biol. 2021;4(1):226.
3. Hashemi H, Heydarian S, Hooshmand E, et al. The prevalence and risk factors for keratoconus: a systematic review and meta-analysis. Cornea. 2020;39(2):263-270.
4. Hersh PS, Stulting RD, Muller D, Durrie DS, Rajpal RK; United States Crosslinking Study Group. United States multicenter clinical trial of corneal collagen crosslinking for keratoconus treatment. Ophthalmology. 2017;124(9):1259-1270.

Pediatric Eye Exams Lagging Behind Pre-Pandemic Levels



Pediatric eye exam rates across the United States declined from 2016 to 2022, according to research published in the American Journal of Ophthalmology. The study, which analyzed data from the National Survey of Children's Health, showed that only about one-third of children receive care from an eye doctor, with significant disparities being linked to insurance status, income, and race. Pediatric eye exam rates slightly rebounded to 35.7% in 2022 from the pandemic low of 30.2% in 2020, but they remained below the 2016 peak of 38.6%.

The study demonstrated that children aged 0 to 5 years were least likely to receive exams, especially those without insurance. Black non-Hispanic children and those below 400% of the federal poverty level were disproportionately affected. The following were listed as top barriers for caregivers:

- **Cost:** 59.9%
- **Appointment access:** 47.7%
- **Eligibility concerns:** 32.4%

Researchers emphasize the need for targeted interventions to improve access, follow-up, and health literacy.

SOURCE

Khan S, Bowers KE, Cavuoto KM. Socioeconomic determinants of unmet vision care needs and gaps in eye examinations in pediatric populations from 2016 to 2022. Am J Ophthalmol. 2025. Jun 13 [Epub ahead of print].

The Great Masquerader: Why Screening for Ocular Rosacea Matters

Despite its long history, ocular rosacea remains underdiagnosed compared to facial rosacea.¹ Ocular rosacea is most common in fair-skinned women aged 30 to 60 years of age, but it can occur in all types of skin.² The pathogenesis of rosacea involves neural, vascular, immune, microbiome and sebaceous dysfunction, leading to chronic inflammation and vessel dilation. Environmental triggers—such as ultraviolet exposure, heat, alcohol, spicy foods—can also play a role.^{3,4} Although triggers can vary from patient to patient, it is vital to consistently avoid known personal triggers to achieve long-term control.¹

Ocular Rosacea

Ocular rosacea is a chronic inflammatory condition of the eyelids, ocular surface, and meibomian glands, often linked to abnormal eyelid blood vessels. It affects both sexes equally, typically appearing after 30 years of age, with peak incidence between ages 40 and 59 years. While associated with facial rosacea, it can occur independently, complicating the diagnosis. Up to 72% of facial rosacea patients develop ocular involvement, but 90% of ocular cases show minimal or no skin signs, making recognition a challenge.⁵⁻⁸

Ocular rosacea continues to be an underdiagnosed condition because of its complex clinical picture, wide range of manifestations, and the fact that it may occur with little to no skin involvement. The diagnosis relies on patient history and careful slit lamp examination.¹ In fact, ocular rosacea is sometimes referred to as a “great masquerader” because its signs and symptoms overlap with many other conditions. Because findings often overlap with other eye conditions, diagnostic vigilance is essential. It is important to view ocular rosacea as an overarching condition rather than many separate disease states to facilitate patient education and streamline management.¹

Treatments Can Help

Multiple therapeutic options are available for ocular rosacea, and the selection of treatment should be guided by symptoms, clinical signs, and coexisting ocular surface disease. Because the condition can

affect multiple eye structures, management typically requires addressing both primary inflammation and secondary complications. No FDA-approved therapy currently exists, but several effective strategies are available. Anti-inflammatory therapy is the cornerstone of management. Most patients benefit from a topical immunomodulator, with short courses of mild corticosteroids reserved for flares.¹

Meibomian gland dysfunction (MGD) management often plays a central role in treating ocular rosacea. Intense pulsed light therapy is considered the gold standard. It targets abnormal vessel architecture, reduces inflammation, improves meibomian gland function, lowers microbial load and enhances eyelid and conjunctival appearance.⁹ Additional MGD-directed treatments can also be beneficial.

Key Takeaways

When managing patients, it is important to look beyond isolated diagnoses like MGD or dry eye and consider ocular rosacea as the root cause. Early identification and comprehensive management are essential for preserving ocular health and patient comfort.¹

SOURCES:

1. Abbott K. Ocular rosacea: how to recognize and react. *Rev Optometry*. Published November 15, 2025. <https://www.reviewofoptometry.com/article/ocular-rosacea-how-to-recognize-and-react>
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GLP-1 Therapies May Reduce AMD Risk



Glucagon-like peptide-1 (GLP-1) receptor agonists were initially developed for diabetes and other cardiometabolic disorders but have also demonstrated systemic benefits and potential for ocular protection. Recent data suggest GLP-1 receptor agonists may reduce the risk of age-related macular degeneration (AMD). A study published in *Ophthalmology Retina* compared patients prescribed GLP-1 agonists with those receiving alternate glucose-lowering or lipid-lowering medications. The analysis used the TriNetX US Collaborative Network, which encompasses nearly 120 million patients.

Results showed that a GLP-1 drug prescription was associated with a significant reduction in hazard ratio (HR) for dry AMD compared to glucose-lowering medications over 1 year (HR, 0.79), 2 years (HR, 0.75), and 3 years (HR, 0.77). Similar protective effects were observed against wet AMD across all timepoints. Importantly, GLP-1 therapy did not increase conversion risk from non-neovascular to neovascular AMD. These findings position GLP-1 receptor agonists as a promising adjunct in systemic disease management with potential ocular benefits.

SOURCE

Allan KC, Cohn EF, Bala S, et al. Glucagon-like peptide-1 receptor agonist use and risk of neovascular age-related macular degeneration in a national cohort study. *Ophthalmology Retina*. 2025 Nov 4:S2468-6530(25)00504-4. ¹



Navigating Compliance: Best Practices for Prompt-Pay Discounts



Throughout the United States, some healthcare providers are offering prompt-pay discounts to patients who are not using insurance—or private-pay patients—where payments are made in full at the time of service. While this can benefit patients and providers alike, it is important to understand the legal and contractual implications of offering discounts below the usual, customary, and reasonable charge.¹

Since the costs to optometry practices can be less when no insurance is involved, healthcare providers sometimes offer prompt-pay discounts to patients without insurance.¹ According to the American Optometric Association (AOA), prompt-pay discounts offered to private-pay patients should be no more than 20% to 25% of the total patient bill. The AOA defines private-pay patients as patients who do not use any form of insurance but instead use cash, check, or credit/debit card at the time of the service or purchase.

To follow best practices, it is important to regularly review state and federal policies and to consult a legal or financial professional. These individuals can help mitigate risks associated with prompt-pay patient arrangements.¹ Here are 5 helpful tips and tricks to be prepared to offer prompt-pay discounts while maintaining compliance with legal and contractual obligations:¹

1. Review third-party payer contracts

Before implementing prompt-pay discounts, make sure it is permitted by carefully reviewing contracts with insurance payers. Violating these agreements could lead to penalties, contract termination, or other legal consequences.

2. Think about federal and state laws

Discounts offered to help patients receive other services payable by Medicare, Medicaid, or other government programs may

violate federal fraud and abuse laws. Two rulings—the Anti-Kickback Statute and Civil Monetary Penalties Law—prohibit offering remuneration to induce referrals for services covered by federal health programs. State laws sometimes have anti-kickback statutes and regulations regarding discounts. Of note, some contracts explicitly require the collection of copays, coinsurance, and the patient cost-share amounts.

3. Document pricing and payment policies

It is important to maintain clear internal policies on prompt-pay discounts and pricing. Ensure that staff are trained to apply discounts consistently and document any prompt-pay discounts accurately to prevent discrepancies.

4. Monitor your practice's proportion of prompt-pay patients

If prompt-pay patients become a significant portion of your practice and you offer prompt-pay discounts, review your “usual and customary” rates reported to the CMS and other insurers.

5. Be mindful of advertising

While offering prompt private-pay discounts is permissible, a practice generally should not advertise that they are offering fee for private pay and a separate fee for patients using insurance.

The Bottom Line

Prompt-pay discounts can enhance patient satisfaction and streamline payment processes but require careful planning. By following best practices and maintaining compliance, optometrists can offer these discounts confidently while protecting their practice.¹

SOURCE:

1. American Optometrist Association. 5 best practices for offering prompt-pay discounts. Published November 10, 2025. <https://www.aoa.org/news/practice-management/billing-and-coding/5-best-practices-for-offering-prompt-pay-discounts>



Botulinum Toxin Microinjections Help With AACE



Although acute acquired comitant esotropia (AACE) accounts for only ~0.3% of pediatric strabismus cases, its incidence is rising. Botulinum toxin type A (Botox) has emerged as a key treatment option for AACE because of its ability to reduce recovery time, enhance stereoacuity, and minimize scarring.

A retrospective study of 35 patients living with AACE who were treated with Botox microinjections. The mean onset age of the study group was 8.86 years while the mean strabismus duration was 3.37 months. At 6-month follow-up, deviation angles for near and distance fixation decreased significantly, with an 80% success rate. Binocular vision metrics—including fusion range and stereopsis—improved after treatment with Botox.

Risk factors for recurrence included older age at onset (odds ratio, 1.477), longer strabismus duration (odds ratio, 1.615), and limited pre-injection fusion range (odds ratio, 0.722). Each additional month of strabismus increased recurrence risk by ~68% and reduced near stereopsis recovery.

SOURCE

Zhang H, Han H, Xu H, et al. Botulinum toxin for acute acquired comitant esotropia: clinical outcomes and predictors. BMC Ophthalmol. 2025;25(1):607.

Eye doctors say:

Nearly 100% water at the surface* of the lens^{1,2}

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*Based on in vitro measurements of unworn lenses.

†In a typical day of ≥8 hours of digital device use. Based on statements, "I am satisfied with the comfort the study lenses provide when I use digital devices for ≥8 hours" and "I am satisfied with the vision the study lenses provide when I use digital devices for ≥8 hours" (n=32).

References: 1. Thekveli S, Qui Y, Kapoor Y, Liang W, Pruitt J. Structure-property relationship of delecticon A lenses. *Cont Lens Anterior Eye*. 2012;35 (suppl 1):e14. 2. Angelini TE, Nixon RM, Dunn AC, Uruena J, Pruitt J, Sawyer W. Viscoelasticity and mesh-size at the surface of hydrogels characterized with microrheology. *Invest Ophthalmol Vis Sci*. 2013;54(15):500. 3. Pérez-Gómez I, Giles T. European survey of contact lens wearers and eye care professionals on satisfaction with a new water gradient daily disposable contact lens. *Clin Optom*. 2014;6:17-23. 4. Wong S, Woods J, Schulze MM, Fadel D, Stahl U, Jones L. Performance of delecticon A daily disposable contact lenses in a group of digital device users. *Clin Ophthalmol*. 2025;19:2439-2452.



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INSIGHTS

A Free, Online Resource for Vision Insurance



Confusion from patients about what is covered by their insurance plans is a common barrier to proper eyecare. Many patients struggle to understand the difference between vision insurance and medical coverage, especially during open enrollment periods. To address this issue, Prevent Blindness has introduced an online guide, Understanding Insurance Benefits for Eye Care, to simplify these processes.

The guide, available for free at <https://preventblindness.org/understanding-eye-care-benefits>, breaks down key insurance terms and explains coverage for routine eye exams, eyeglasses, contact lenses, medical eye care, and surgical procedures. It also provides links to financial assistance programs, advocacy opportunities, and even a platform for patients to share personal stories regarding their vision.

The guide is intended to empower patients to make informed decisions about their eye health using clear, accessible information. For optometrists, this tool offers a practical way to support patients who are navigating complex insurance landscapes.

SOURCE

Prevent Blindness. <https://preventblindness.org/understanding-eye-care-benefits>.



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