Building Your Dry Eye Center of Excellence

A digital resource guide to creating, building out, and generating Dry Eye revenue, this approach to the business aspect of Dry Eye therapy describes in detail the crucial "how-to-incorporate -and-execute" topics that separate successful Dry Eye practitioners from those who are unsuccessful.

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Produced by Review of Optometric Business in collaboration with the Intrepid Eye Society, a diverse group of emerging thought leaders in optometry with a goal of promoting excellence and growth in our field. The Intrepid Eye Society's initiatives include advancement of optometry through innovative thought sharing on topics related to future medical therapeutics, diagnostics, practice development, research and development, and collaborative care with ophthalmology.

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Your 'How-To' Guide to Build Your Dry Eye Center of Excellence

Leslie O'Dell, OD, FAAO,
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With the increasing prevalence of ocular surface complications, including dry eye disease (DED), there is well-documented medical evidence showing the potential negative impact on a patient's quality of life. Inherently, this necessitates all of us to embrace the diagnosis and treatment of this chronic, progressive disease state. Bearing in mind the recent events we have all been living through over these past few months, transitioning your practice to include ocular surface disease management is gratifying, both socially and financially, along with attainable and thoughtful consideration given to a limited capital equipment investment.

Dry Eye Disease represents an unmet need in patient care.

Succinctly, DED represents an unmet need in patient care. The public has been seeking better treatments for DED for a long time, and optometry is in an impeccably qualified position to fill this void. Everyone will thank you—patients, staff, and your referral network alike.

This compendium is a perfectly elegant resource to get you started on how to model your practice for success. You will find inside a step-by-step "how-to" guide for diagnosing dry eye disease, including a detailed outline of coding techniques as well as concise tips for communicating to patients about their out-of-pocket expenses. We hope these shared experiences engage your hearts and minds to develop an innovative service that best fits your particular setting.

The Dry Eye Problem

Justin Kwan, OD, FAAO

Dry eye presents challenges on many fronts. It is a frustrating disease to live with and is costly to each patient at an average annual direct cost of $800.[1] Productivity loss in the workplace is an estimated $11,302 per year per patient with dry eye disease [Yu Cornea 2011, PMID 21045640]. As a multifactorial, complex disease state, dry eye prevalence can be wide ranging depending on definition and diagnostic criteria. The landmark and still influential Tear Film and Ocular Surface Society Dry Eye Workshop (TFOS DEWS) in 2007 referenced studies that stated prevalence of 5.5 percent to 33.7 percent.[2] The TFOS Meibomian Gland Dysfunction (MGD) Workshop in 2011 reported prevalence of MGD as 3.5 percent to 69.3 percent in adults ≥ 40 years of age.[3]

When considering symptoms and signs, TFOS DEWS II in 2017 found an overall prevalence of 8.7 percent to 30.1 percent from five population-based studies.[4] Data analyzed from 75,000 participants in the 2013 National Health and Wellness Survey found that 6.8 percent of the U.S. adult population was projected to have diagnosed dry eye disease.[5] Gupta et al. found that 42 percent of subjects aged 4 to 17 years had meibomian gland atrophy.[6] The frequency of symptomatic mixed dry eye was 17.4 percent in a sample with age range of 17 to 35 years.[7]

Therefore, in an average clinical practice spanning all ages, the case can certainly be made that dry eye and/or MGD is the most common diagnosis after refractive error. With an assumption of 3,100 patient encounters in an average year, up to two thirds can be dedicated to the medical management of dry eye. Yet, the average patient with dry eye suffers with symptoms for 6.5 years before seeking care from an eye care practitioner [Schein 1999, PMID 10386512]. Barriers to intervention are primarily lack of awareness leaving the patient to suffer and worsen needlessly, assuming their symptoms are normal, perhaps attributed to environment and aging.

> **42 percent of patients without clinical signs had clinically significant symptoms.**

The prevalence of dry eye is likely even higher considering the amount of patients who demonstrate non-classic symptoms such as vision

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While the prevalence of dry eye makes it among the most common ocular diagnosis, as many as 42 percent of patients who do not have clinical signs actually have clinically significant symptoms. Add to that the fact that dry eye symptoms increase the odds of depression by 50 percent and suicidal ideation by 47 percent, and it becomes obvious that the intervention of an eyecare professional is necessary. However, because insurance typically does not cover dry eye treatments, payment options are needed and available to help make them more affordable to patients. Click here for more.

fluctuation and tired eyes without overt signs. Those with non-obvious MGD[8] are often written off since there are no visible signs of meibomian gland obstruction or ocular surface/eyelid margin inflammation. Another multicenter study found that 42 percent of patients without clinical signs had clinically significant symptoms per the OSDI (Ocular Surface Disease Index).[9]

Dry eye and/or MGD is the most common diagnosis after refractive error.

The number of people with autoimmune disease in the U.S. is an estimated 14.7 million[10] to 23.5 million. The most common autoimmune diseases are rheumatoid arthritis, Hashimoto's thyroiditis, celiac disease, Graves' disease, diabetes mellitus Type 1, and vitiligo. Immune-related dry eye can present five to 16 years earlier than classic dry eye[11] and is far more common in the context of rheumatic disease and often more severe. In the presence of ocular surface instability, it is imperative to tease out these details. Women have dry eye signs and report dry eye symptoms more often than men, presumably due to their susceptibility to have autoimmune disease and hormonal variations [Rapoport 2016, PMID: 27101252]. Other studies find the sex differences equivocal, and Pult did not find sex to impact meibomian gland loss [2018, PMID: 29438123].

Having dry eye symptoms increases the odds of depression by 50 percent and suicidal ideation by 47 percent.[12] Data from surveyed members of the Dry Eye Zone community, a website that allows members to share their experiences and resources, found that 55.6 percent had seen four or more eye care providers in search of a proper diagnosis and relief. Additionally, patients are turning to social media for patient-centered support groups such as on Facebook's "Dry Eye Syndrome Support Community." In particular, this group has grown 47 percent year on year, accounting for approximately 10,000 members, with the majority in the United States. •

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It is imperative that optometry embrace the ocular surface.

What You Need to Get Started Treating Dry Eye Now

Jacob Lang, OD, FAAO

If you are an optometrist, you have already been managing the ocular surface, whether you realize it or not. It might be as simple as asking the patient to blink between "one" and "two" or administering an artificial tear prior to taking keratometry or topography measurements, but these little things are an acknowledgment that the ocular surface is critical for crisp and clear vision. Because we are referring to dry eye as a vision disease, it is imperative that optometry embrace the ocular surface…now more than ever!

THE CULTURE

For countless reasons, it is becoming increasingly important for optometry to become diverse in patient care by augmenting its medical care component. Patient engagement with Ocular Surface Disease (OSD) optometry can begin to move the profession toward a more medically focused practice. Adding, modifying, and refining a Dry Eye Center of Excellence sub-specialty within your current practice will take time and ongoing maintenance. However, development and expansion of this sub-specialty can be much easier and incremental than it may seem.

Your staff interacts with your patients as much if not more so than the doctors treating them, so it is equally important for them to be educated about OSD. They can then share information about potential treatments as well as their costs with patients upfront. Not only will this ensure that your patients get the care they need, but it will also keep them in your practice rather than seeking care elsewhere.

Every organization, no matter the size, structure, or objective, has a culture. As a leader, you can decide

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It is the provider's responsibility to acknowledge, diagnose, and discuss dry eye with the patient. The staff can assist with this education of the patient. It is also imperative for everyone involved to impress upon the patient that there are often multiple treatments prescribed simultaneously, which could result in additional out-of-pocket costs not covered by insurance. Fortunately, financing options are available with the CareCredit credit card at enrolled providers, and this "Dry Eye Treatment Cost Worksheet" is a helpful tool to help you share with your patients what financing options are available. Click here for more.

Ultimately, a patient does not care how much you know until they know how much you truly care about them.

to create the culture you wish to have, or not. If you do not form, mold, and create this ideology, someone or something else will. By taking an active role in educating your team about OSD, you can help build a culture of recognition, treatment, and acceptance within your organization. This can be as simple as keeping your staff up to date with lunchtime learning sessions. Don't forget to talk to them about the importance to your business strategy. Even a quick conversation in the hallway about how OSD was the root of "Mrs. Smith's" complaints or how she's doing better with your treatment plan can enhance the staff's enrichment journey.

This culture will permeate your practice and pay dividends in the future, as your team sees the benefits and importance of recognizing and treating OSD. This will not only manifest within interactions with patients, but it will also filter down to home life where friends and family can exponentially increase your culture's reach.

Unfortunately, OSD has been overlooked and undervalued by eye care providers, optometry, and ophthalmology alike, for decades. Now, with an expanded understanding of the importance of the ocular surface along with further insight into the pathophysiology of this condition, there are new therapies to treat these conditions[1].

Subsequently, it is the provider's responsibility (along with an educated staff) to acknowledge, diagnose, and discuss this condition with the patient. By discussing clinical findings associated with OSD, the patient will start to understand that you are here to be at their service to treat their medical eye conditions. It is this "aha" moment that illustrates you care about their vision, which includes their complete ocular health.

Patient education is a crucial step to demystify the sporadic and variable symptoms of OSD. Ultimately, a patient does not care how much you know until they know how much you truly care about them.

THE DETAILS

One fortunate component about OSD is that it is external. When examining the ocular surface, the tear film quantity, meibomian glands, and other critical structures are easily accessed for examination at the slit lamp. While there are new instruments that can ease the acquisition time, don't place too much focus on new technology. A thorough slit lamp exam is still king of the mountain to touch, feel, and visualize the disease state.

Due to the intricacies of the ocular surface, the multitude of comorbidities, and masquerading syndromes, the moment of diagnosis is not the ideal time to completely assess the patient's ocular surface. However, it can be the perfect occasion to start acute treatments and educate the patient about the big picture. The ocular surface necessitates a complete evaluation of all the moving parts in this disease spectrum. Sharing the viable options to manage this chronic and sometimes debilitating condition can go a long way in easing the patient's concerns.

THE EXAMINATION

The examination should include an evaluation of the patient's eyes bolstered by symptom questionnaires such as the SPEED II (Standardized Patient Evaluation of Eye Dryness), DEQ-5 (Dry Eye Questionnaire), or OSDI (Ocular Surface Disease Index). When reviewing the ocular surface, a complete evaluation of tear fluid height, lid disease, lid structure, and functionality, including blink rates and efficiency, are important. Of course, assessing the meibomian glands and the quality of their meibum is a critical part along with additional attention given to nasolacrimal drainage and punctal stenosis. Grading these findings by using scales such as Meiboscale[8] or similar can help the clinician keep an objective perspective on the patient's pathology and also assist in tracking the patient's disease state over time. Use conjunctival and cornea vital dye staining with sodium fluorescein and lissamine to observe structural abnormalities or reactions that may not have been obvious otherwise to rule in or out further pathology.

Newer technologies that measure inflammation, such as InflammaDry (Quidel), and ascertain tear film osmolarity (TearLab), can aid in treatment recommendations. Additionally, there are several tools to image the tear film's stability, volume, and other attributes, including meibomian gland imaging. Although not mandatory for *getting started*, the information and understanding these technologies provide can speed up the provider's learning curve when diagnosing and classifying the type of dry eye disease. They also allow for a more detailed and quantitative assessment of treatment success (or failure). To be most successful, these tools must rest upon a strong foundation of OSD culture.

Increase your OSD aptitude by taking advantage of the plethora of OSD-focused educational opportunities.

RESEARCH

Thankfully, there has been extensive research in the area of OSD over the last several years, including landmark publications such as the TFOS DEWS II report[2], the TFOS MGD workshop[3], the CEDARS report[4], and the ASCRS OSD guidelines[5]. Although the provider may not want to sit down and digest the whole compendium of OSD publications, DEWS II's executive report continues to be a great enduring summary[2]. The content lends itself well as a foundation for providers to build on with further reading to fill gaps and delve deeper when necessary.

TFOS DEWS II helped confirm some notions that we have been assuming for some time, especially in reference to the hallmark basis of OSD being deeply rooted in inflammation compounded by the hyperosmolar environment and more broadly neuro-inflammatory processes[2]. The other breakthrough that TFOS DEWS II provided was the pathophysiological interplay between MGD and aqueous deficient dry eye. While these two help understand the underlying processes, the confirmation that these conditions occur in conjunction and not in isolation has schematically fleshed out that there are spectral entities of disease[6, 2, 7]. Therefore, addressing the ocular surface holistically is an important concept when treating these patients.

Finally, increase your OSD aptitude by taking advantage of the plethora of OSD-focused educational opportunities, whether in print, online, or in person.

DISEASE CLASSIFICATION AND TREATMENT

After assessing the ocular surface as a whole, the practitioner should classify the patient's disease state on the spectrum of disease with pure aqueous deficiency on one end and pure meibomian gland disease on the other. They should also note any other comorbidities or contributing pathologies to the patient's disease state and their influence on the patient's position on this disease spectrum.

Best practices for treatment involve a stepwise approach that first addresses the "principal offender" in the patient's disease state based on the comprehensive ocular surface examination. Once this primary disease state is addressed, other sub-offenders and comorbidities should be treated until the ocular surface is entirely rehabilitated.

In most cases, treatment involves managing ocular inflammation with pharmacologic agents such as lifitegrast, cyclosporine, doxycycline, etc. and/or in-office treatments such as intense pulsed light. This is typically done while encouraging normal tear production by removing meibomian gland obstruction with thermal pulsation treatments (such as LipiFlow, TearCare, and iLUX). Once these improvements are maximized, further increase of aqueous volume can be improved with punctal plugs and other outflow-reducing treatments. •

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Checklist of What You Need to Get Started

THE NECESSITIES

- ❑ symptom questionnaire (SPEED, DEQ-5, OSDI, etc.)
- ❑ fluorescein
- ❑ lissamine green
- ❑ Schirmer strips (I rarely use these anymore, but they are still standard and sometimes necessary)
- ❑ meibomian gland expresser and/or lid everter (Meibomian Gland Evaluator / Johnson & Johnson, Q-Tip, Epstein lid everter, paper clip, finger)
    - ❑ Q-Tips can also be helpful for testing corneal sensation.

NEXT LEVEL EXAM AND DIAGNOSTIC TECHNOLOGIES

- ❑ slit lamp photography / videography
- ❑ point-of-care "biochemistry" tests to analyze dry eye disease biomarkers
    - ❑ osmolarity (TearLab)
    - ❑ MMP-9 testing (Inflammadry / Quidel)
    - ❑ lactoferrin (Lactofferin Diagnostic Kit / ATD)
    - ❑ IgE (Total Immunoglobulin E Diagnostic Test Kit / ATD)
- ❑ tear film analyzers and meibographers
  These have varying tear film and ocular measures based on the device.
    - ❑ LipiView II (Johnson & Johnson Vision)
    - ❑ Keratograph 5M (Oculus)
    - ❑ Meibox (Box Medical Solutions)
    - ❑ ICP (MiBo Medical Group)
    - ❑ LacryDiag (Quantel Medical)

TREATMENTS & THERAPEUTICS

- ❑ a handout or brochure describing recommended therapies
- ❑ an Rx pad (or ERx) for pharmacologics
    - ❑ Xiidra (Novartis), Restasis (Allergan), Cequa (Sun), Lotemax (Bausch + Lomb), Flarex (Alcon), doxycycline, etc.
- ❑ thermal pulsation and expression
    - ❑ LipiFlow (Johnson & Johnson Vision), TearCare (Sight Sciences), iLUX (Alcon), etc.
- ❑ intense pulsed light
    - ❑ M22 (Lumenis), etc.
- ❑ gland probing
    - ❑ Maskin Meibomian Gland Intraductal Probes
- ❑ lid debridement
    - ❑ spud, Karpecki debrider, Epstein lid debrider, etc.

- ❑ therapeutic contact lenses including biologic bandages (amniotics)
    - ❑ sclerals such as BostonSight, soft lenses, Prokera (biotissue), AmbioDisk (Katena), etc.
- ❑ lid cleaners, home heat treatments
    - ❑ Bruder Mask, Zocular, HyClear (Contamac), Avenova, HypoChlor (OCuSOFT), etc.
- ❑ tear supplements
    - ❑ Systane (Alcon), Refresh (Allergan), Blink (Johnson & Johnson Vision), Oasis, TheraTears (Akorn)
- ❑ nutraceuticals
    - ❑ fish oil (Omega-3s)
    - ❑ DE3 (PRN)
    - ❑ HydroEye (Science Based Health)
    - ❑ Super Omega-3 (Fortifeye)
    - ❑ Omega 3 (Nordic Naturals)
- ❑ autologous serum processor/distributor
    - ❑ Vital Tears, etc.
- ❑ collaborative care consultations
    - ❑ oculoplastic, cornea, neurology, rheumatology, etc.

How to Present Dry Eye Therapies to Patients

Mark Schaeffer, OD

According to the groundbreaking TFOS DEWS II report, dry eye disease is a *"multifactorial disease of the ocular surface characterized by a loss of homeostasis of the tear film, and accompanied by ocular symptoms, in which tear film instability and hyperosmolarity, ocular surface inflammation and damage, and neurosensory abnormalities play etiological roles."*[1] Most patients may not properly understand this information if it were to roll off your tongue in the exam lane. When educating the patient, provide the diagnosis in a scientific way either through pictures, tests, or dynamic imaging that ties into symptoms and problems the patient is having. This creates an important connection between the disease state and the treatment itself. When patients understand the role of each prescribed treatment, they can better manage their own disease.

Using analogies, stories, or other ways to relate to our patients creates a common language. Patients won't remember words such as "thermal pulsation" or "immunomodulation," but they will remember "heated massage" and "resetting back to normal." When you position any of these treatments, whether written or verbal, always bring it back to the why it is necessary to treat. Exact phrasings that will resonate with your patient will differ on an individual basis, but concepts will remain the same.

When you position your therapies, emphasize that everything builds on each other. No single treatment is a panacea. Explaining to your patients that each piece is an equally important part of the puzzle carries more weight than discussing each separately.

When patients understand the role of each prescribed treatment, they can better manage their own disease.

STAFF INVOLVEMENT

If you are not willing or do not think it is a good idea for your staff to get involved, consider whether you would be willing to take care of all your contact lens sales or all patient education? You wouldn't. The staff is and will always be an integral part of the positioning of your dry eye therapies. They have more time with each patient, answer questions over a longer time span, and have the pleasure of

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Patients can use financing options with the CareCredit credit card to pay for out-of-pocket procedures such as dry eye treatments. Following scripts reinforced via role-play are an effective way to train your staff how to discuss this with patients. CareCredit offers sample scripts to make the financial conversation easier.
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being there after the OD is finished. It is critical that your staff is just as enthusiastic as you, if not more than, about treating ocular surface disease.

When starting to get the staff involved, you will notice that some will have a knack and understanding for this sooner than others will. Encourage those staff members to be a "champion" or an "advocate" to not only help patients but also other colleagues.

The right positioning of your dry eye therapies and staff involvement are keys to your success.

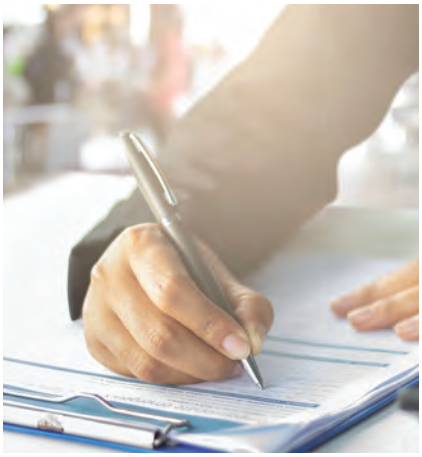
Just as some doctors prefer some specialties, some staff members may not feel comfortable taking the lead in this area. When there is a staff person who is a champion, there is another person who can answer patient and staff questions instead of having everything go through the OD. In addition, when those prior authorizations start rolling in, you are going to want to delegate them.

STAFF TRAINING

Whenever you integrate anything new into the office, you will want the staff involved and trained to help facilitate with patients. Work with all vendors for lunch-and-learns and in-service training on equipment. Every pharmaceutical company is willing to come to your office and help train the staff on clinical information regarding their products. Use this time as the OD to add clinical pearls regarding the diagnosis and/or management of these patients. Take pictures of corneas and make notes about patients as case presentations for your staff. Presenting this information to your staff also helps educate patients. It will amaze you how many questions you will receive from the staff regarding clinical care for these patients. Dedicated training time allows the office to come together and learn something new.

STAFF ROLE-PLAY

Another important logistical step is aligning the office message. When the whole practice consistently communicates, everyone wins. Role-play is an interactive time to shape the correct language



Without strategy and support, there is no structure.

in a safe environment. When stand-up comics hit the road to tour, they are working on the set up, delivery, verbiage, and timing in order to craft the perfect bit. Thinking about education in this way should have the most impact.

Role-play should be a live interaction. Avoid having participants use phrases such as "I'd say..." or "I'd ask..." but rather commit to actually playing a role. Bringing in non-staff members to play the role of the patient is a great way to simulate what it will be like in real time. The more realistic the situation, the better the staff will get. Offer feedback to your staff in a positive way. Open the floor to your staff to share their opinions about what went well in each presentation and what could be better.

USE SCRIPTS

Using scripts or standard operating procedures can also help with training and implementation by creating a reference point for anyone to use to guide the messaging. You want a realistic and authentic conversation between patient and staff. Within reason, allow all team members to make the dialogue their own while also maintaining scripts to serve as a backup in case you have new members of the team or if you start hearing the messaging veer off track.

The right positioning of your dry eye therapies and staff involvement are keys to your success. Without strategy and support, there is no structure. •

How to Discuss Dry Eye with your Patients

FIVE THINGS *NOT* TO SAY:

1. Do not use the words "cure" or "heal." All dry eye patients live on a continuum from no signs or symptoms to severe disease state. The goal of treatment is to move closer and closer to the "normal" side. None of the treatments is guaranteed as a one-time therapy that rids patients of this disease.

2. "This may or may not work, I don't know" expresses a lack of confidence in treatment. While we don't want to oversell therapies, lack of confidence in treatment can derail compliance before the patient has even left the office.

3. Don't establish unexpected expectations, but present them clearly. Be sure your patient knows there is a strategy, letting the patient know there is a plan in place regardless of the outcome of the first round of treatment.

4. Instead of asking, "Do you have any questions?" ask, "What questions do you have for me?" This open-ended query gives the patient permission to ask because they will always have questions.

5. Do not ask, "How are you feeling?" While you will want to know how the patient is doing, many times, the answer may not be as simple as you would like to receive at the time of the visit. Inherently, the disease easily can confound the patient because they may not notice a huge change in symptoms. This can be discouraging to the process. Instead, stick to positive reinforcement about taking the medications as prescribed and the information gathered in your clinical exam.

ITEMS TO DISCUSS WITH PATIENTS:

1. Recap your treatment plan or put it in writing. Attached is a worksheet that has different categories and space to add, change, or edit as time goes along.

2. Share expectations on the prior authorization process. When patients hear the word "not covered" by their pharmacist or the retail price of medications, there is an immediate pushback from the patient. By outlining the process that it takes time to get it approved, you'll alleviate those fears before they get the call from their pharmacy.

3. Review what you expect to see at a follow-up visit. At the first follow-up appointment, the focus should be compliance and tolerance. Most results for any treatment or regimen addressing clinical signs is around 90 days, but seeing the patient before allows the ECP to encourage their progress to attain improvement.

4. Explain financing options for out-of-pocket procedures. Give the patient time and resources to make the decision regarding these services.

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Treatments and Therapies in Your Dry Eye Center

Jade Coats, OD

When it comes to managing dry eye disease (DED), individual treatment and therapy plans may vary among patients, depending on the underlying problems. Considering DED is a multifactorial portion of the ocular disease spectrum, a combination of options listed below may be an appropriate treatment plan in your dry eye practice to treat a wide variety of these conditions. This list of treatments and therapy options serves as a guide, but you, as the patient's doctor, should determine what treatment combinations might be in the patient's best interest.

THERAPEUTIC PHARMACEUTICALS

When building a Dry Eye Center, it is important to pay attention to factors such as the patient's age, autoimmune conditions, systemic comorbidities, as well as the possible side effects of long-term medications that may be associated with aqueous deficiency and/or evaporative dry eye. Patients typically pay for therapeutic pharmaceuticals via private insurance with the assistance of commercial copay programs dependent on the product or HSA/FSA (Health Savings/Federal Savings) accounts, coupon cards from apps such as GoodRx, financing options such as the CareCredit credit card or general purpose credit cards, or cash.

Determine what treatment combinations might be in the patient's best interest.

Cyclosporine

Patients with presumed keratoconjunctivitis sicca caused by reduced tear production and even those afflicted by Sjögren's syndrome can benefit from the addition of a topical cyclosporine.[1]

The current options to improve the signs of DED by increasing tear production include cyclosporine 0.05 percent (Restasis, Allergan), cyclosporine 0.09 percent (Cequa, Sun Pharma), or cyclosporine 0.1 percent (Klarity, Imprimis).[1]

Lifitegrast

Acting as an LFA-1 antagonist directly on the surface of the cornea, lifitegrast ophthalmic solution 5 percent (Xiidra, Novartis) is a treatment option for mild, moderate, and severe DED. Post-surgical patients, contact lens wearers, and patients who exhibit the signs and

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symptoms of DED may experience relief from this ophthalmic medication in two to 12 weeks.[2]

STEROIDS

Patients experiencing moderate to severe inflammation that cannot be controlled by cyclosporine or lifitegrast alone may benefit from the synergistic use of a topical corticosteroid. In general, this drug class has been reserved for short-term treatment to manage signs and symptoms associated with ocular inflammation peri and post operatively during the surgical period.

A combination of options may be an appropriate treatment plan.

Off-label topical steroids such as loteprednol etabonate ophthalmic gel and suspension 0.38 percent and 1 percent, respectively, (Lotemax SM, Bausch & Lomb; Inveltys, Kala Pharmaceuticals) or fluorometholone acetate ophthalmic suspension 0.1 percent (Flarex, Eyevance Pharmaceuticals) can quickly quell ocular surface symptoms along with the added benefit of their ability to be used in conjunction with artificial tears and as a complement to other more long-term treatments. For those seeking for an on-label indication, there will be a new product available utilizing loteprednol etabonate suspension 0.25 percent (Eysuvis, Kala Pharmaceuticals) by the end of 2020 to early 2021.

CENEGERMIN

For cases of severe DED with decreased corneal sensitivity and/or neurotrophic keratitis, the FDA has recently approved cenegermin ophthalmic solution 0.002 percent (Oxervate, Dompé), a recombinant human nerve growth factor that targets the pathogenesis of neurotrophic keratitis.[3] My early observation is that testing for corneal hypoesthesia should be added to the diagnostic battery as many patients are clinically flying under the radar.

Typically, coverage for these pharmaceutical options for the treatment of mild, moderate, and severe DED are included under medical insurance, less the copay and deductible.

SUPPLEMENTS AND MORE

When building a Dry Eye Center it is important to consider oral dietary supplements as an added option to treat and prevent DED. Patients typically pay for supplements with HSA/FSA insurance saving programs, financing options such as the CareCredit credit card or general purpose credit cards, or cash. Certain manufacturers provide special pricing for direct purchases made in office or mail order.

OMEGA-3 (EPA + DHA)

Omega-3 fatty acids such as eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA) provide added anti-inflammatory benefits.[4] Data published has demonstrated that taking a high quality re-esterified omega-3 supplement, such as PRN Dry Eye Omega Benefits softgels (PRN Physician Recommended Nutraceuticals), shows statistically significant improvement in tear osmolarity, omega-3 index levels, TBUT, MMP-9, and OSDI symptom scores.[4]

The FDA generally considers 3 grams of omega-3, EPA and DHA fatty acids, per day as safe.[6] Adequate intake of omega-6 for adults ages 19 to 50 is 17 grams per day for men and 12 grams per day for women.[6]

LIFESTYLE, ENVIRONMENTAL, AND NUTRITIONAL CHANGES

In addition to oral supplements, lifestyle and nutritional changes are important factors to consider when treating patients with DED. Eliminating potential inflammatory foods from the diet can help provide the best systemic foundation to prevent DED.

Environmental conditions (i.e. dry climate, allergens, smoke including vaping) likely also contribute to DED. Consequently, it is important to be cognizant of environmental factors such as ceiling fans, fireplaces, and poorly ventilated places that may also contribute to the overall problem.

OMEGA-6 (GLA)

Dietary supplementation of a unique omega-6 fatty acid, gamma linolenic acid (GLA), has also been shown to optimize anti-inflammatory activity and clinically decrease symptoms of dry eye disease.[5] GLA derived from black currant seed oil combined with adequate amounts of EPA and DHA has been incorporated in oral supplements such as HydroEye (Science Based Health) to help improve tear film stability.[5]

THERMAL TREATMENTS

When building a Dry Eye Center, patients with evidence of meibomian gland dysfunction may benefit from an at-home or in-office thermal treatment. Patients typically pay for thermal treatments with HSA/FSA insurance saving programs, financing options such as the CareCredit credit card or general purpose credit cards, or cash.

HEATED MASKS

For patients with MGD, poor lid hygiene, and blocked meibomian glands, a heated mask or hot compress can also be an effective at-home treatment option to improve the flow of meibum. Hot compresses and eyelid warming masks, such as a Bruder Mask, heat the meibomian glands enough to allow expression of the meibum oils. Facilitating the flow of blocked meibum can help to improve the tear film stability.[7]

LIPIFLOW

The LipiFlow thermal pulsation system (Johnson & Johnson Vision/Surgical Care) is an in-office device that consists of a section placed behind the eyelids to provide controlled heat and an outer section that applies directional pressure by gently massaging the eyelids to express the obstructed meibum. One procedure lasts about 12 minutes with both eyes treated simultaneously.[8]

TEARCARE

The TearCare system (Sight Sciences) delivers intelligently targeted thermal heat (sensors assess surface temperature throughout the procedure) to the anterior surface of the eyelids. Patients are allowed to keep their eyes open throughout the experience for comfort, and the physician can further express meibum with the cleaning instrument provided with each device.[9]

ILUX

The iLUX MGD treatment system (Alcon) is a handheld device that uses localized light energy (yellow LED) to soften the meibum. With magnification and direct visualization, the physician can focus on certain areas of MGD to apply manual compression.[9] In contrast to the above options, each eyelid is treated individually. It has been shown to be clinically equally effective as other thermal treatment options.[8]

While hot compresses and masks may be a budget-friendly out-of-pocket expense, other treatments options such as LipFlow, TearCare, and iLUX may be a more effective option, albeit more expensive. For all dry eye treatments not covered by insurance, offer patient financing products such as the CareCredit credit card as a form of payment. CareCredit offers special financing options on purchases of $200+ at enrolled providers, allowing patients to pay over time.

OTHER TREATMENTS

INTENSE PULSE LIGHT (IPL)

Patients exhibiting erythema and telangiectasia near the eyelids and adnexa caused by ocular rosacea and/or blepharitis can benefit from intense pulse light (IPL).[11] IPL uses non-coherent light (from visible 515 nm to infrared spectrum 1,200 nm) applied to the periocular area to be absorbed by abnormal blood vessels to reduce inflammation.[11]

NASAL NEUROSTIMULATION

The TrueTear intranasal neurostimulation device (Allergan) increases tear production by stimulating the trigeminal nerve via the nasal canal. This nasal neurostimulation triggers the nasolacrimal reflex leading to immediate production of mucin from goblet cells, meibum from the meibomian gland, and aqueous from the main lacrimal gland.[12] For the sake of transparency, Allergan has decided to discontinue this product effective immediately as of July 2020.

While IPL and TrueTear offer an effective dry eye treatment option, they are not typically covered by insurance. For any unplanned out-of-pocket expenses, CareCredit provides payment solutions to help patients have access to the best treatment for long-term visual health.

The diagnosis and treatment of dry eye and ocular surface disease has significantly changed over the last few decades. Thanks to the innovation and advancement of technology, optometrists and ophthalmologists are now better equipped to tackle one of the most untreated diseases in health care. Whether the signs and symptoms of DED are worsened by aqueous deficient dry eye, evaporative dry eye, or a combination of both, it is important to be familiar with conventional and emerging treatment options to treat this multifactorial disease. •

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Dry Eye In Relation To…

Refractive and Cataract Surgery, Contact Lens Wear & Overall Dropout Rate, and Scleral Lenses

Melissa Barnett, OD, FAAO, FSLS, FBCLA

While dry eye is highly prevalent, many patients remain undiagnosed. This can lead to worse outcomes following surgical procedures such as inaccurate intraocular lens calculations and erroneous axis and magnitude of astigmatism. The Prospective Health Assessment of Cataract Patients' Ocular Surface (PHACO) study evaluated the incidence and severity of dry eye in patients being screened for cataract surgery using the International Task Force (ITF) scale.[1] Although the majority of patients did not complain of dry eye symptoms, up to 80 percent demonstrated conjunctival or corneal staining.

The majority of patients experience dry eye disease after cataract surgery. More than 87 percent of patients who have had cataract surgery use artificial tears one-month postoperatively.[2] The type of cataract surgery may influence the severity of dry eye symptoms. A study compared dry eye signs and symptoms after femtosecond laser-assisted cataract surgery and conventional phacoemulsification. Postoperatively, both methods worsened dry eye. Femtosecond laser-assisted cataract surgery had higher risk for ocular surface staining and dry eye symptoms than patients undergoing conventional cataract surgery.[3] A study evaluated dry eye after cataract surgery in meibomian gland dysfunction patients.[4] This study determined that the characteristics in this patient population are different from other cataract patients. In the early postoperative phase, changes to the ocular surface were caused by surgical factors. In the later postoperative phase, impairment to epithelial function was mainly associated with the inflammation of the meibomian glands and eyelids.

The majority of patients experience dry eye disease after cataract surgery.

Dry eye symptoms are common complaints (95 percent of patients) after LASIK (Laser-Assisted

THE BUSINESS OF DRY EYE

Treating ocular surface disease post-surgery enables you to continue to treat the patient comprehensively, addressing the potentially resulting dry eye and offering them options to pay for it. Also, scleral lenses continue to grow in popularity to treat dry eye and correct refractive error. Financing options available with the CareCredit credit card can help patients fit the cost of treatment and vision correction into their budgets. Click here for more.

In-situ Keratomileusis) surgery.[5] Early in the postoperative period, patients complain about gritty, uncomfortable eyes and general ocular fatigue, vision fluctuation, and ocular injection.[5] With time, dry eye symptoms reduce in LASIK patients, with 20 percent to 40 percent of patients experiencing dry eye symptoms six months after surgery.[5] Postoperative symptoms may negatively impact perceived surgical satisfaction and quality of life. Pre-existing dry eye may impact wavefront and corneal topography readings, leading to residual refractive error.

Dry eye symptoms are common after LASIK surgery.

LASIK may increase dry eye severity by two levels (from either mild to moderate or moderate to severe), thus uncontrolled dry eye is a contraindication for refractive surgery, according to the American Academy of Ophthalmology. Careful evaluation and management of ocular surface disease is critical prior to refractive surgery. There are techniques to minimize the severity of dry eye during refractive surgery. Making smaller, thinner flaps during LASIK will reduce the number of nerves cut. Creating shallower laser ablation depth will reduce the severity of dry eye. Hyperopic LASIK may increase the risk of dry eye due to a larger flap and treatment zone. The type of refractive surgery may influence the severity of dry eye symptoms. A study evaluated the short-term (up to one month) impact of FS-LASIK (femtosecond) and SMILE (SMile Incision Lenticule Extraction) on dry eye metrics.[6] Both FS-LASIK and SMILE provided good refractive and visual outcomes. There were increased dry eye symptoms after FS-LASIK compared with SMILE. For the majority of the other ocular surface metrics, there were no significant differences between procedures.[6]

CONTACT LENS DROPOUT

In the global market, contact lens dropout is estimated to be approximately equal to the number of new wearers each year.[7] Numerous publications have established that the rate of contact lens dropout ranges from 15 percent to more than 20 percent.[8-10] Contact lens dropout increases around age 40 and significantly increases around age 42. Under the age of 45, comfort issues are the key reason for contact lens dropout.[11] After age 45, vision and comfort are almost equally stated as the reasons for contact lens dropout.[12] Of interest in the soft contact lens population, 93 percent of patients were not wearing multifocal contact lenses at the time of dropout. If ocular surface disease is present, the quality of the tear film is diminished, increasing contact lens discomfort. Dry eye significantly increases the chance of contact lens drop out.[7]

A consistent, stable tear film is required for good visual performance and comfort, especially in contact lens wearers.[13] Tears are essential to maintain corneal moisture, integrity, and health with each blink. A dysfunctional tear film is directly associated with ocular discomfort and contributes to dryness related to contact lens wear, reduced wearing time for the patient, and increased chair time for the practitioner, which can result in contact lens dropout.[14] Contact lenses inherently disrupt the tear film. Patients with dry eye disease need to be managed and appropriately fit with contact lenses in order to achieve a stable tear film.

SCLERAL LENSES

Stability of the pre and post-lens tear film is critical for all soft, rigid gas permeable, and hybrid contact lenses. Scleral lenses are large diameter gas permeable lenses that vault the cornea and land on the scleral conjunctiva. The main indications of scleral lenses are visual rehabilitation in irregular corneas and the therapeutic treatment of ocular surface disease.[15] The post-lens fluid reservoir of the scleral lens provides continuous corneal lubrication and ocular protection. Scleral lenses prevent mechanical damage and tissue desiccation, which promotes healing and disrupts the neuropathic cycle. Large diameter scleral

Scleral lenses may be an option to treat dry eye.

lenses cover most of the ocular surface and protect corneal and conjunctival tissue from potential aggravation due to friction between the ocular surface and the palpebral surface of the lids.

When conventional treatments are insufficient, scleral lenses are a viable management option for dry eye patients.[15] Therapeutic scleral lens indications for ocular surface disease include neurotrophic keratitis, exposure keratitis, dry eye syndrome, graft vs. host disease, Steven Johnson Syndrome, ocular cicatricial pemphigoid, chemical burns, limbal stem cell deficiency, Sjögren's syndrome, and persistent epithelial defects.[15] Additionally, scleral lenses have been indicated for the treatment of conditions that are associated with neuropathic ocular pain.[15]

According to TFOS DEWS II, scleral lenses are tertiary therapy. This treatment strategy is placed after prescription medications and overnight treatments such as ointment or moisture goggles but before long-term use of steroids, amniotic membrane grafts, surgical punctal occlusion, or other surgical procedures such as tarsorrhaphy or salivary gland transplantation.[16]

Scleral lenses are ideal for presbyopic patients who often have concomitant dry eye. Numerous multifocal scleral lens options provide good vision at all distances. Since scleral lenses protect and bathe the ocular surface, they are beneficial for patients with dry eye. Additionally, multifocal scleral lens optics may be used in patients with corneal irregularities since the post-lens fluid reservoir of a scleral lens neutralizes irregularities.

BEST PRACTICES

To obtain best outcomes, it is pertinent to evaluate and manage dry eye disease prior to surgical procedures such as cataract surgery or LASIK. It is equally essential to evaluate and manage dry eye prior to contact lens wear. For those interested in contact lens wear, scleral lenses may be an option to treat dry eye and correct refractive error. The popularity of scleral lenses is immense and continues to grow. Multifocal scleral lens options may be considered, especially in a patient with symptomatic dry eye. •

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Billing Ocular Surface Disease

Tracy Doll, OD, FAAO

Recent advances in diagnostic and treatment options for Ocular Surface Disease (OSD) have increased both doctor and patient need for clear direction when it comes to billing and coding. The ability to navigate this scene successfully ensures patients receive quality care that is within reach.

Any patient identified to have OSD diagnoses in a standard vision exam (92004 or 92014) should return for medical care.[1] OSD includes a host of medical conditions that require the same amount of diagnostic and treatment time as other complex ocular disease states (see Table 1 for a brief list). When coding ICD-10 diagnoses, the practitioner should seek to be as specific as possible, including eye or eyelid location and avoiding codes listed as "unspecified."[2]

TABLE 1: Common OSD Diagnoses and ICD-10 Codes[2,3]

Ocular Surface Disease Condition	ICD-10 Codes
Dry Eye Syndrome of Lacrimal Gland	H04.121 through H04.123
Keratoconjunctivitis sicca, not specified as Sjögren's	H16.221 through H16.223
Sicca Syndrome with Conjunctivitis	M35.01
Meibomian Gland Dysfunction	H02.881 through H02.885 H02.88A/AAB- upper and lower
Squamous Blepharitis	H01.021 through H01.023
Punctate Keratitis	H16.141 through H16.143
Trichiasis, without entropion	H02.051 through H02.055
Rosacea Conjunctivitis	H10.821 through H10.823
Other Rosacea (includes Eyelid Rosacea)	L71.8

Any patient identified to have OSD should return for medical care.

Some medical insurance plans require a pre-authorization for continued medical treatment with utilization of E/M codes (992XX).[2,3] Need for prior authorization should be determined before the patient's return. Some medical codes will be considered "below the line," meaning that even though there is a medical diagnostic code, the condition may

THE BUSINESS OF DRY EYE

Diagnostics and treatments may not be reimbursed. This could result in many patients declining care. To prevent this, offer patients various means of financing their care upfront. It can mean the difference between patients saying "yes" or "no." Click here for more.

not be considered "severe enough" to warrant coverage. Conditions that are covered or "above the line" will be dependent on the patient's individual plan.

The initial OSD work-up can be time-intensive and thus can warrant billing an E/M level 3 or 4 (i.e. 99214), while follow-ups generally run as a level 2 or 3 (i.e. 99213).[2,3] During medical E/M visits, OSD diagnostic/point-of-care testing will fall under different billing strategies.

Diagnostic/point-of-care tests that are considered part of the medical E/M visit are called "incidental." These tests do *not* have specific CPT codes

- Sodium Fluorescein Tear Break-Up Time
- Tear Meniscus Height
- Vital Dye Evaluation (Lissamine Green or Rose Bengal)
- Phenol Red/ Schirmer 1 or 2
- Meibomian Gland Evaluator (*MGE by Johnson & Johnson Vision/Surgical Care*)
- Lid seal test

CLIA: CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

In order to obtain a Clinical Laboratory Improvement Amendments (CLIA) waiver certificate, you must submit an application. The Centers for Medicare and Medicaid Services (CMS) will issue a waiver and a CLIA along with an invoice for the CLIA fees. Coding must be modified (QW) and lateralized (RT and/or LT) at the CPT and ICD-10 level (CPT 83861/83516/etc, ICD-10 H16.22x). Note that state laws in Massachusetts, Nevada, and Hawaii currently prohibit optometrists from obtaining a CLIA Certificate of Waiver. Contact TearLab or Quidel for specific requirements in your state.

The biennial CMS fee for the CLIA Certificate of Waiver is $150 and is borne by the practice, as required by law. This fee is for a two-year period for one location only. Multiple locations will require multiple CLIA Waivers. In some states there may be additional licensure fees. Additional details are available here: https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_Certificate_International_Laboratories.

CPT-coded diagnostic/point-of-care tests can be billed along with an E/M medical office visit. These tests may require a modifier to clarify eye location (RT/LT/59) or indicate medical laboratory testing (QW).[3]

- Osmolarity (*TearLab*): CPT 83861 (add QW for Medicare, and/or RT/LT/59 modifier for bilateral treatment when requested)[3]
- External Ocular Photography/ Meibography: CPT 92285
- MMP-9 -Testing (*InflammaDry / Quidel*): CPT 83516 (QW modifier for Medicare, and/or RT/LT/59 modifier for bilateral treatment when requested)

CPT III-coded diagnostic/point-of-care tests are *not* reimbursed. These CPT III codes include emergent technologies that may be covered someday in the future. You *can* bill CPT III along with an E/M code, but expect that the test cost will be passed onto the patient.

- Lipid Layer Thickness/ Tear Film Imaging (CPT-0330T, *tear film imaging, unilateral or bilateral, with interpretation and report*)[4,5]

There are also advanced diagnostic tests that are *not* currently billable and *do not* have CPT codes. These would always be billed out-of-pocket.[5]

- Non-Invasive Tear Break-Up Time (NIKBUT) (*Oculus Keratograph 5M by Oculus*)
- Blink Dynamics (*LipiView II by Johnson & Johnson*)

Treatments for OSD also have different billing strategies. To ensure proper reimbursement, it's important to know which codes *cannot* be combined with E/M codes and which codes may also require a modifier. Common modifiers for OSD treatments can be seen in Table 2.

CPT III treatments, like CPT III diagnostics/point-of-care tests are *not* reimbursed. You can expect that the cost will be passed onto the patient.

- LipiFlow Vectored Thermal Pulsation (*Johnson & Johnson*) or iLUX (*Alcon*): CPT-0207T, *evacuation of meibomian glands, automated using heat and intermittent pressure unilateral*[5,6]
- TearCare (*Sight Sciences*): CPT 0563T, *evacuation of meibomian glands, using heat delivered through wearable, open-eye eyelid treatment devices and manual gland expression, bilateral*[5,6]

"Miscellaneous CPT code" treatments are also rarely reimbursed as they have no set guidelines. Like CPT III, you *can* bill "miscellaneous" treatments in addition to an E/M code but are unlikely to be reimbursed. The cost is passed onto the patient.

- Intense Pulsed Light Therapy for OSD: CPT 17999 "*Unlisted procedure, skin, mucous membrane, and subcutaneous tissue*"[7]
- BlephEx or LidPro (*MiBo Medical Group*): CPT 67999 "*unlisted procedure eyelid*"[8]

There are also OSD treatments that are *not* covered and do *not* have CPT codes. These would be out of- pocket costs for the patient.

- eyelid debridement
- hand meibomian gland expression
- tea tree oil *Demodex* blepharitis treatments

OSD treatments that are billed as minor medical procedures with CPT codes *cannot* be billed with an E/M code on the same day*. These treatments may require a modifier to clarify location (E1-E4).

- punctal plugs: CPT-68761 with -E1 -E4 per eyelid (and -25 modifier when appropriate)
  - There is a 10-day global period after first punctal plug placement.
  - Reimbursement for the first plug is 100%, with each subsequent plug at 50%, so normally only two plugs are placed at the first visit.[2]
- eyelash epilation: CPT- 67820, with E1-E4 per eyelid
- amniotic membrane (cryopreserved *Prokera by BioTissue* or dehydrated): CPT 65778- *placement of amniotic membrane on the ocular surface without sutures.*[9]
  - There is no global period.
  - This is considered a monocular procedure as the membrane can blur vision while worn.

Managed care guidelines are clear that the eye care office must only offer one price per CPT code,

TABLE 2: Treatment Modifiers for OSD Medical Billing Code[3,4]

-E1	upper left eyelid
-E2	lower left eyelid
-E3	upper right eyelid
-E4	lower right eyelid
-RT	right eye
-LT	left eye
-59	separately identifiable E/M service provided by the same doctor on the same day as another procedure, also sometimes requested for bilateral testing

no matter whom is covering the cost of the bill.[10,11] To offer differing fee schedules for insured vs. out-pocket patients would be "discriminatory billing patterns" and can result in monetary damages to the practice.[12] It is helpful to have a document prepared for OSD patients listing the cost of available services. This document should clearly state which OSD tests and treatments are not reimbursed by insurance (example: LipiFlow). Every office should include paperwork requiring a patient signature clearly stating the patient is responsible for any procedures not covered by insurance. Clear documentation and discussions about the financial aspect of OSD therapies help prevent miscommunications and gaps in patient care and reimbursement.[12]

Table 3 shows an example billing approach with testing and treatment through three OSD visits. Keep in mind that diagnostic and treatment options will vary depending on availability and individual doctor treatment strategy. ●

*There is one exception to this rule when a patient presents with two different medical diagnoses concurrently. This situation could allow for billing of the medical procedure *and* an E/M code with the appropriate modifier (-25). A good example would be a glaucoma follow-up that also presents with trichiasis. The E/M code would account for the glaucoma follow-up, and the medical procedure CPT code for the eyelash epilation. Both glaucoma and trichiasis ICD-10 codes would need to be billed.[2]

TABLE 3: Example Three-Visit Billing and Coding for OSD

Visit 1	**ICD-10:** · H02.88A: Meibomian Gland Dysfunction of Upper and Lower Eyelids OD · H02.88B: Meibomian Gland Dysfunction of Upper and Lower Eyelids OS · H16.223: Keratoconjunctivitis Sicca, not specified as Sjögren's, bilateral **Billable/ Reimbursable** · 92004: New Patient Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program · 92285: External Ocular Photography **Not Reimbursable** · Incidental screening tests: MGE, TBUT, Lissamine Green Staining
Visit 2	**ICD-10:** · H02.88A: Meibomian Gland Dysfunction of Upper and Lower Eyelids OD · H02.88B: Meibomian Gland Dysfunction of Upper and Lower Eyelids OS · H16.221: Keratoconjunctivitis Sicca, not specified as Sjögren's, right eye · H16.222: Keratoconjunctivitis Sicca, not specified as Sjögren's, left eye **Billable/ Reimbursable** · 99213: E/M for Dry Eye Work-Up · 92285: External Ocular Photography for Meibography · 83516: (RT/LT)- MMP-9 Testing · 83861: (RT/ LT)- Osmolarity **Not Reimbursable** · Incidental diagnostic tests: MGE, Lissamine Green staining, Lid Seal Test · 0330T – Lipid Layer Thickness (LLT) · Blink Dynamics · NIKBUT
Visit 3	**ICD-10:** · H02.88A: Meibomian Gland Dysfunction of Upper and Lower Eyelids OD · H02.88B: Meibomian Gland Dysfunction of Upper and Lower Eyelids OS · H16.221: Keratoconjunctivitis Sicca, not specified as Sjögren's, right eye · H16.222: Keratoconjunctivitis Sicca, not specified as Sjögren's, left eye **Billable/ Reimbursable** · 99213: E/M for Dry Eye Follow-Up/Treatment · 92285: External Ocular Photography **Not Reimbursable** · Incidental point-of-care tests: MGE, Lissamine Green staining · 0207T: iLUX or LipiFlow procedure with eyelid debridement

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A Frank Discussion on Cost

Vin Dang, OD, FAAO

All dry eye therapies have a cost. In-office microblepharoexfoliation procedures such as BlephEx or AB Max can range from $160-$350 per treatment depending on the office. Thermal treatment costs vary as well and are typically higher. Devices with consumables, or parts disposed after each use, have a higher inherent cost. Devices such as iLUX (Alcon) and TearCare (Sight Sciences) vary from $500 to $900 per treatment. To put these prices in perspective, when LipiFlow (Johnson & Johnson Vision/Surgical Care, formerly TearScience) was FDA approved and commercialized in 2011, the cost of the bilateral treatment ranged from $1,800 to $2,200. As recent as March 2019, the decreased price of LipiFlow consumables effectively lowers the LipiFlow treatment ranging from $700 to $1,200. Devices without consumables, such as MiBo Thermoflo (MiBo Medical Group), have been offering the procedure in package deals to reduce the barrier to entry (i.e. three MiBoFlo treatments for $600 to $800).

All these procedures are not currently covered by insurance and are considered a shared cost. Patients usually assume insurance should automatically cover these services because you have diagnosed them with dry eye, which is a medical condition, but that is often not the case.

Patients do have freedom, depending on their insurance selection, using financial instruments such as a flex spending account (FSA) or a health savings account (HSA). These medical procedures can be paid in full with banked pre-tax dollars. Usually these plans will require some form of itemized documentation detailing the procedure and cost to allow for reimbursement. It is important to impress upon your patient the benefits of treating early in the disease process and potential for repeated in-office procedures in order to plant the seeds for financial planning purposes. By taking a proactive approach, these procedures are more effective and will minimize the risk of long-term damage, which would cost significantly more to treat.

Personally, I discuss the cost of the procedure with my patient at the end of the examination. I do not shy away from telling them the prescribed procedure is what is best for treating their condition. Similar to when we prescribe polarized sunglasses or blue light blocking lenses for digital device use, I recommend what is best for the patient and allow them the ability to make a shared medical decision. Invariably after discussing treatment options, I find a patient will ask me what they should do. At that point, you have earned your patient's trust and they

Patients usually assume insurance should automatically cover these services.

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While patients assume that insurance will cover the cost of dry eye services, this is often not the case, so other payment options must be offered, and the practitioner is in the best position to suggest them, showing the patient how they can accept the recommended treatments for their condition. Click here for more.

will likely follow your recommendations.

Keeping affordability in mind, one treatment, Intense Pulsed Light (IPL) can be broken down into a pay schedule per treatment or a total amount for all recommended sessions. If they do pay upfront, they can qualify for a discount per treatment, which helps reduce the overall cost to the patient. The typical out-of-pocket cost for IPL ranges between $300 and $500. The treatment usually involves a series of four to eight treatments. The total cost could be prohibitive to some patients. However, patient financing options can help make it easier and more affordable.

Cost should never be a deterrent to your patients.

After I have educated my patient on their care maintenance needs to manage the condition, I walk them over to our patient coordinator. I hand the patient one or two pamphlets about the recommended procedures while we walk. Physically having something in hand solidifies the fact that what they have is important enough to provide documentation that can always be reviewed at their leisure from the comfort of their own home. At our practice, our patient coordinator arranges payment and scheduling along with answering any remaining questions. The coordinator goes over the estimated out-of-pocket cost for each of the different procedures. The patient coordinator reiterates what the doctor had prescribed. The science indicates that in order for a person to act on a message they hear, they must hear it 14 times. This is called effective frequency. I try to express the gravity of their situation multiple times to engage them in their care. Our practice offers patient financing through the CareCredit credit card. It can be used for out-of-pocket expenses not covered by medical insurance to help patients receive the treatment they need with the added benefit of special financing options, allowing the patient to pay over time for treatment. If the patient still declines, schedule a one-month follow-up appointment with the doctor to continue treatment, check on progress, and make sure the patient is not lost to follow-up.

Tips for communicating to patients about their out-of-pocket expenses:

- ❑ Discuss each treatment and why it is recommended as well as options if they are available.
- ❑ Be transparent about the cost of the recommendation; is it covered or out of pocket.
- ❑ Discuss insurance coverage, the deductible, and the co-pay, if applicable, as well as out of pocket.
- ❑ Be sure to advise *every* patient of payment options available such as self-pay, general purpose credit cards, and patient financing options such as the CareCredit credit card.
- ❑ If a patient still can't have multiple treatments due to cost, then recommend the most crucial one based on the individual's need.
- ❑ DED is chronic, and patients may need repeat treatments or different treatments depending on their condition. Do not tell the patient that this is a one-time treatment.

MAKING IT EASY FOR PATIENTS TO SAY 'YES'

Cost should never be a deterrent to your patients receiving the care that is appropriate for them. While many patients are covered by managed vision care plans, some therapies are not. In addition, many patients do still choose private pay while also seeking the most cost-effective way to do so. Therefore, eye care professionals should first present the optimal eye care regimen while then providing various ways to cover the cost. Fortunately, there are many payment options available, so patients do not need to scrimp on their eye care. Many patients decline care due to the initial outlay of funds. You can help patients say "yes" to both diagnostics and recommended DED treatments upfront by offering available financing options. Present monthly payment options to prevent patients from having any excuse for not moving forward with their prescribed care.

When diagnosed with a chronic vision condition such as ocular surface disease, and more specifically dry eye, there can be an unexpected and long-term expense. As many dry eye disease therapies and treatments are not covered by insurance, they often must be paid out of pocket. This may become an objection to the treatment and should be addressed by providing options. When discussing treatments for this disease, the eye care professional should always discuss these potential costs (whether co-pay, deductible, or private pay) so the patient can make an informed decision. These conversations are not one-size-fits-all, so ECPs should be prepared to discuss all payment options.

PAYMENT SOLUTIONS

Fortunately, there are several payment solutions that make it easy, both for the patient to pay as well as for the office to manage. Of course, private

pay is the simplest transaction for everyone, but few patients prefer this. Health savings accounts (HSAs) or Federal Savings Accounts (FSAs) help cut costs by enabling patients to spend pre-tax dollars. Other options include private insurance, managed vision care plans, or coupon cards from apps. A health care credit card, such as CareCredit, is designed specifically for health and wellness needs. The benefit to approved patients is the option to make monthly payments over time, with deferred interest options in order to pay for treatments and procedures. The main benefit for the practice is full payment minus fees, paid within two business days. It is a win-win situation for the finances of both the patient and the practitioner, particularly during this unprecedented economic climate affected by the current pandemic. We also offer the patient the ability to pay with multiple methods of payments (such as cash, general purpose credit cards, HSA/FSA, and CareCredit).

Another benefit is that some products offer resources to assist staff with how to have this important financial conversation with patients. Once trust is built with the patient, it is time to discuss financing, which should never feel like a structured sales pitch. Consequently, paying for the service is transformative, as it becomes part of an overarching plan emphasizing eye care health needs with less weight placed on the cost model. The right training and preparation will help ensure your staff's success when discussing out-of-pocket costs and different forms of payment.

Be sure to utilize resources available for staff training and role-play. Scripts and tips can make it easier to discuss cost and payment solutions. Other helpful tools include online applications, instant credit decisions, and mobile apps for managing patient accounts.

In a recent study*, many consumers expressed interest in credit-based financing options and/or indicated they have derived lasting value from such options. However, many consumers [patients] may not be aware that such options are available. Offering a financing solution like a health care credit card and prominently promoting it could help differentiate you from other providers and make it easier for a patient to say yes to recommended treatments.

Overcoming any barriers to treatment is important.

Using a health care credit card is helpful for patients covered by managed care, as it can be used to pay for copays, deductibles, and uncovered procedures, and it is also beneficial to private payers.

Unlike general purpose credit cards, CareCredit offers promotional financing options that can be used multiple times at enrolled providers for many different health care needs, including dental work, veterinary visits, cosmetic, chiropractic care, surgery, med spa, skin treatments, and much more, allowing patients to reserve general purpose credit cards and savings for other purchases.

Some patients may already have a CareCredit card, having previously opened an account, either at your practice or for another specialty such as dental or veterinary. Clearly indicating that you are a provider who accepts CareCredit allows additional options for patients to use their card.

Beyond offering your patients an attractive payment solution, CareCredit can also help your practice spend less time on billing and collections. When cardholders pay with the CareCredit credit card, you receive payment within two business days with no recourse* if the cardholder delays payment or defaults, assisting in the practice cash flow. Options such as easy online applications, which can be made directly from the patient's cell phone or tablet, and instant credit decisions, make patient financing easy for the office and the patient.

Overcoming any barriers to treatment is important. With many patients facing higher out-of-pocket health care costs and with the economy affecting many patients' finances, budget concerns can lead to delayed appointments or treatment. Offering a variety of payment options, will help overcome these obstacles and make it easy for patients to say, "Yes!" •

**The Patient Path to Purchase, Source: CareCredit, Path to Purchase Research, 2018. ©2019 Synchrony Bank. Subject to the representations and warranties in your agreement with CareCredit including but not limited to only charging for services that have been completed or that will be completed within 30 days of the initial charge, always obtaining the patient's signature on in-office applications and the cardholders' signature on the printed receipt.*

5 Steps to Marketing Dry Eye Services

Damon Dierker, OD, FAAO

The dry eye disease (DED) market in the United States was valued at over $4 billion in 2018, with projections to increase to over $6 billion over the next five years.[1] To capture a piece of this rapidly expanding segment of eye care, a marketing strategy is needed. Fortunately, this doesn't have to break the bank.

Here are five steps we have used in my practice to market DED services.

1 Make Sure You Have Something to Market

An investment in time and energy to promote DED services will not yield positive results if your product is not worth very much. Consider taking the following steps to ensure that what you offer is valuable to your patients:

Educate yourself on the latest thoughts in diagnosis and treatment through various channels including perusing trade journals, reviewing major peer-reviewed works (start with the TFOS DEWS II Executive Summary), joining DED social media groups (OSDocs on Facebook is excellent), attending immersive, interactive CE events and industry-sponsored opportunities, and engaging with like-minded colleagues.

Establish workup protocols and treatment algorithms that are streamlined and efficient. There is no one-size-fits-all solution, as every practice will require a customized approach.

Spend time educating staff about your vision and goals of DED services at your practice. Develop key phrases to use when engaging with patients. If everyone is on message, your chances for success will escalate. For example, when a patient asks why they are being asked to fill out a validated DED symptom questionnaire at check-in, your staff can be trained to reply: "Dry eye disease is one of the most common problems we see in our practice. We specialize in diagnosing and treating this problem. Filling out this survey will help us determine if you are having symptoms of dry eye such as fluctuating vision and eye fatigue."

To capture a piece of this rapidly expanding segment of eye care, a marketing strategy is needed.

2 Actively Collect Patient Success Stories

I've found this to be the simplest, most cost-effective method of marketing DED services in my practice. Happy patients are often more than willing to

THE BUSINESS OF DRY EYE

In addition to promoting your dry eye services, all of your marketing techniques can also be used to inform patients about all available financing options as well. Providers enrolled in the CareCredit network have access to a wealth of educational and marketing tools at no cost. These include worksheets, scripts, displays for your waiting area and exam rooms, and custom links to include on your practice website, email, social posts, and other digital channels. Click here for more.

Once you have collected reviews from your patients, share them.

share their stories...*but you need to ask them to do this*. Every DED patient in our practice that has "turned the corner" in their journey, whether through conservative measures (environment modification, OTC solutions such as nutritional supplements, lid scrubs, etc.) or more aggressive therapy (Rx drops, in-office procedures), is identified. This triggers a text message from the practice asking them to consider posting a review on Facebook, Google, or Yelp. We've seen our reviews increase ten-fold since implementing this.

3 Utilize Social Media to Increase Impact

Once you have collected reviews from your patients, share them on your website and social media channels (*see example*). Consider focusing on a particular service that you offer. For example, we've had great success with the recent integration of Intense Pulsed Light (IPL) for patients with meibomian gland dysfunction (MGD) and ocular rosacea. We've posted some IPL patient reviews on our

Facebook and Instagram pages and plan to utilize patient quotes in our new practice brochure. We see new patients on a weekly basis that have seen an online review and come in asking for IPL treatment. Social media is a great way to let patients know not only of the services you offer but also that financing options are available as well.

4 Target Patients in Your Existing Database

If you have already been diagnosing DED, MGD, blepharitis, etc. and are actively recording this in your EHR, consider data mining to identify patients who may benefit from a new service you have added. For example, if you are going to invest in technology to treat MGD obstruction with an in-office therapy, send an email to everyone with an MGD diagnosis explaining the benefits of the procedure and asking them to schedule an appointment to discuss further. Add a video link leading them to an animation of the procedure so they know what to expect. These educational/promotional pieces should also be posted on social media and added to your website blog.

5 You Don't Have to Go at it Alone

We lean heavily on industry partners to provide our practice with patient-focused animations, videos, and printed educational handouts. We manage our social media in-house, but this can also be outsourced in a cost-effective manner. If you do not have time or energy to market yourself, several options at various price ranges are available to produce customized media and marketing solutions for your practice.

These straightforward steps have been crucial for success in our practice. The key is letting your patients do most of the work, singing your praises so you do not have to. Consequently, your job is simply to shepherd the message. •

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1 https://www.reportlinker.com/p05790925/Dry-Eye-Disease-Market-Growth-Trends-and-Forecast.html?utm_source=PRN accessed 4/13/2020

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Build Your Dry Eye Center of Excellence with the Help of CareCredit

Dry eye syndrome effects millions of patients across the U.S. Given the complexities of the ocular surface and many possible contributing factors to DES, utilizing a variety of therapeutic approaches is essential in creating effective, long-term treatment plans for individual needs. While a few treatments have some level of insurance coverage – after patients satisfy their copays and deductibles – many options including thermal pulsation, lid exfoliation, IPL, neurostimulation, autologous serum tears, scleral lenses, and others do not. Out-of-pocket expenses can easily extend into the thousands each year and quickly become a deterrent to patients from all walks of life. To help patients move forward with optimal treatment plans, it is important for practices to provide both treatment solutions and payment solutions.

Successful Patient Conversations

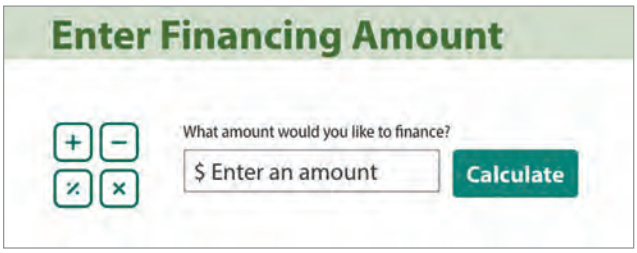
Given the medical nature of DES, many patients are surprised by the lack of insurance coverage and total out-of-pocket treatment expense. This is a hurdle to be anticipated and actively addressed with empathy, honesty, and transparency.

Best Practice Tips

· Build trust and rapport by educating patients on their diagnosis, the chronic nature of the disease and value of recommended treatments. This may require a little time and flexible communication styles as patients will want various degrees of detail. But this ultimately lays the foundation of understanding and treatment acceptance.

· Be upfront and transparent about cost and the need for multiple treatments. Discuss medical insurance and vision plan coverage, and explore possible HSA/FSA availability.

· Proactively break down total out-of-pocket costs into estimated monthly payments. Patients appreciate when you anticipate their needs, and you never know when it will make the difference between a patient accepting the full treatment plan and/or moving forward immediately.




Meibomian Gland Dysfunction Treatment Options

With MGD, your eyelids may not produce enough protective oils to keep your eyes healthy and moist. We recommend these options to improve gland function and oil production.

Patient Name _____ Date _____

Diagnosis: _____

Treatment Recommendations	Cost	Est. Insurance	Est. Out-of-Pocket
1 _____	$ _____	$ _____	$ _____
2 _____	$ _____	$ _____	$ _____
3 _____	$ _____	$ _____	$ _____
4 _____	$ _____	$ _____	$ _____
Total	$ _____	$ _____	$ _____

Pay over time on qualifying purchases of $200 or more with your CareCredit credit card account.* Visit carecredit.com to learn more or apply today.

Estimated Monthly Payments* 6 mo $ _____ 12 mo $ _____

Next Appointment _____

Please call us at any time if you have questions about your eye health. We're here to help you see clearly and feel more comfortable every day.

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· Reinforce that early treatment can minimize the risk of long-term damage, which may be more difficult and costly to treat.

· If patients still decline an optimal treatment plan, schedule a follow-up appointment to help monitor the condition and to revisit options once they have had some time to reflect and discuss with family and friends.

Free Tools

Download the Meibomian Gland Dysfunction Treatment Options worksheet to help summarize the diagnosis, along with treatment options, associated costs, and estimated monthly payments. Easily estimate monthly payments using CareCredit's payment calculator for enrolled providers.

Excellence Requires a Trained Staff

Having a coordinated plan between team members can help deliver a consistently positive patient experience. It starts by creating uniform processes and training procedures.

Best Practice Tips

· Educate your team on dry eye syndrome and available treatment options as they will need to reinforce the value of the doctor's recommendations.

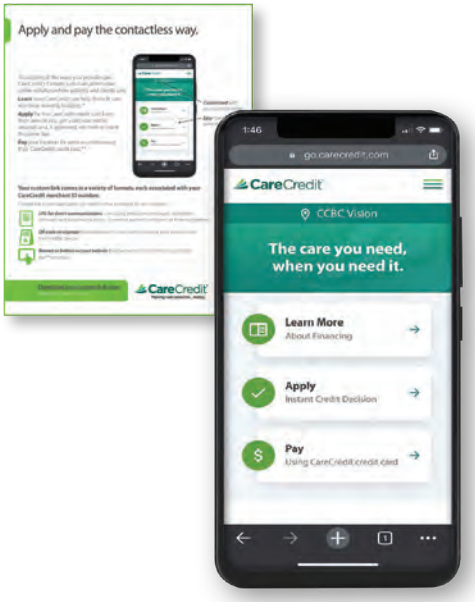
· Create a systematic handoff between doctor and staff, in which the diagnosis and treatment recommendations are repeated in front of the patient.

· Role-play the financial conversation to ensure staff can deliver payment options with ease and confidence.

· Track patient treatment acceptance/conversions and meet with staff regularly to review.

Free Tools

Download the scripts and tips guide to help illustrate how simple it can be to introduce financing options to patients. Streamline financing solutions even further for your team by taking advantage of contactless application and payment processes for enrolled providers. With the new CareCredit Custom Link, patients can privately learn about and quickly apply for the CareCredit credit card or conveniently pay for services.



Marketing your Dry Eye Center

Projected to reach over $5 billion by 2024[1], the dry eye market in the United States has been growing steadily. To capture a piece of this expanding and underserved patient segment and to successfully differentiate your practice offering and revenue mix, you need a marketing strategy. Fortunately, this can be a simple, streamlined, and cost-effective endeavor.

Best Practice Tips

· Add dry eye messaging, along with payment solutions, to your current patient communications including enewsletters, appointment reminders, website, social media, and advertising.

· Request reviews from happy patients who are benefiting from the results of DES treatment.

· Create a DES referral incentive program for DES patients.

· Let your professional referring network know that DES is a clinical specialty you are now servicing and be sure to acknowledge received referrals with a handwritten thank you note from the doctor.

Free Tools

Download ready-made assets for enrolled providers that can seamlessly integrate into your digital communications.

· Social media posts dedicated to dry eye and eye health

· Buttons, banners and a Custom Link to add to your website and emails

To schedule a FREE team training session or for assistance with any of the featured tools, contact your Practice Development Team at 1.800.859.9975 (press 1, then 6). Not yet enrolled? Call 866.853.8432 or visit carecredit.com/optometry to get started at no cost.

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