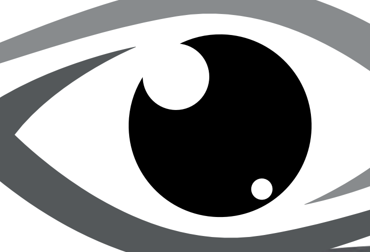
Winter Live Webinar

November 23-24, 2024



Sunday PowerPoint Lecture Handouts

Winter Live Webinar

Sunday, November 24, 2024			
7:45 am to 8:00 am	**AM Session: Virtual Conference Entry Period**		
8:00 am to 8:05 am	Announcements & CE Credit Overview		
8:05 am to 9:45 am	**New Technologies in Dry Eye Disease** *Selina McGee, OD*	2 D/T Hours	COPE ID # 95162-TD
9:45 am to 9:55 am	Break		
9:55 am to 10:45 am	**When Rosacea Meets Dry Eye: Strategies for Relief and Management of Ocular Rosacea** *Kaleb Abbott, OD*	1 D/T Hour	COPE ID # 94839-TD
10:45 am to 10:55 am	**Break**		
10:55 am to 11:45 am	**Beyond the Surface: Corneal Nerves and the Complexity of Dry Eye Symptoms** *Kaleb Abbott, OD*	1 D/T Hour	COPE ID # 94838-TD
11:45 am to 11:50 am	Conclusion – AM Session		
11:50 am to 12:45 pm	Lunch Break		
12:45 pm to 1:00 pm	**PM Session: Virtual Conference Entry Period**		
1:00 pm to 1:05 pm	Announcements & CE Credit Overview		
1:05 pm to 1:55 pm	**Common Pitfalls in Medication Documentation, Billing, and Coding** *Andrew Kemp, OD, FAAO*	1 GEN Hour	COPE ID # 94841-PM
1:55 pm to 2:05 PM	Break		
2:05 pm to 2:55 pm	**2024 Professional Responsibility Course for Texas Optometrists** *Andrew Kemp, OD, FAAO*	1 GEN/PR Hour	COPE ID # 89781-EJ
2:55 pm to 3:05 pm	Break		
3:05 pm to 3:55 pm	**Opioids: Ongoing Challenges in Pain Management** *David Dinh, OD, FAAO*	1 D/T Hour	COPE ID # 90789-PH
3:55 pm to 4:05 pm	Break		
4:05 pm to 4:55 pm	**Human Trafficking Training for Health Care Providers** *Natalie Pirrone, MBA - Poiema Foundation*	1 GEN/HT Hour	COPE ID # 92851-PB
4:55 pm to 5:00 pm	Conclusion – PM Session		

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New Technologies in Dry Eye Disease

1) Introduction, Disclosures, and Review of Objectives
   a) Incidence of DED
   b) Screening for DED
   c) Clinical Implementation and Why
2) Anatomy of the Ocular Surface
   a) Lids
   b) Conjunctiva
   c) Cornea
   d) Physiology
   e) Other Considerations
      i) Inflammatory pathways
      ii) Dysfunctional tissue repair
3) Types of DED/OSD
   a) Aqueous Deficient
   b) Evaporative
   c) Mixed Mechanism

4) Blepharitis
   a) Anterior
      i) Staph
      ii) Serborrhea
      iii) Demodex
   b) Posterior
      i) MGD
      ii) Cutaneous Rosacea
         (1) Incidence/Prevalence
      iii) Ocular Rosacea
         (1) Incidence/Prevalence

5) Diagnostic Equipment
      i) Meibography
      ii) Tear Osmolarity
      iii) MMP-9 MGD Grading Scales
         (1) Gland Dropout
         (2) Gland Shortening
         (3) Gland Distortion

   b) Current Literature Review

- i) Ocean Group
  - (a) BEISTO
  - (2) Toyos et al
  - (3) Further studies

6) Why? How it affects more than you may realize.
   - i) Refraction/Optical/Contact Lenses
   - ii) Refractive & Cataract Surgery
   - iii) Oculoplastic Surgery
   - iv) Ultimately patients' quality of life.
     - (1) Productivity
     - (2) Economic Impact
   - b) Theories of Therapy
     - i) Underlying Pathology/Conditions
       - (1) "Boxing", Categorizing, and Prioritizing
     - ii) The Ocular Surface as a System
     - iii) Interrupting the Inflammation
   - c) Steroids
     - i) "Canadian Consensus"
     - ii) Lotemax vs. FML vs. Prednisolone vs. Durezol
     - iii) Titration and Selection
     - iv) Side Effects
     - v) Combos (Zylet Tobradex)
     - vi) NSAIDs
   - d) Cyclosporine
     - i) What it Does & Does it Work?
     - ii) Cyclosporine 0.09% vs. 0.05%
       - (1) 0.1% for VKC
     - iii) Dropperette vs bottle
   - e) Lifitigrast
     - i) Differences
     - ii) Experience
   - f) Varenicline 0.03%
     - i) Mechanism
     - ii) Differences
   - g) Doxycycline
     - i) What it Does
     - ii) Vs. Azithromycin
   - h) Autologous Serum
     - i) How it Works
     - ii) How to Order It and Where
   - i) Amniotic membranes
     - (1) Types/Differences
   - j) Cenegermin
     - i) How it Works
     - ii) When and Why (Neurotrophic)

k) Nutraceuticals
   i) Omega-3
l) Anti-evaporative
   i) Semi-fluorinated alkanes
m) Lid Disease
   i) Demodex Bleph
   ii) Rosacea
n) Pipeline Options
   i) Anti-keralytics
   ii) 512

7) How Intense Pulsed Light (IPL) works
   a) Lasers vs IPL
      i) Monochromatic vs polychromatic
      ii) Wavelengths
   b) Target tissues
      i) Chromophores
         (1) Oxyhemoglobin
         (2) Melanin
         (3) Water
         (4) Exogenous Pigment
   c) Clinical Endpoints
8) Patient Selection
   a) Fitzpatrick scale
   b) Skin Typing
   c) Indications
9) Parameters Overview
   a) Cut-off filter wavelength
   b) Fluence (in J/cm^2)
   c) Pulse Parameters
      i) Number of sub-pulses
      ii) Sub-pulse durations
      iii) Sub-pulse delays
   d) Delays
10) Contraindications
   a) Tan Skin
   b) Skin Type V and VI
   c) Dysplastic nevus
   d) Active infections
   e) Active Lupus
   f) Melasma?
11) Treatment Protocol
   a) Pre-treatment Discussions
      i) Consent Form
   b) Settings
      i) Treatment Parameters

- c) Patient Preparation
- d) Treating the Patient
    - i) Treatment Area
    - ii) Test Spot
    - iii) Full Treatment
    - iv) Clinical Endpoints
- e) Post Procedure Care
    - i) Follow up & Expectations
- f) Potential Adverse Effects

12) Lipiflow TearCare and Ilux
- a) How they Work
- b) Compare and Contrast

13) RadioFrequency (RF)

14) Low Level Light Treatment

15) Case Reviews and Discussions
- i) Ocular Rosacea
- ii) Mixed OSD (DED)
- iii) Hordeolum and Chalazia Patient
- iv) Sjogren's
- v) Contact Lens Related Stem Cell Deficiency

When Rosacea Meets Dry Eye:
Strategies for Relief and Management of Ocular Rosacea

Kaleb Abbott, OD, MS, FAAO
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University of Colorado SOM
Dry Eye Clinic
Center for Ocular Inflammation

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Financial Disclosures

- Investigator: Lexitas, Claris Bio, Trinity Life Sciences, Famy Life Sciences
- Consultant: Optase, Tarsus, Dompe, Harrow, Bausch and Lomb, Barti, SunSnap Kids

**All relevant financial interests have been mitigated*

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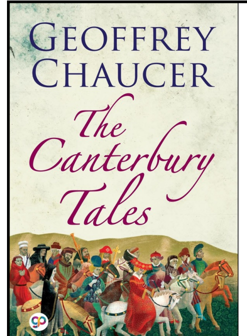

- 1387
- The Summoner
- Described his rosacea and facial redness
- Details treatments consisting of
  - Mercury
  - Lead
  - Brimstone
  - Borax
  - Cream of tartar
  - Arsenic ointment
- Blamed the rosacea on his drinking of strong red wine

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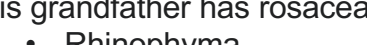
An Old Man and his Grandson
Domenico Ghirlandaio

This grandfather has rosacea:
- Rhinophyma
- Telangiectatic blood vessels of the face
- Slight puffiness of the eyelids



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Rosacea

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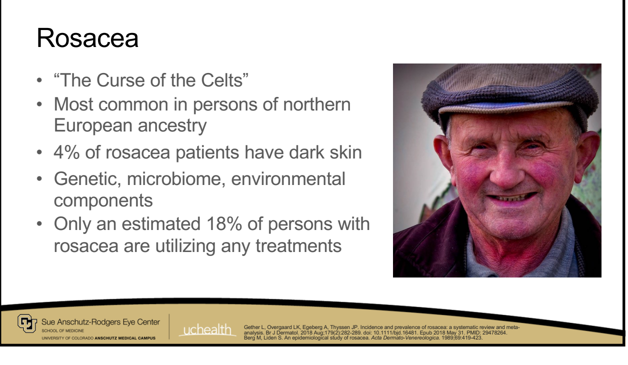

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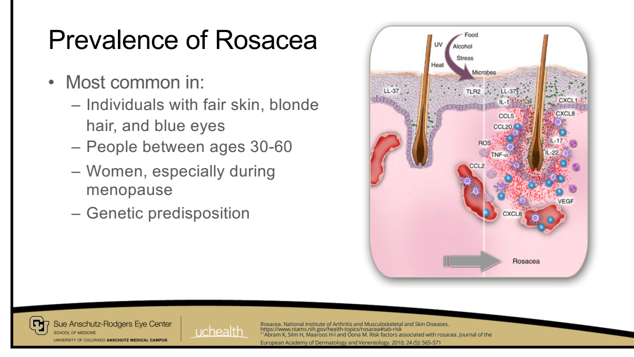

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Prevalence of Rosacea

- As high as 14-15% of Caucasian women
- General prevalence of ~5% of the world population
- 10% of the Swedish population
- Affects at least 16 million Americans

Estimated Rosacea Prevalence In U.S. Adult Population*

*Based on National Rosacea Society membership as a proportion of state populations over 18.

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Rosacea Market - Growth Rate by Region

- High
- Medium
- Low

Source: Mordor Intelligence

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Pathogenesis

- Neural disease where vasodilation is greater and more persistent
- Autoimmune component where body overreacts to "triggers" causing dermal inflammation
- Telangiectasia forms and redness develops
- Fibrosis and hypertrophic scar tissue is produced

Ahn, Christine S., and William W. Huang. "Rosacea pathogenesis." *Dermatologic clinics* 36.2 (2018): 81-86.

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Factors in Rosacea Pathogenesis

Environmental Triggers
Immune Dysregulation
Vascular, Neurovascular and Neuroimmune Dysregulation
Skin Barrier Dysfunction
Microbial Dysbiosis
Metabolic Dysfunction
Sebaceous Gland Dysfunction
Genetic Predisposition
Oxidative Stress
Endoplasmic Reticulum Stress

Original factors
Emerging factors

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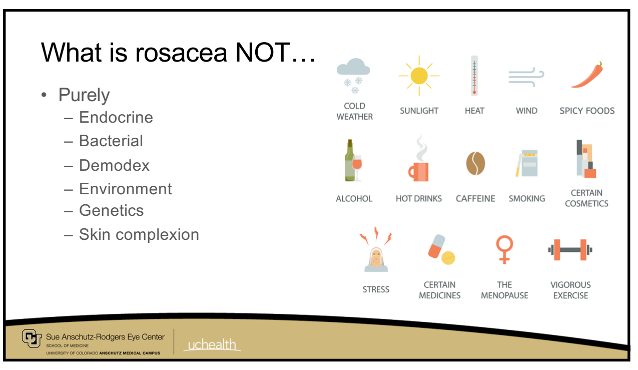

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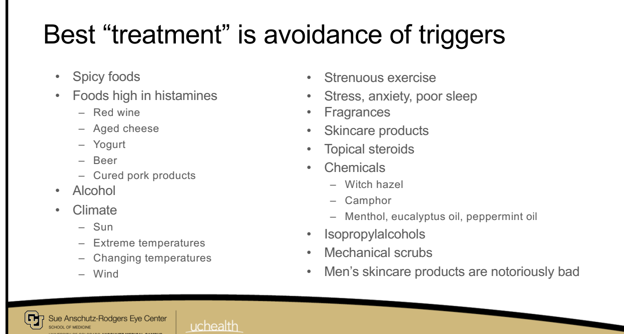

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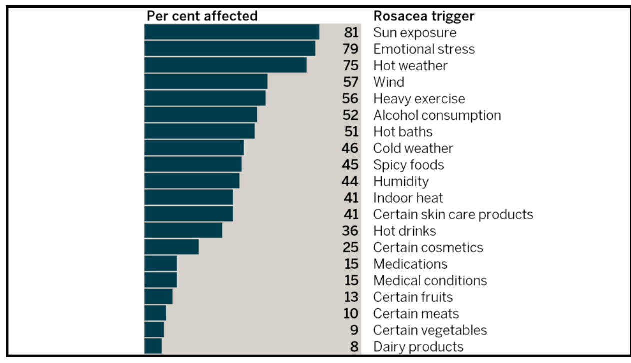

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Sun Exposure

- Sunlight (UVB)
  - Stimulates angiogenesis
  - Stimulates dilation and spreading of roots
- Sunscreen options:
  - EltaMD UV Clear
  - ColoreScience All Calm

UVA (aging, wrinkling)

UVB (burning)

absorbed by Epidermis skin layer

absorbed by Dermis skin layer

Hypodermis skin layer

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Morgado-Carrasco, Daniel, et al. "Impact of ultraviolet radiation and exposome on rosacea: Key role of photoprotection in optimizing treatment." Journal of Cosmetic Dermatology 20.11 (2021): 3415-3421.

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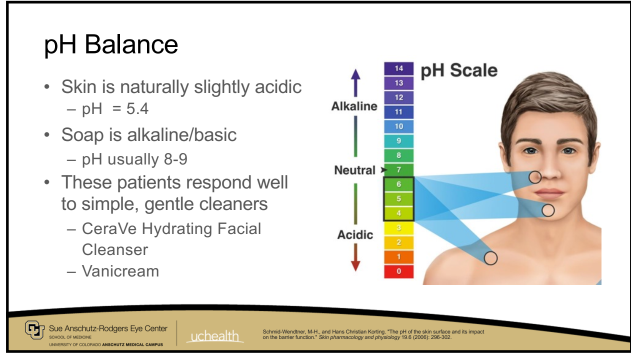

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The Many Faces of Rosacea

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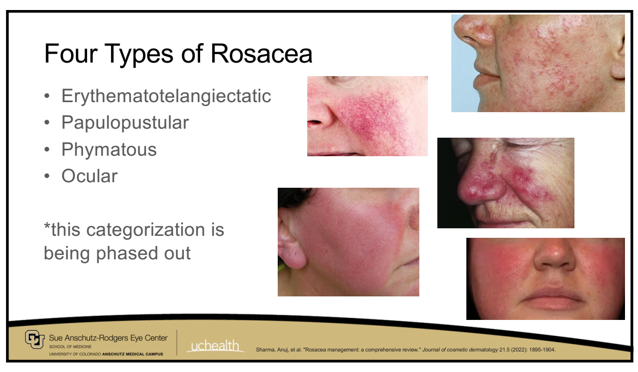

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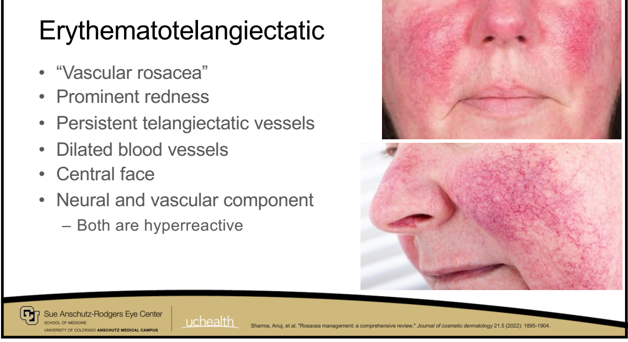

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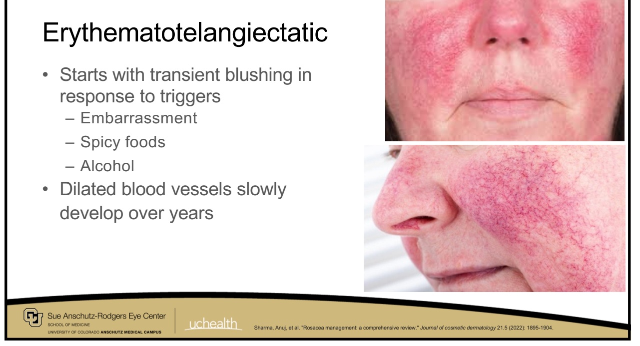

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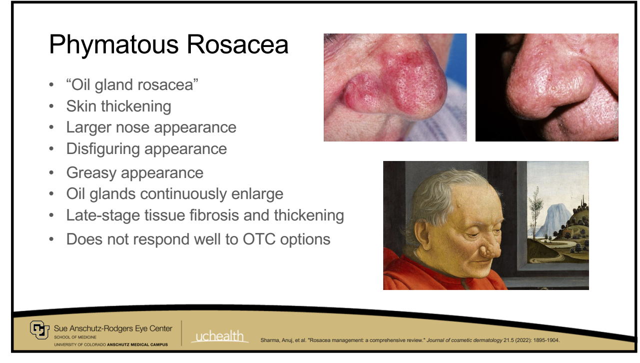

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"The perfect cure of acne rosacea is, in fact, never accomplished."

- Dr. Thomas Bateman (1812)

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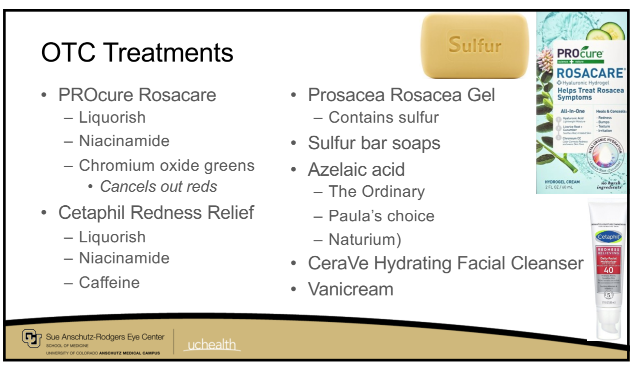

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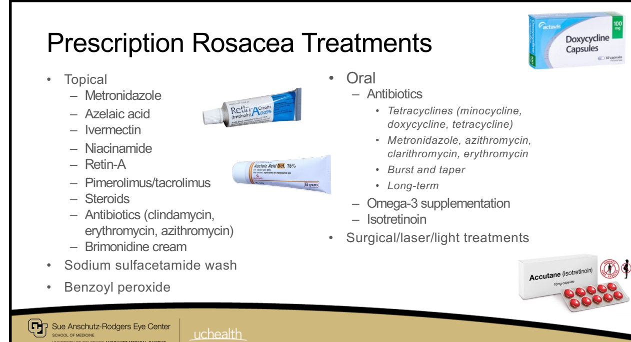

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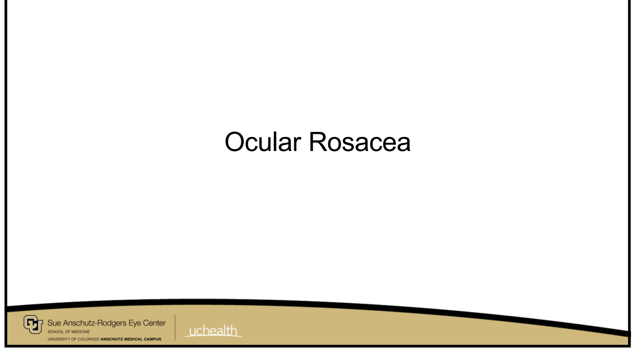

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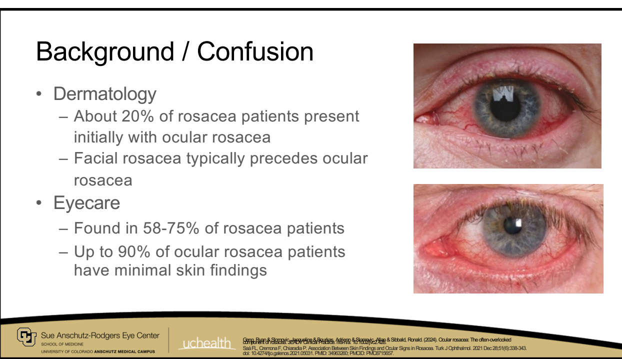

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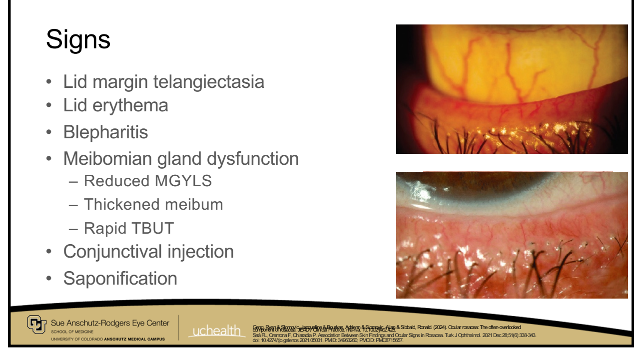

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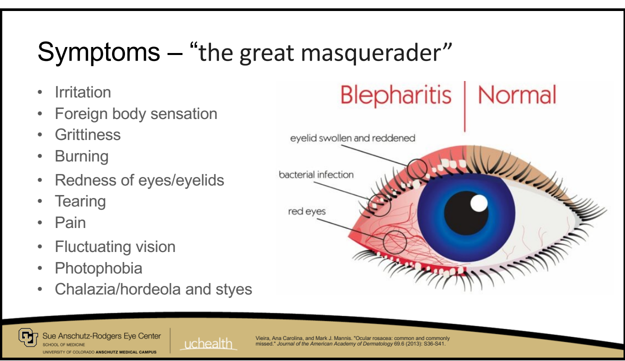

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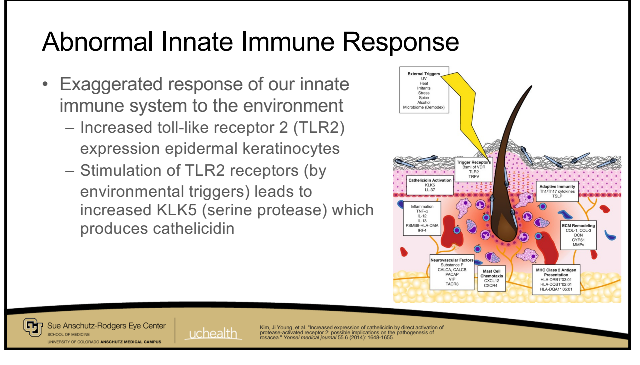

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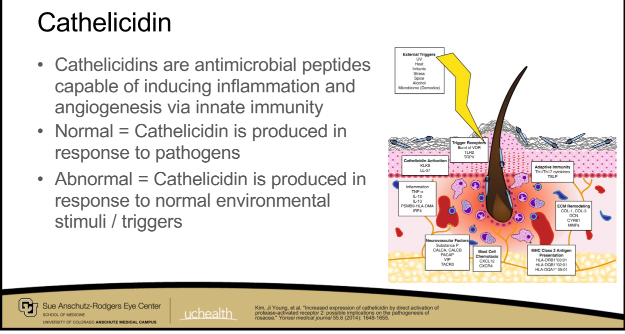

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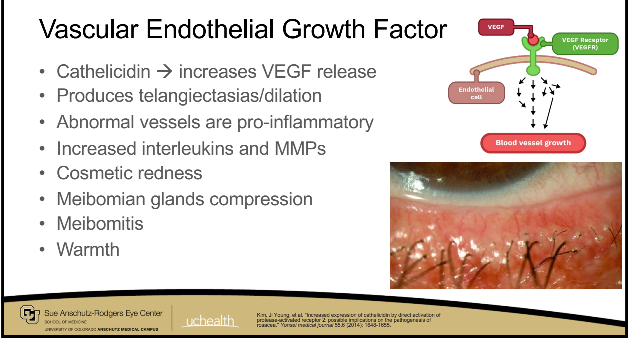

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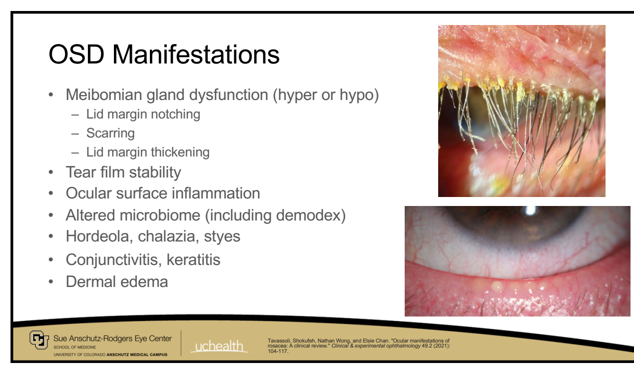

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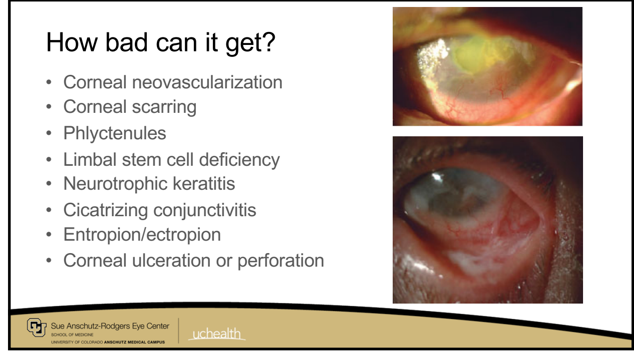

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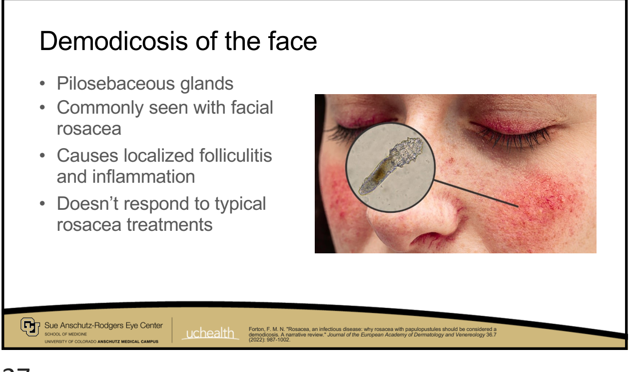

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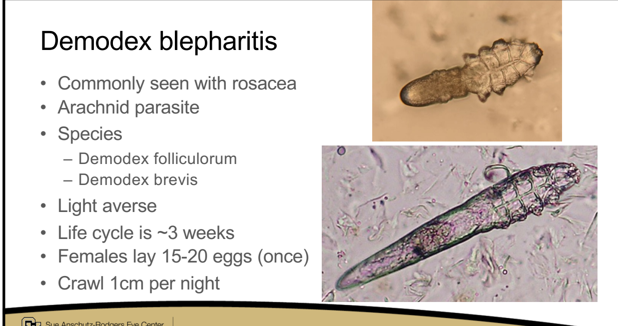

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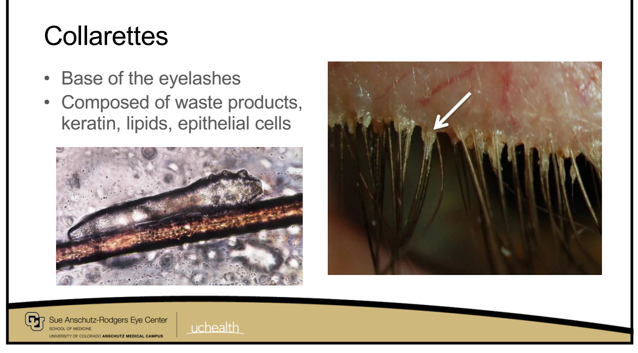

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Ocular Rosacea Treatments

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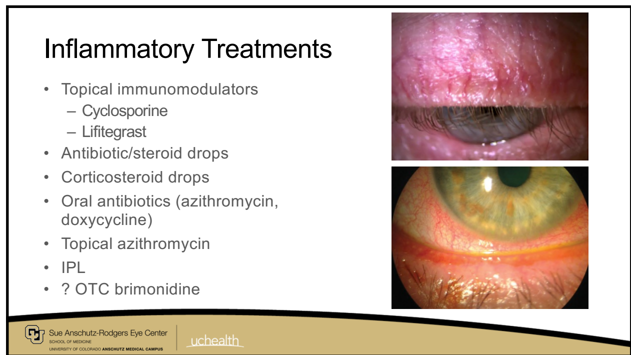

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MGD/Blepharitis/Hordeola Treatments

- Lid hygiene (ex tea tree oil)
- Oral omega-3s
- ? Warm compresses
- Topical azithromycin
- Oral doxycycline
- Procedures
  - Blepharoexfoliation
  - Thermal pulsation
  - IPL
  - MG probing
- Lotilaner (demodex blepharitis)
- Lotilaner (? MGD)

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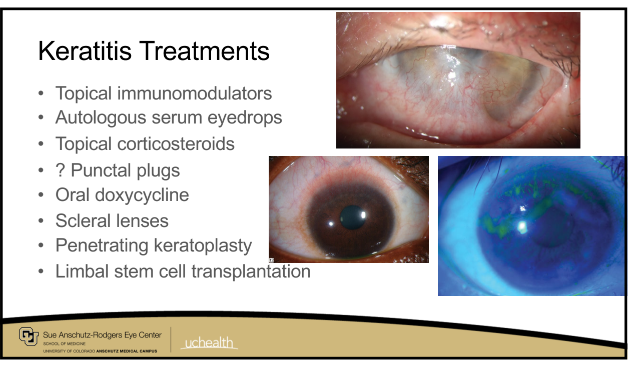

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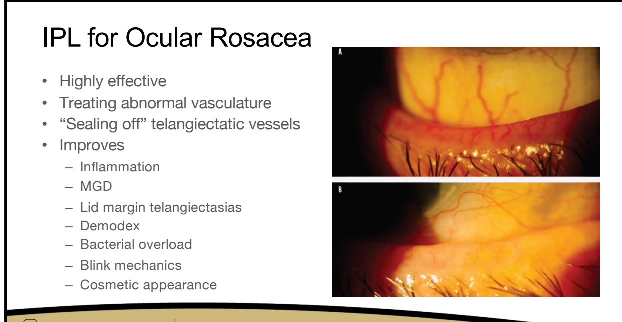

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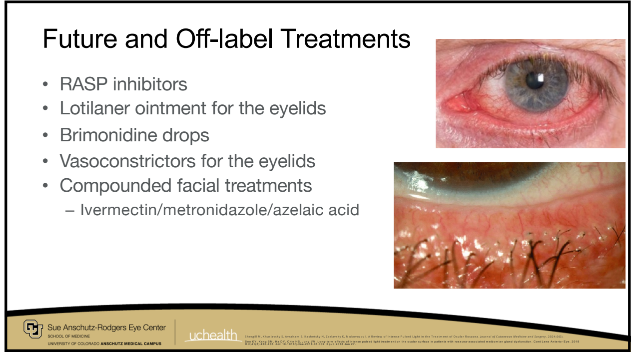

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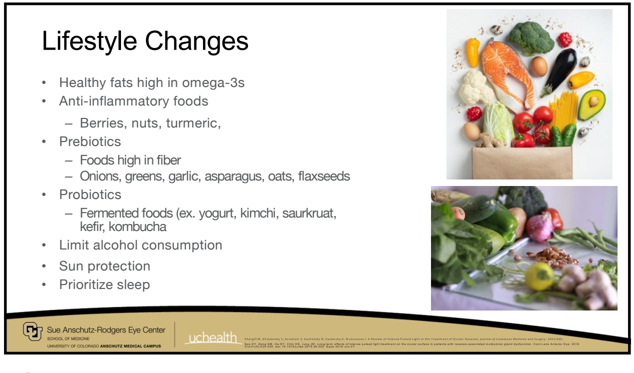

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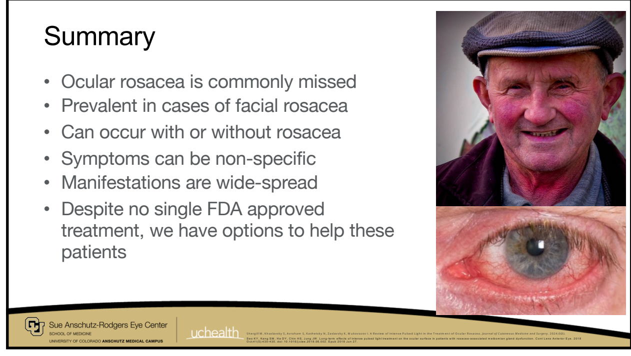

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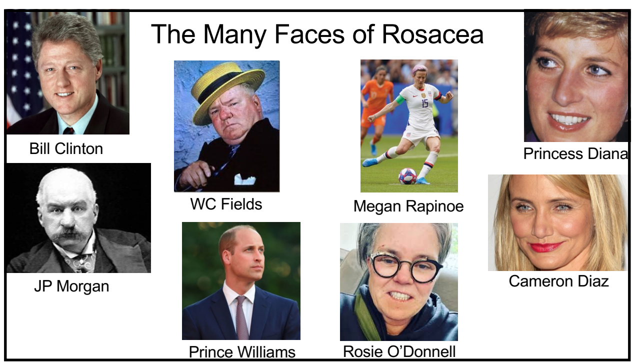

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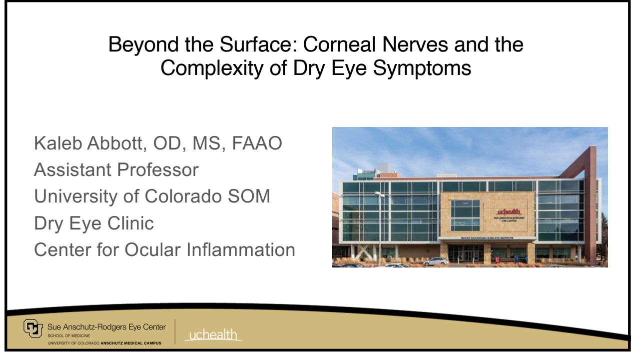

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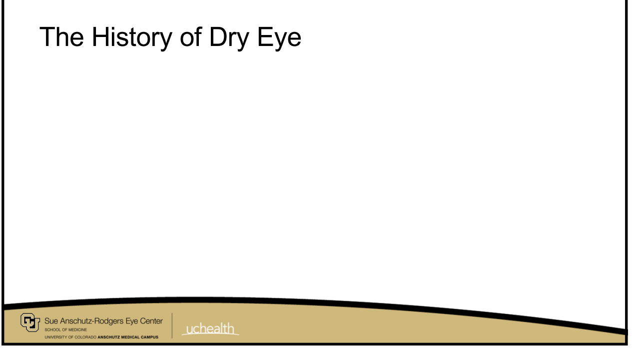

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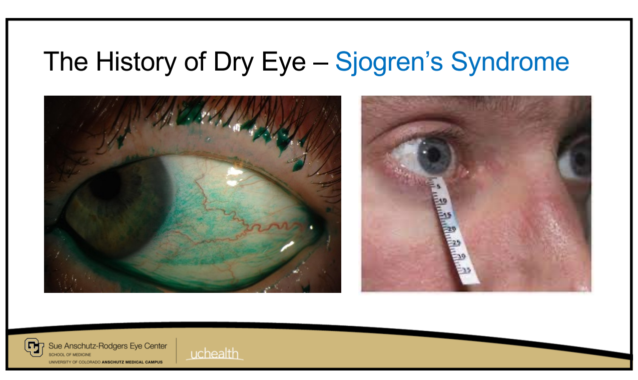

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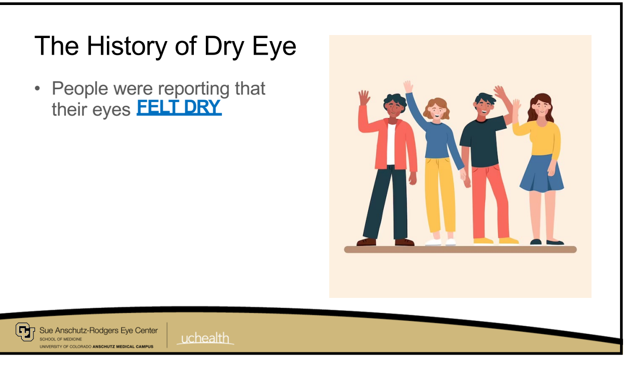

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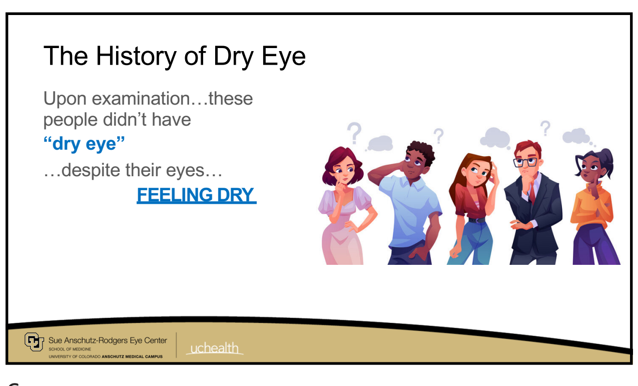

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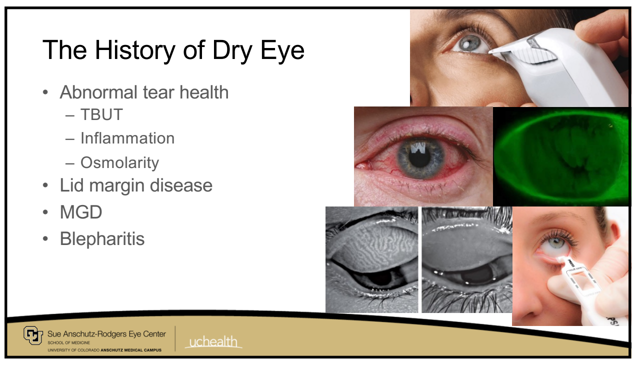

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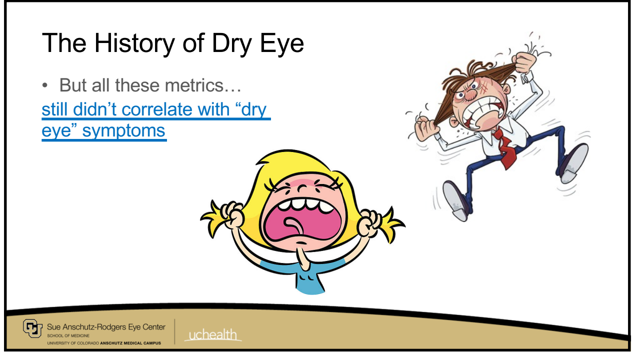

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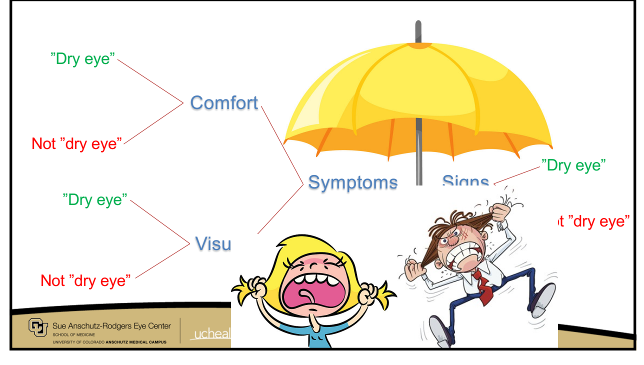

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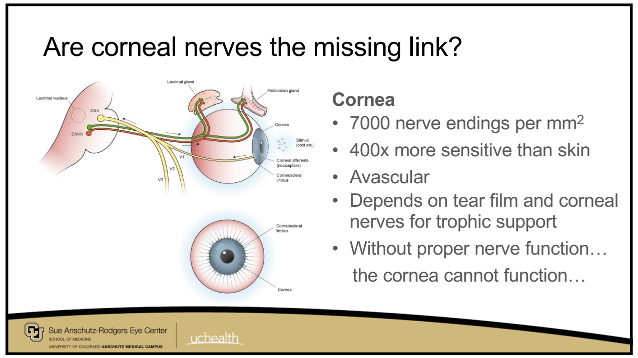

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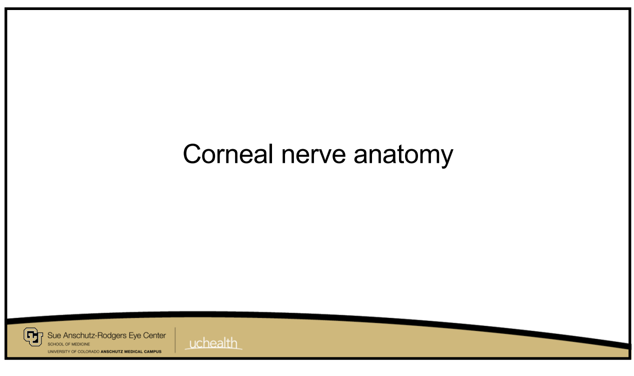

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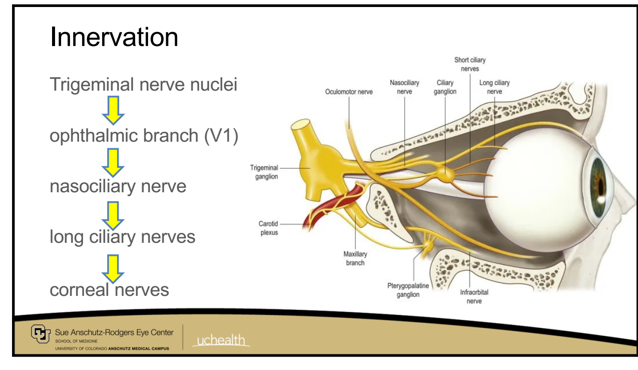

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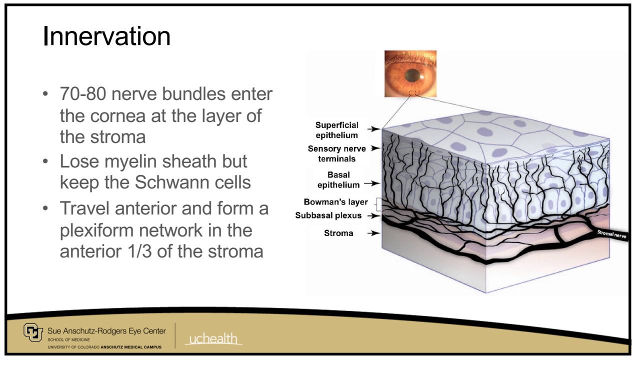

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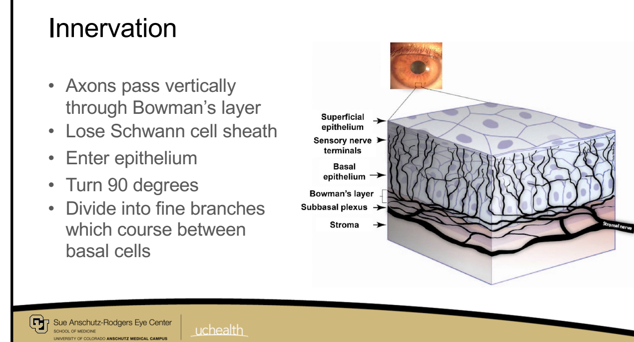

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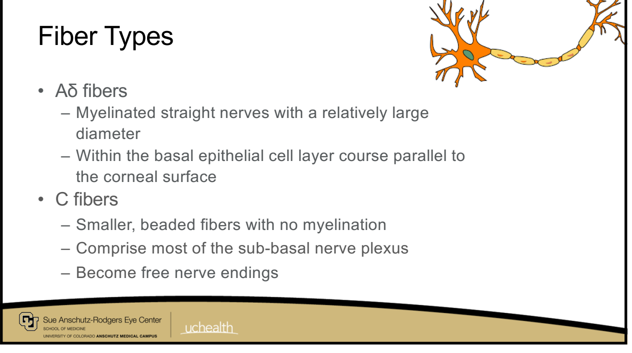

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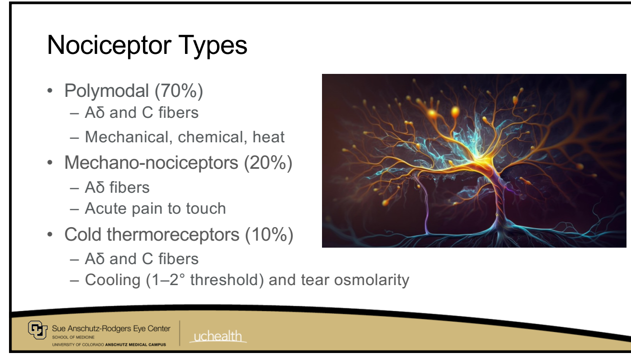

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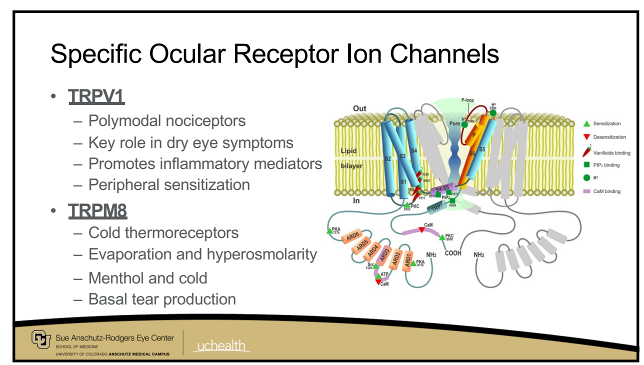

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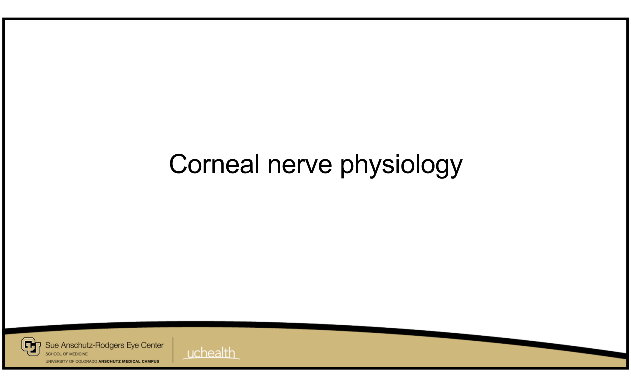

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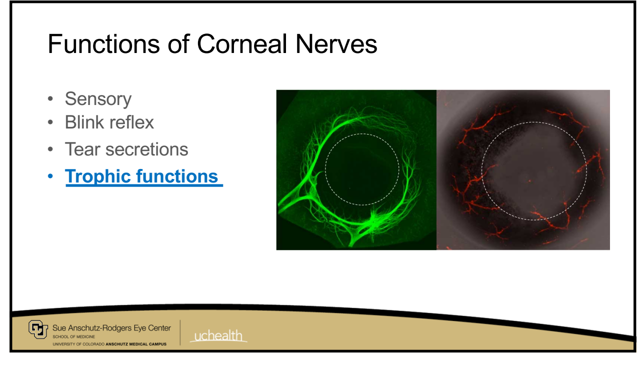

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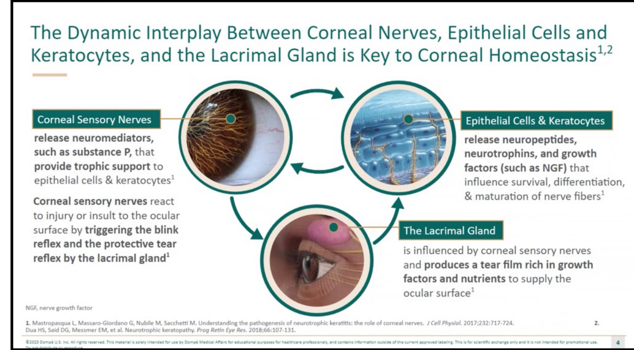

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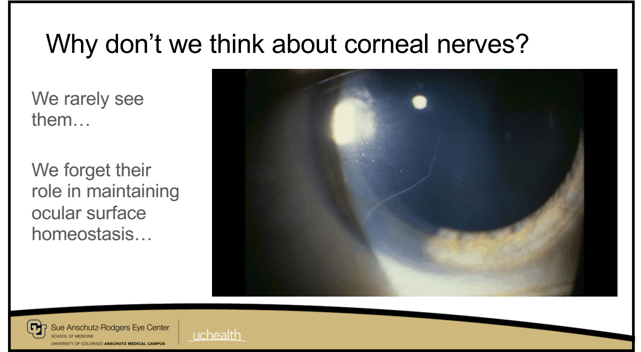

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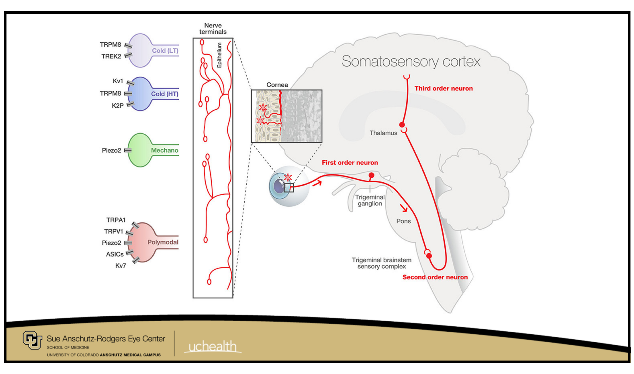

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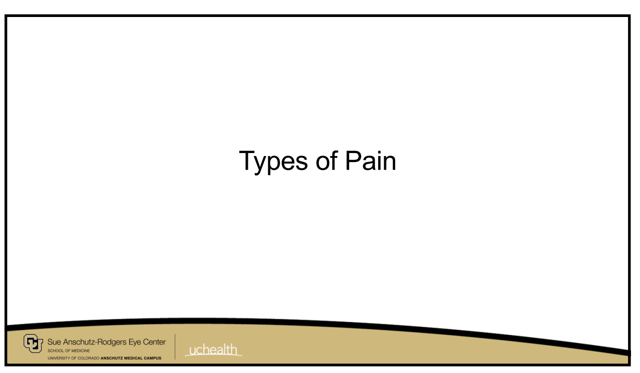

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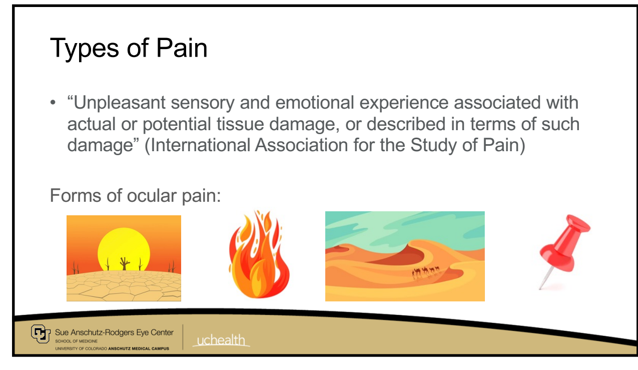

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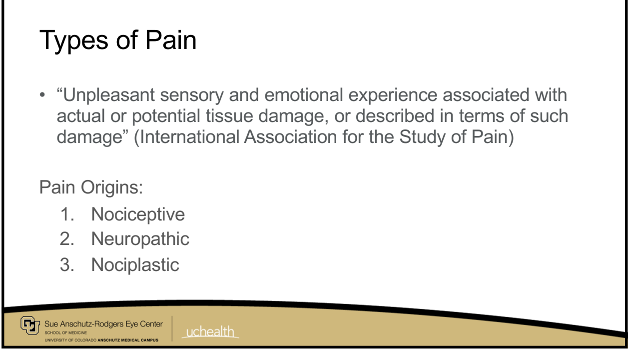

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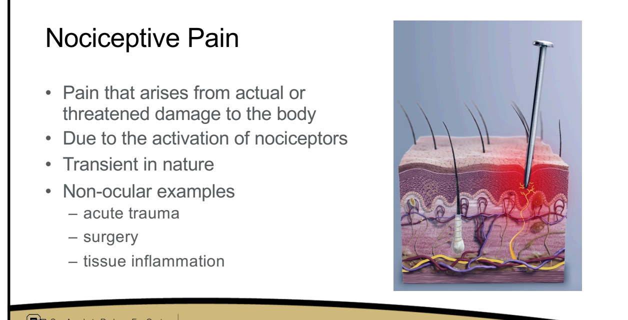

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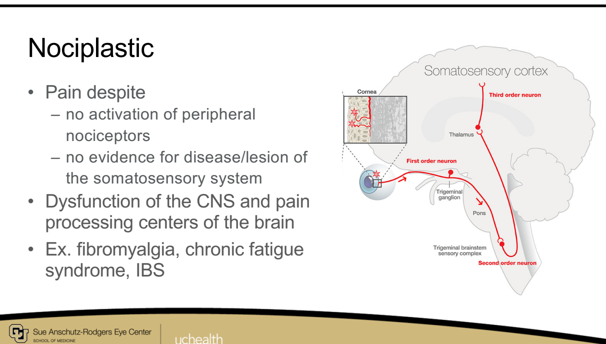

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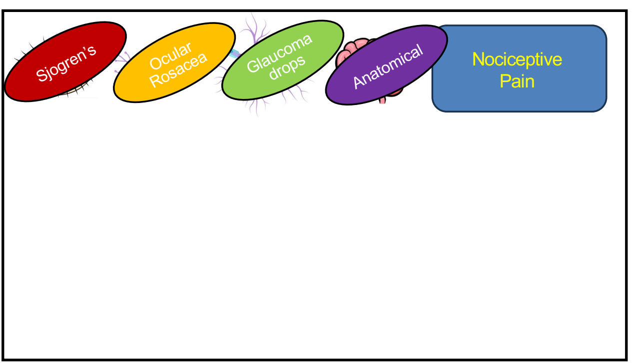

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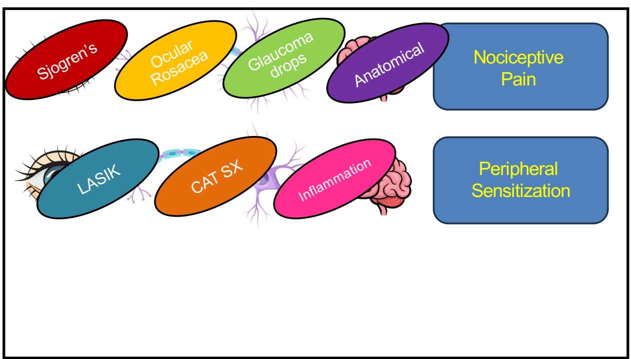

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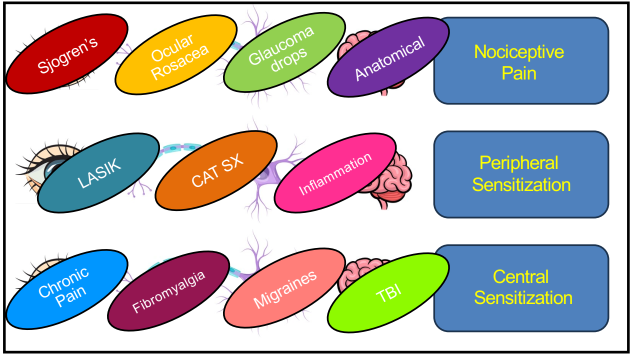

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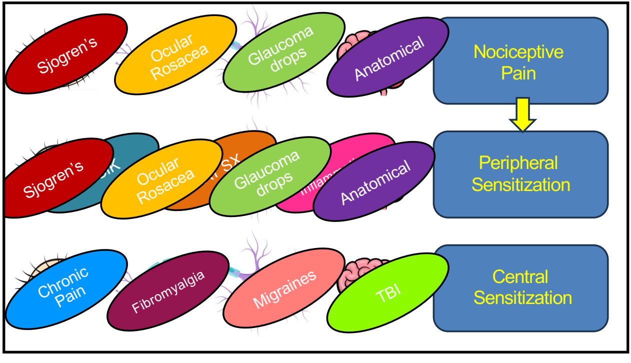

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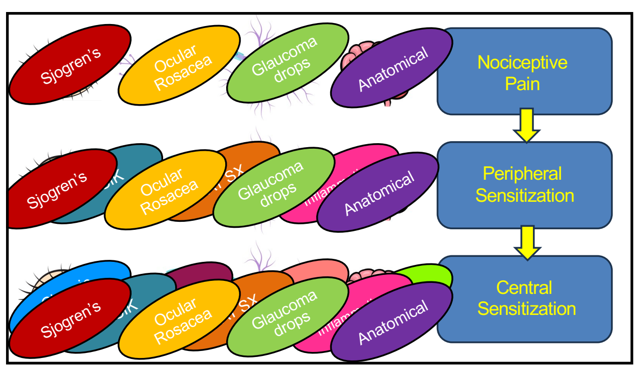

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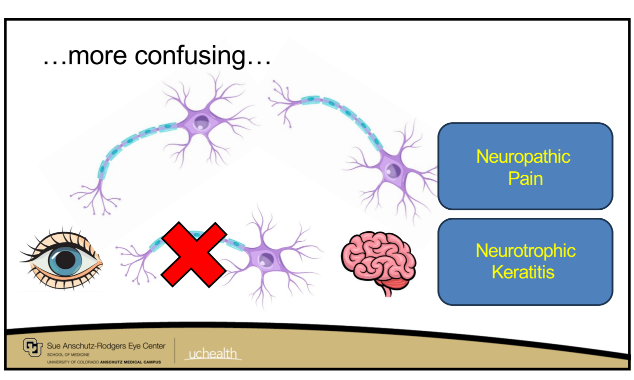

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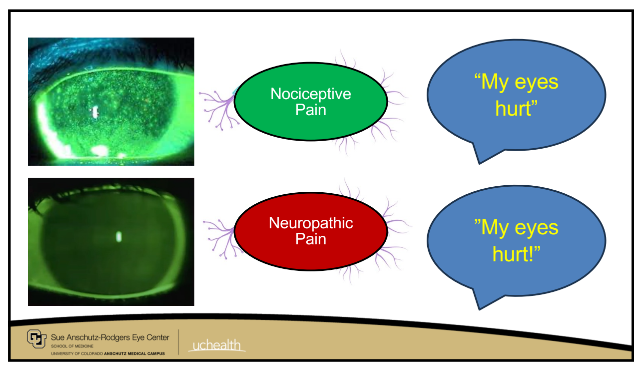

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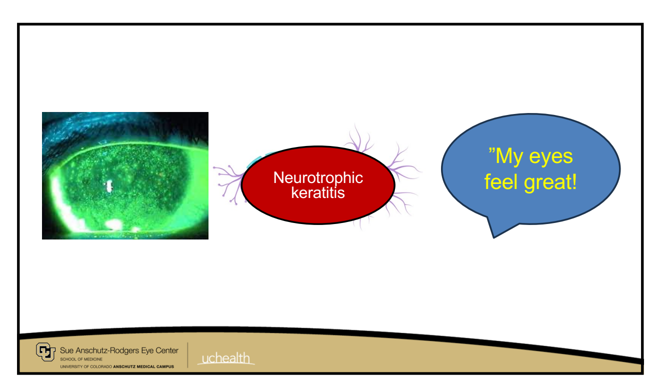

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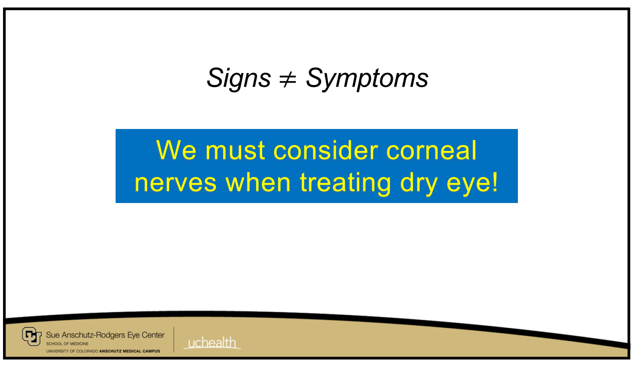

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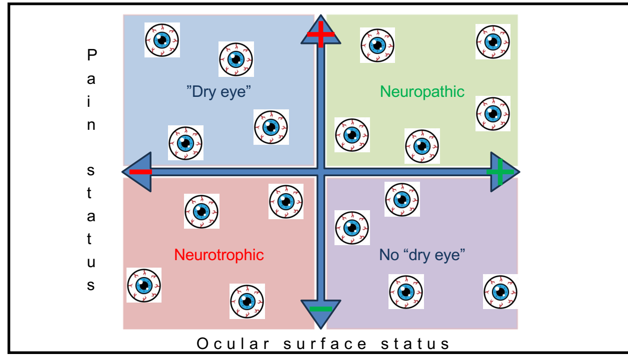

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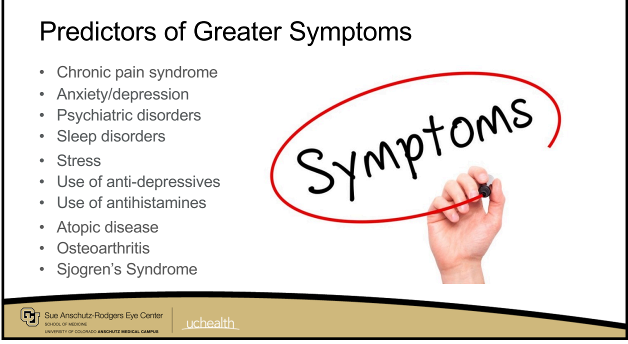

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Dry eye associations

- Dry eye strongly associated with
  - Depression/anxiety
  - Poor perceived health status / health anxiety
  - Sleep disorders
- In asymptomatic vs symptomatic dry eye patients, scores for depression/anxiety were significantly worse in the symptomatic group
- Treating dry eye reduces anxiety/depression levels
- Treatment of anxiety/depression improves the success of dry eye treatments

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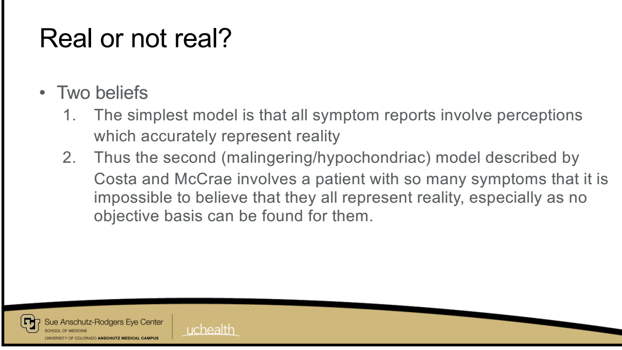

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Real or not real?

- Two beliefs
  1. All symptom reports involve perceptions which accurately represent reality
  2. So many symptoms that it is impossible to believe that they all represent reality, especially as no objective basis can be found for them (malingering/hypochondriac)

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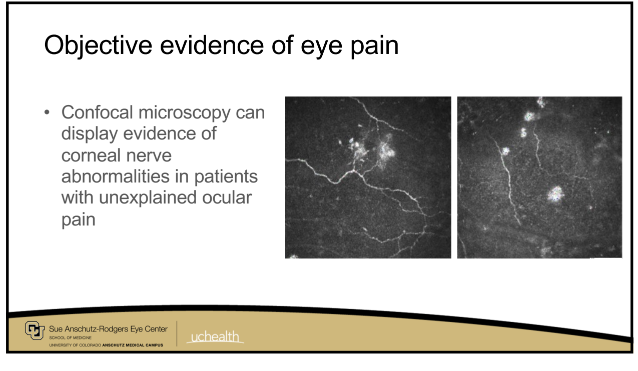
Objective evidence of eye pain

- Confocal microscopy can display evidence of corneal nerve abnormalities in patients with unexplained ocular pain



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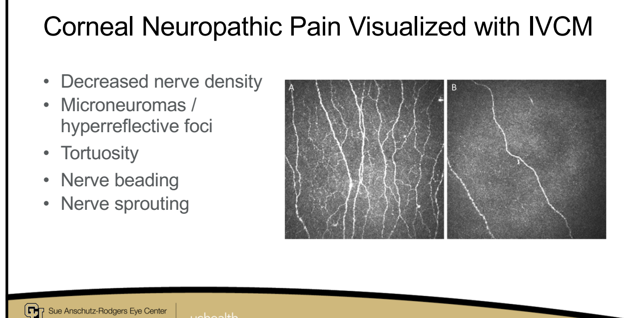
Corneal Neuropathic Pain Visualized with IVCM

- Decreased nerve density
- Microneuromas / hyperreflective foci
- Tortuosity
- Nerve beading
- Nerve sprouting



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Corneal Neuropathic Pain Visualized with IVCM

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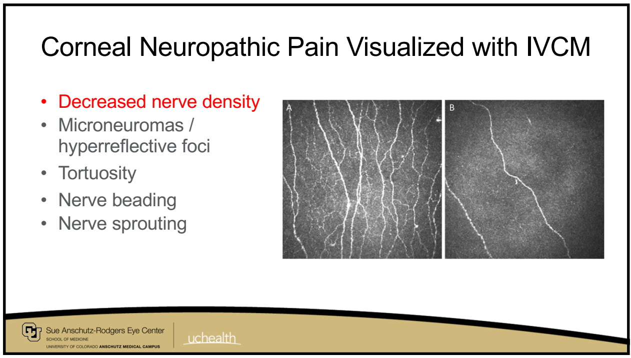

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Corneal Neuropathic Pain Visualized with IVCM

- Decreased nerve density
- Microneuromas / hyperreflective foci
- Tortuosity
- Nerve beading
- Nerve sprouting

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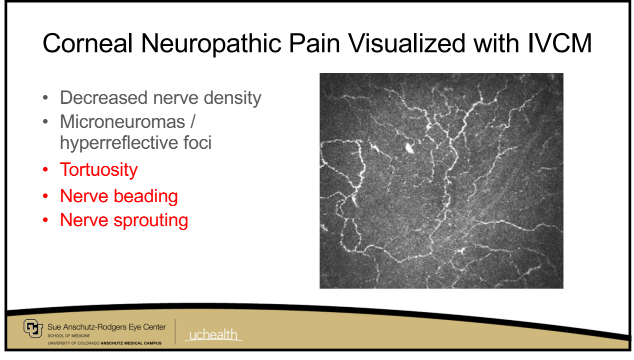
Corneal Neuropathic Pain Visualized with IVCM

- Decreased nerve density
- Microneuromas / hyperreflective foci
- Tortuosity
- Nerve beading
- Nerve sprouting



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Rethinking "dry eye"

- ***Neurosensory abnormalities*** have been recognized as potential contributors to dry eye disease (2017 Tear Film and Ocular Surface definition of dry eye)
- ***Nerve abnormalities*** are not always identified as a component of eye disease, and a neurotrophic or neuropathic component to pain is often missed
- There are many forms of pain whose cause is unknown
- In the case of "dry eye", we often fail to consider neuropathy and mental health conditions as contributing or causative factors

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How do corneal nerve disorders arise?

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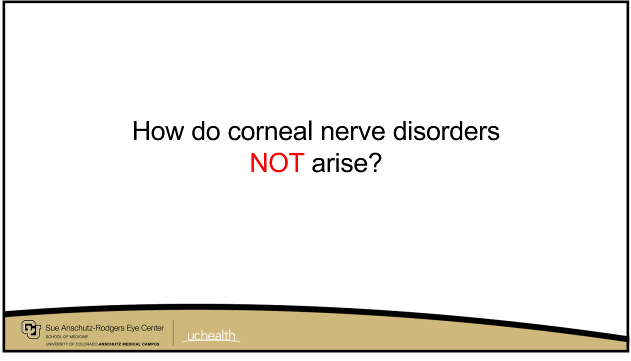

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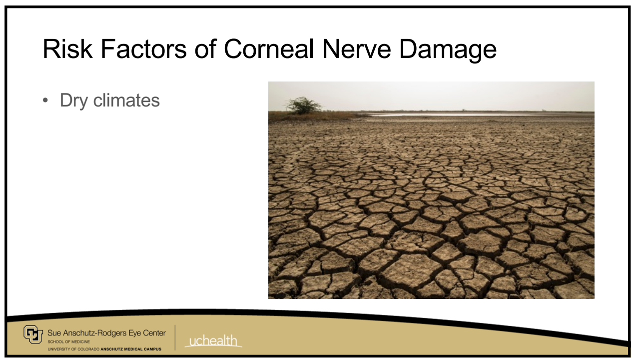

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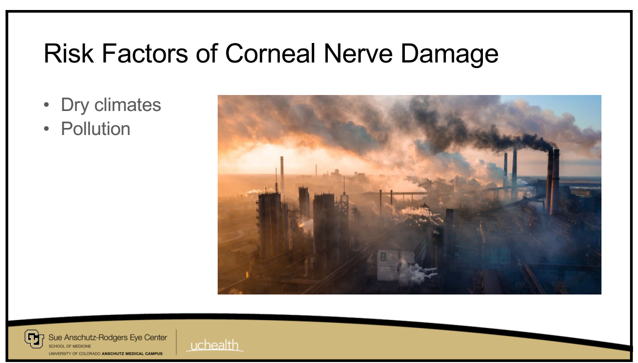

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Risk Factors of Corneal Nerve Damage

- Dry climates
- Pollution
- UV light

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Risk Factors of Corneal Nerve Damage

- Dry climates
- Pollution
- UV light
- Surgery

Normal Nerve Plexus

FS-LASIK

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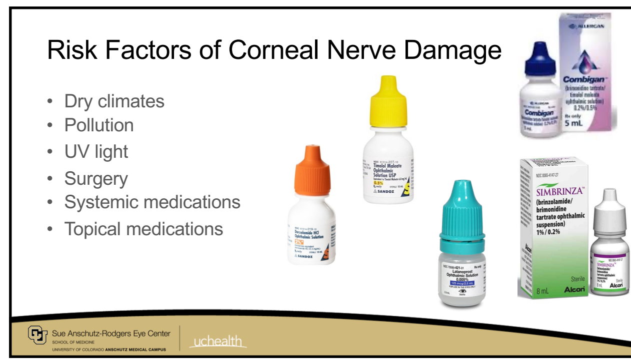

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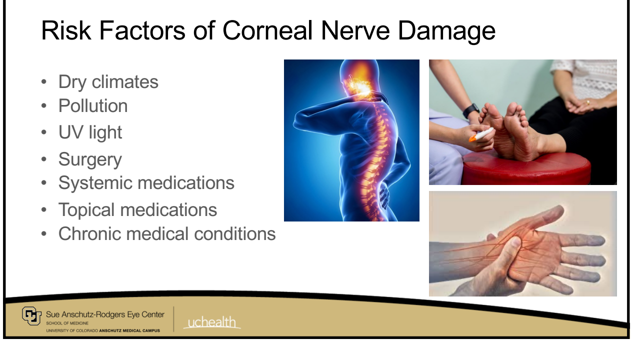

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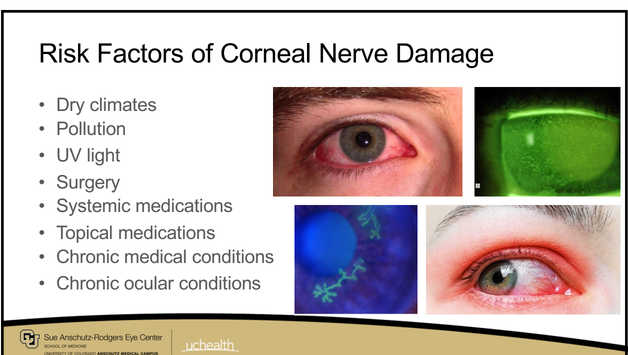

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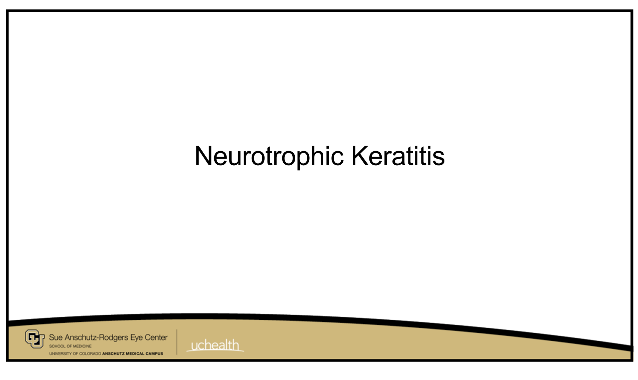

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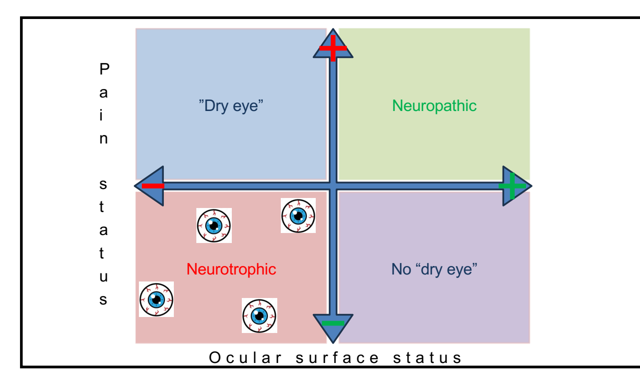

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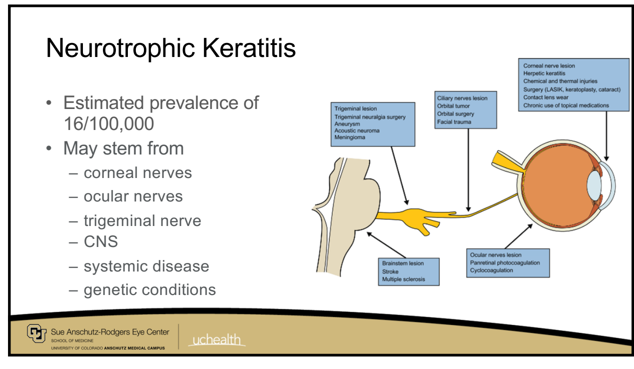

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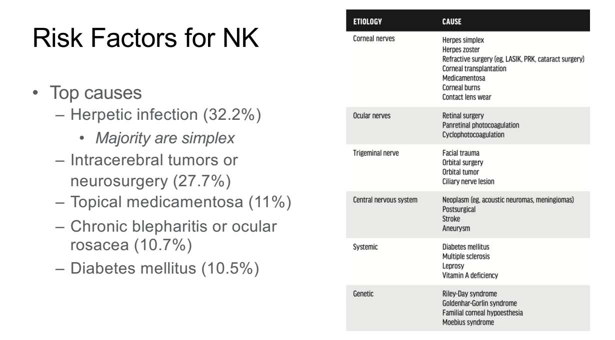

ETIOLOGY	CAUSE
Corneal nerves	Herpes simplex Herpes zoster Refractive surgery (eg, LASIK, PRK, cataract surgery) Corneal transplantation Medicamentosa Corneal burns Contact lens wear
Ocular nerves	Retinal surgery Panretinal photocoagulation Cyclophotocoagulation
Trigeminal nerve	Facial trauma Orbital surgery Orbital tumor Ciliary nerve lesion
Central nervous system	Neoplasm (eg, acoustic neuromas, meningiomas) Postsurgical Stroke Aneurysm
Systemic	Diabetes mellitus Multiple sclerosis Leprosy Vitamin A deficiency
Genetic	Riley-Day syndrome Goldenhar-Gorlin syndrome Familial corneal hypoesthesia Moebius syndrome

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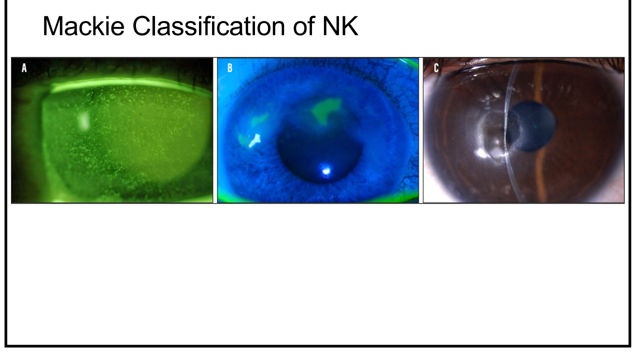

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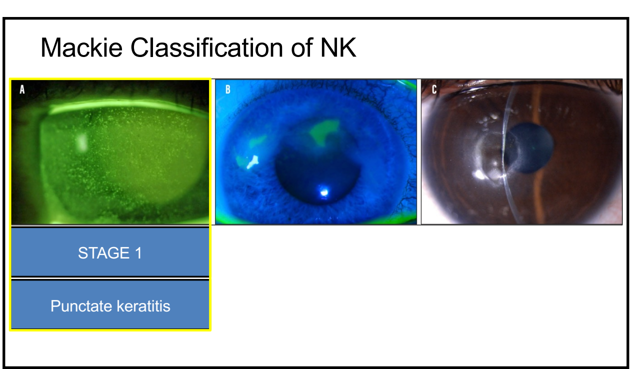

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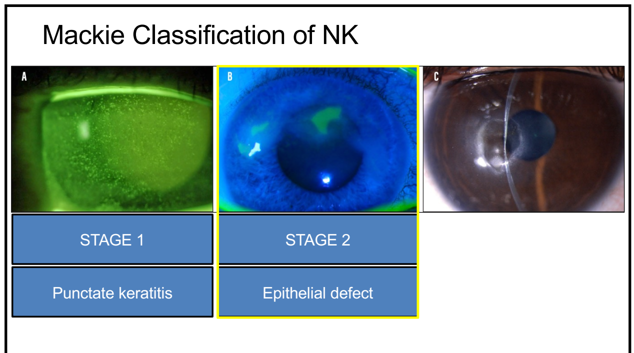

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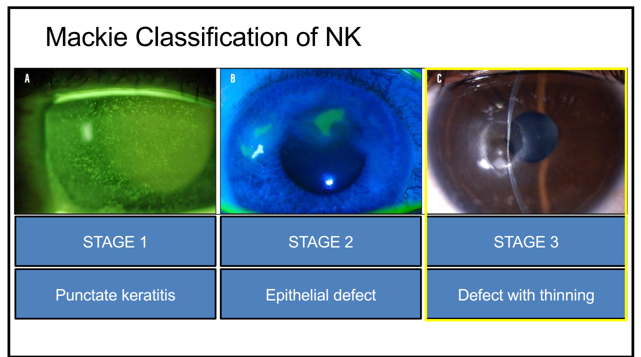

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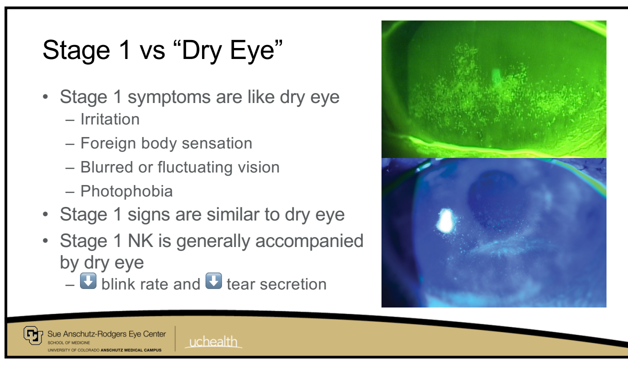

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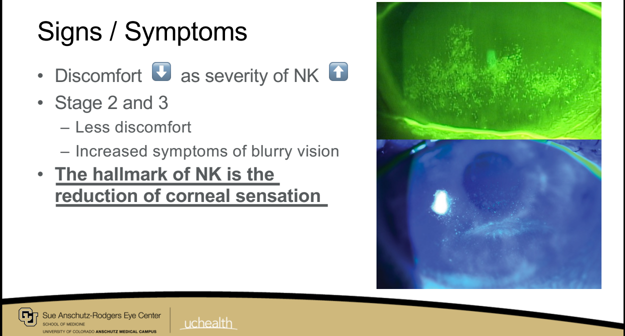

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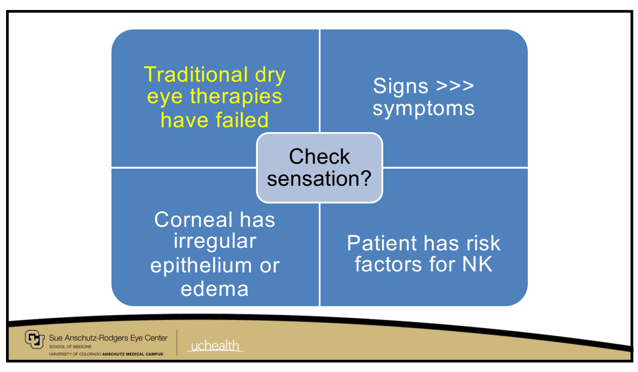

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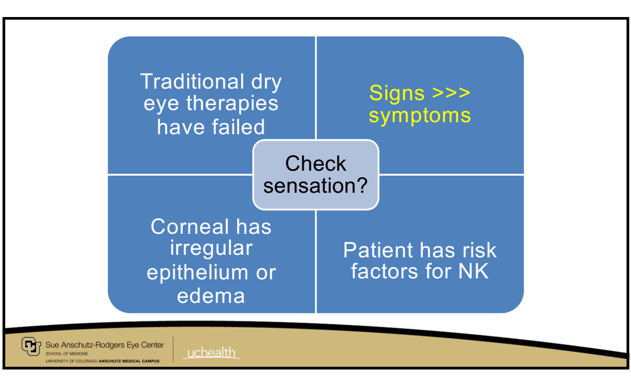

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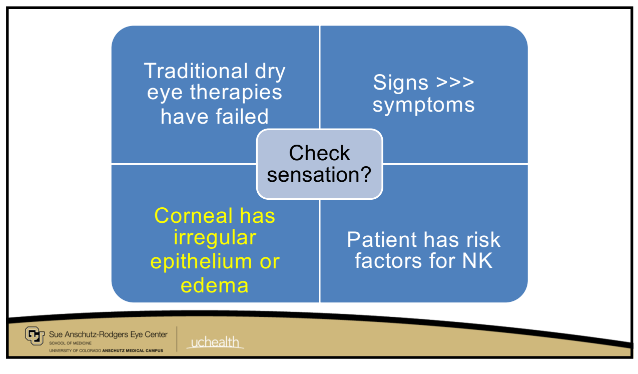

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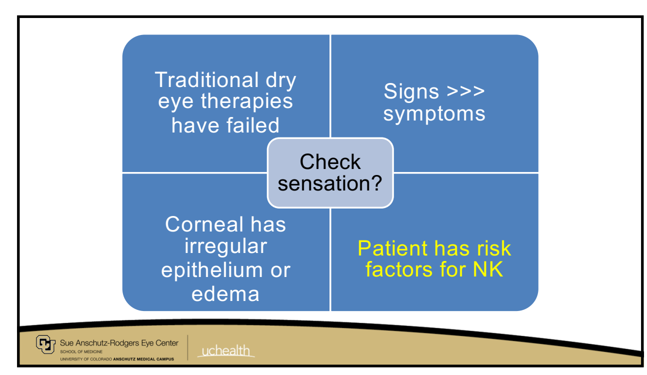

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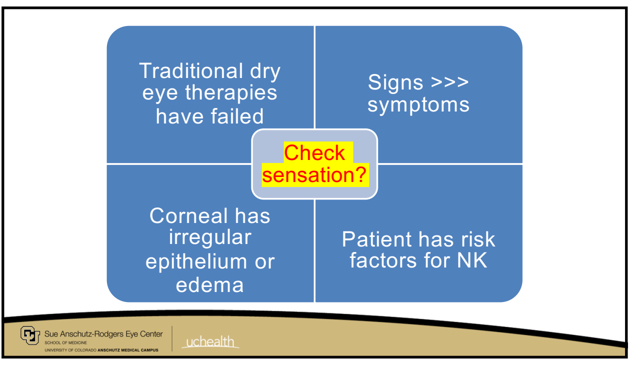

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Esthesiometry (sensation testing)

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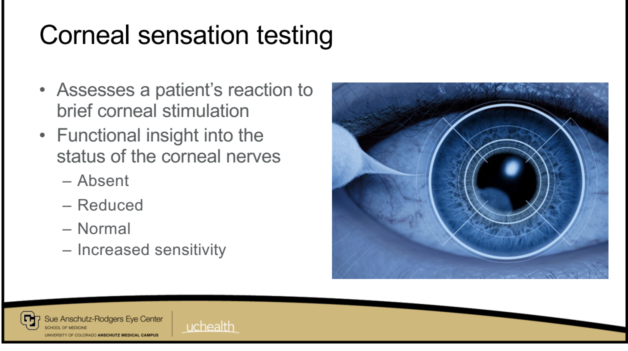

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Corneal sensation testing

- Assesses a patient's reaction to brief corneal stimulation
- Functional insight into the status of the corneal nerves
  - Absent
  - Reduced
  - Normal
  - Increased sensitivity

Absent / Reduced: Diagnostic for neurotrophic keratitis

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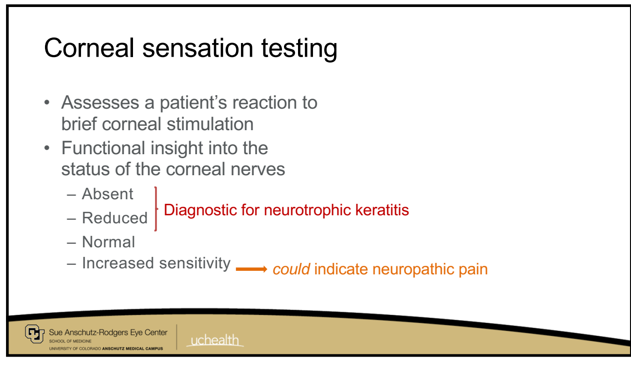

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Qualitative Testing

- Testing methods:
  - Cotton swab
  - Dental floss
  - Tissue paper
- Pros/Cons
  - Low cost
  - Readily available
  - Little training
  - Minimal time
  - Subjective
  - More difficult for bilateral cases

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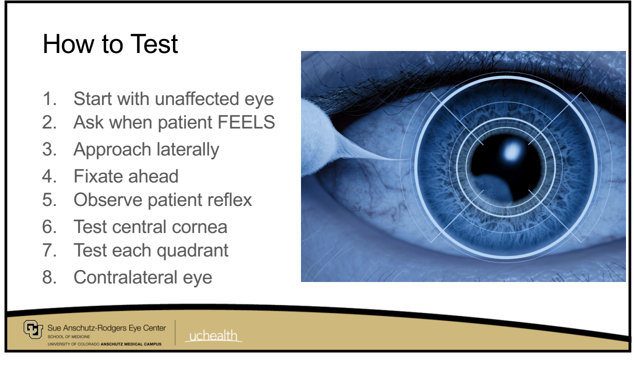

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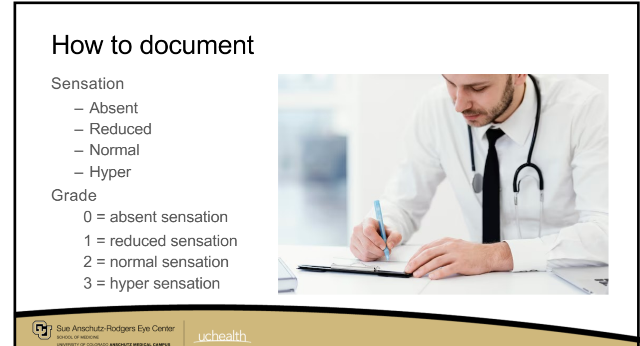

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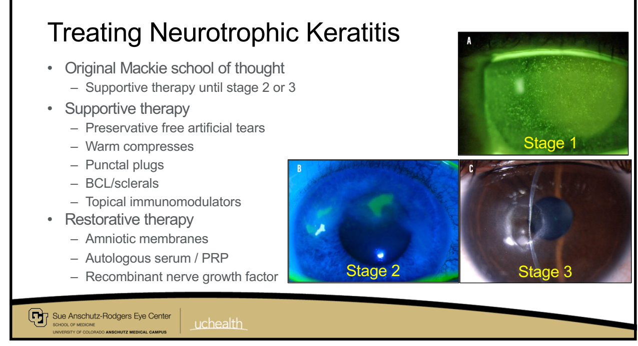

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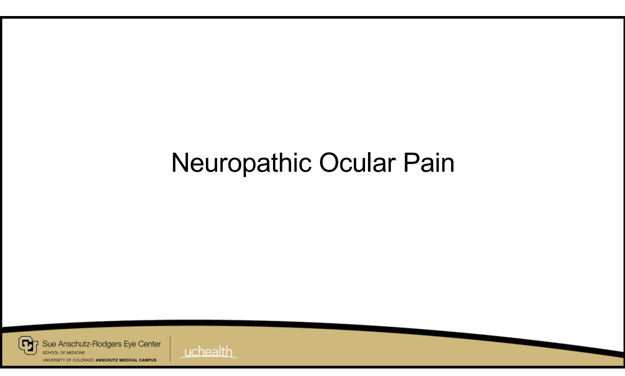

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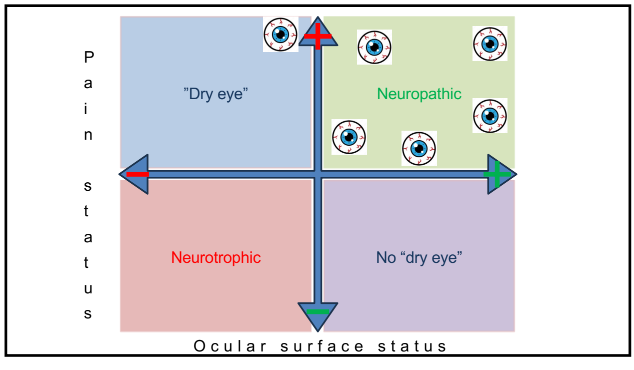

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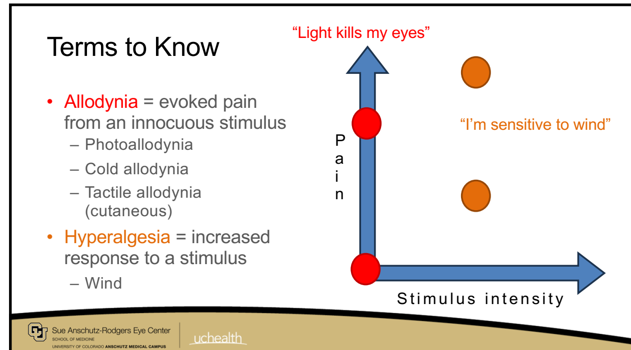

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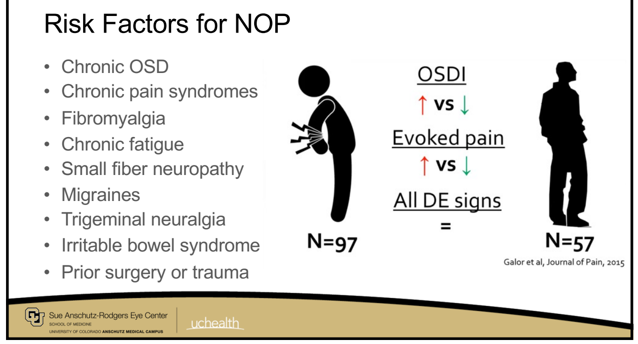

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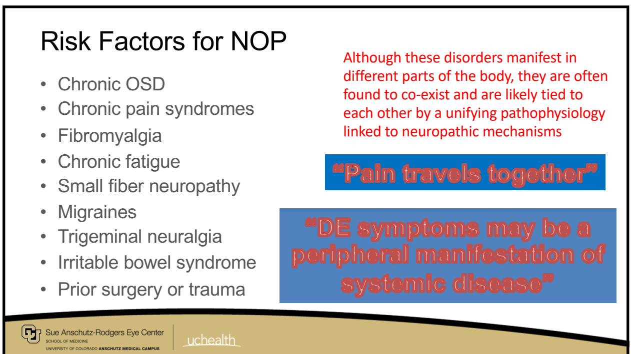

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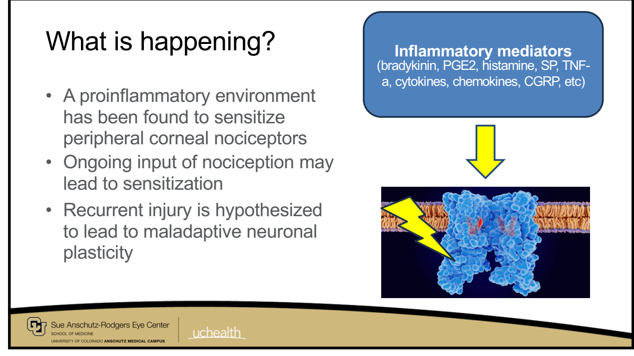

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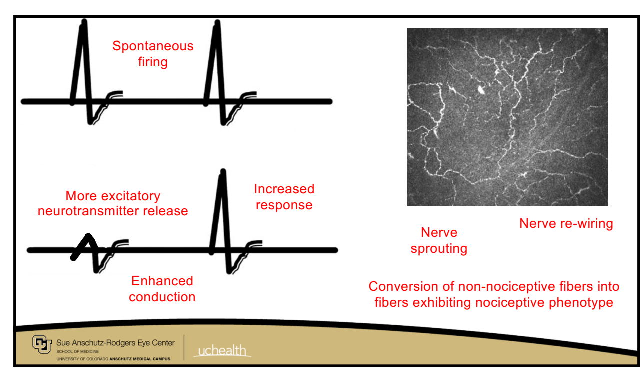

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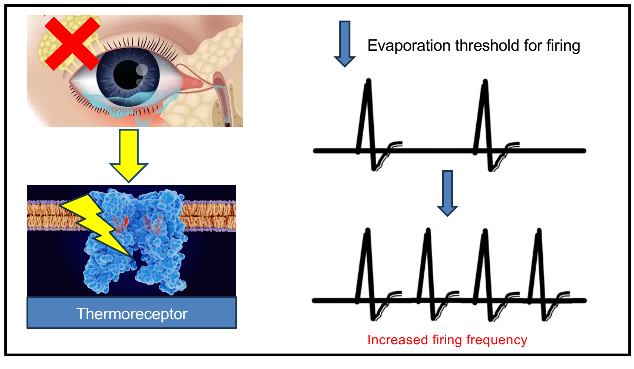

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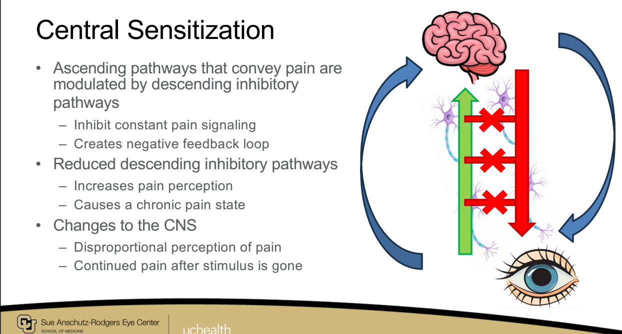

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What to do if you suspect neuropathic ocular pain?

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Proparacaine to disrupt corneal input

Higher cortical areas
Thalamus
Trigeminal ganglion
OPN
SSN
spV

Choudhury et al., 2022, adapted from Cheng et al., J Pain 2021

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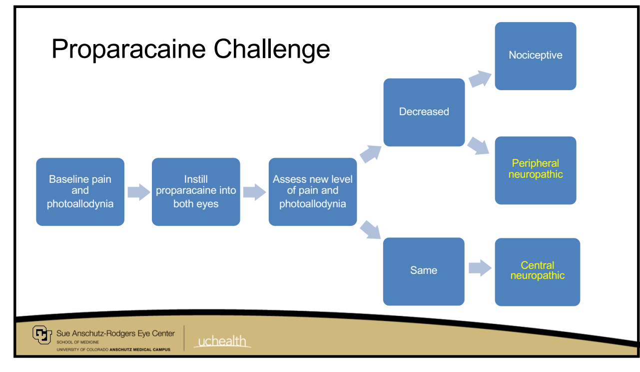

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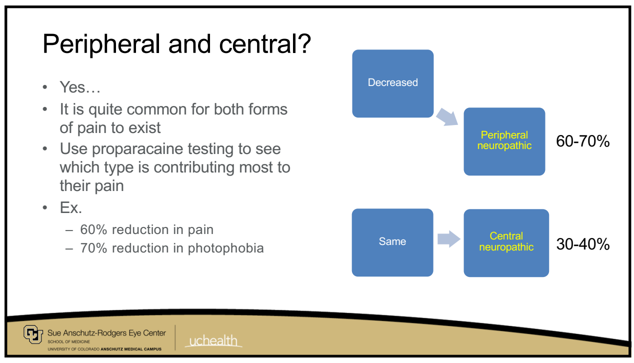

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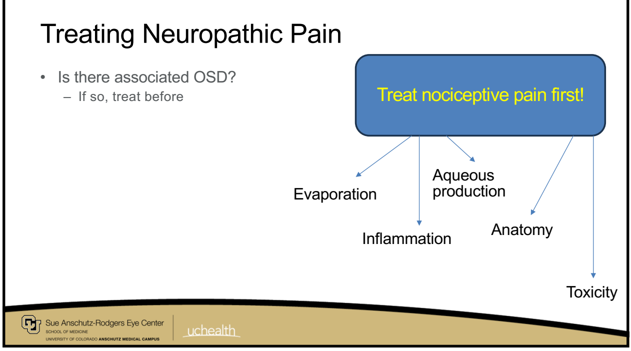

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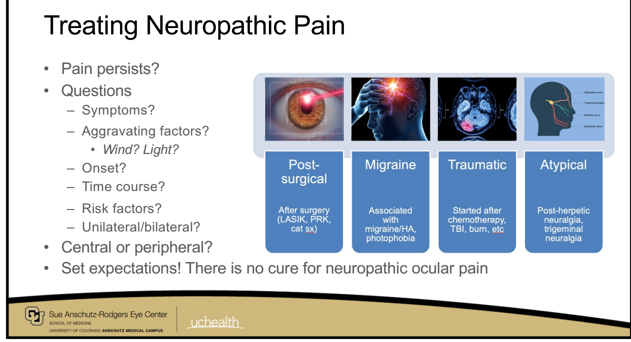

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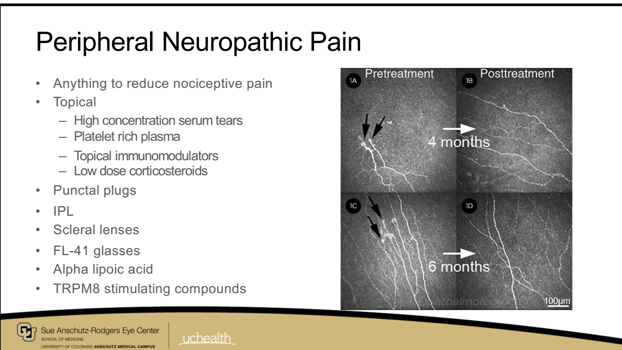

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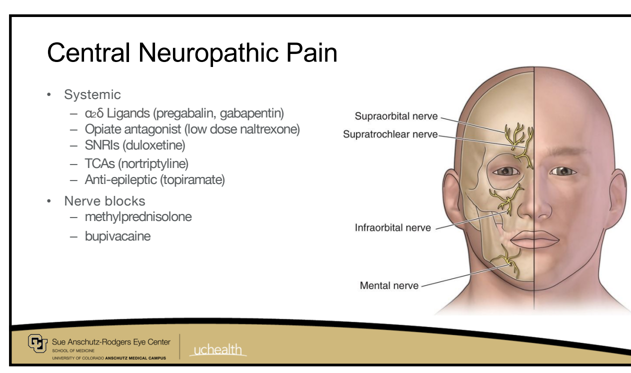

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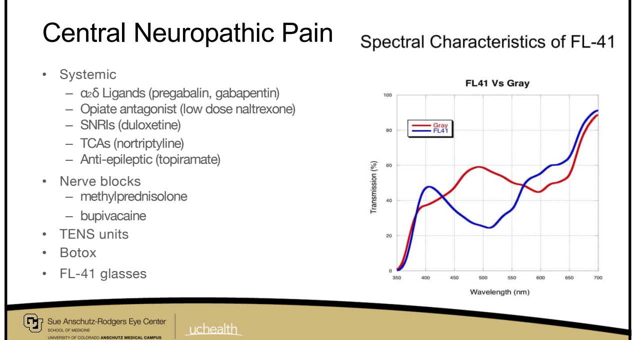

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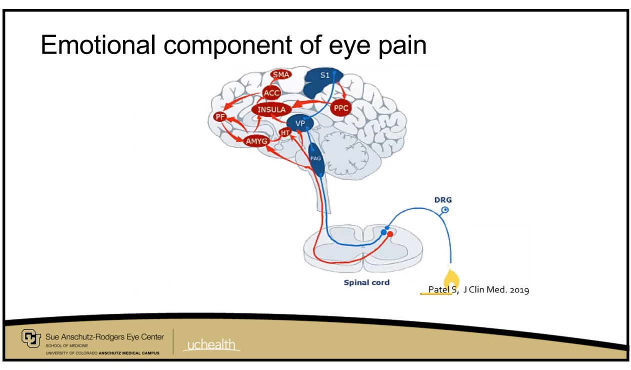

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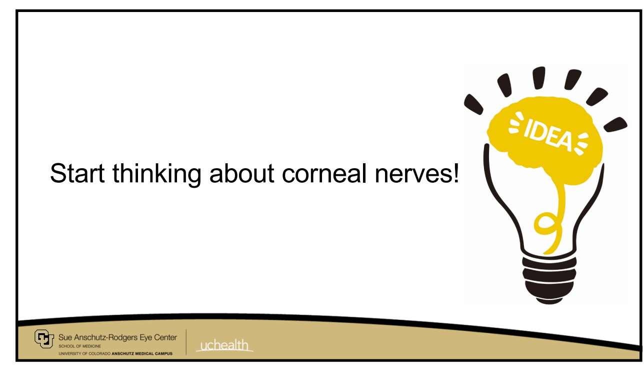

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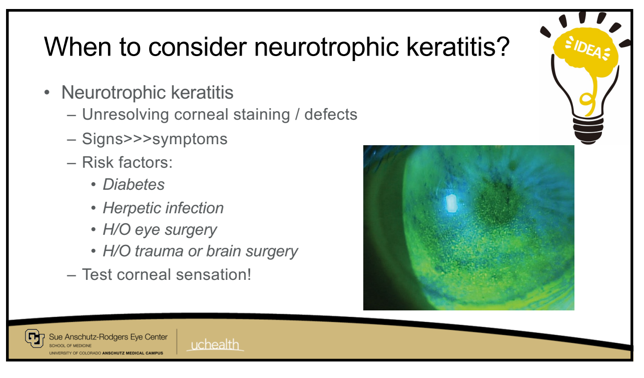

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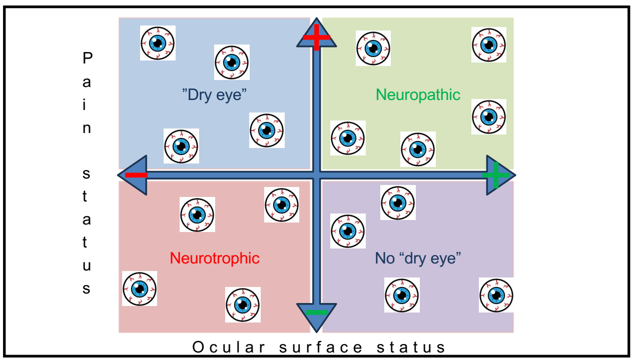

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"Be kind, for everyone you meet is fighting a hard battle"

- Plato

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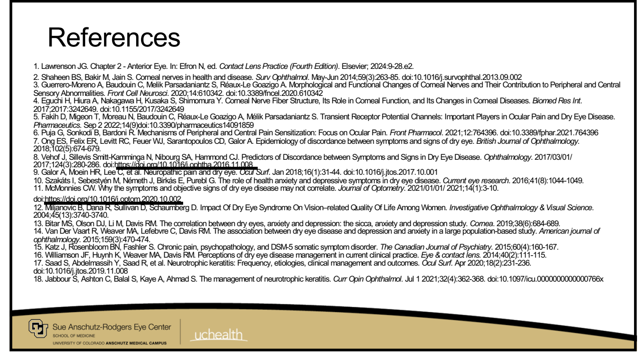

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Common Pitfalls in Medical Documentation and Billing and Coding

Andrew Kemp, OD FAAO
Clinical Assistant Professor
University of Houston College of Optometry

1

Disclosures

- Metro Optics
- Essilor Custom Contacts

2

The "Truth"

Spend time reading these…

- CPT and ICD manuals
- CMS (Medicare/Medicaid)
- Local Medicare carrier (Jurisdiction H – Texas and Colorado → Novitas)
- Medical payers
- Vision plan provider manuals

3

Concepts in Medical Eye Care Billing

The two core concepts of ethical medical care are:
•REASON FOR THE VISIT
•MEDICAL NECESSITY

And the third major concept to support those two items is:
•PROPER DOCUMENTATION OF MEDICAL RECORDS

Then there are SOME rules – not really that many!

4

REASON FOR THE VISIT

5

Reason For The Visit (RFV) - also called Chief Complaint (CC)

- It's simple – why is the patient seeking your care today
- What qualifies as a **medical** reason for the visit
  - Symptoms
  - Direction
    - From the patient
    - From a peripheral physician
    - From the attending physician

6

RFV / CC Documented How?

- Symptoms are documented in a few words that best approximate what the patient said
- Direction is documented by **who** directed the encounter and for **what** reason
- RFV/CC on established patient sometimes includes orders for tests (discussed later)
- **RFV/CC does NOT contain run on information about the symptom or direction – that goes in the History of Present Illness (HPI) – Try to keep these separate!**

7

Levels of RFV/CC

- The severity of the CC will establish the medical necessity for the level of exam. Establishes the "nature of the presenting problem"
  - Minimal severity – presence of the physician is not required
  - Minor severity – likely to run a definite and prescribed course, is transient in nature, and not likely to permanently alter any health care statue
  - Low severity – risk of morbidity is low even without treatment and a full recovery without functional impairment is predicted

8

Levels of RFV/CC

- Moderate severity – risk of morbidity is moderate and there is an uncertain prognosis and increased probability of prolonged functional impairment
- High Severity – risk of morbidity and/or mortality without treatment is high and there is a high probability of severe, prolonged functional impairment

…more on this soon

9

Why is this Important

- The severity of the complaint should dictate a more detailed or comprehensive examination
- Only perform what is necessary to evaluate the reason for the visit
  - Performing a more advanced exam than necessary is fraudulent!
    - i.e. evaluating the retina for a RFV of "itching"

10

MEDICAL NECESSITY

11

What Is Medical Necessity

WHAT DOES MEDICARE SAY

Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

https://www.medicare.gov/glossary/m.html

That seems pretty generic….can we dumb it down some?

SIMPLE APPROACH:

Will the results of this examination or testing influence or dictate my diagnosis and/or treatment of the patient?

12

Medically Necessity

- Medical necessity is **NEVER** determined by the fact that a diagnosis is on an approved payment list
  - CANNOT bill a visual field, OCT, pachymetry, corneal hysteresis, fundus photo for a glaucoma suspect simply because it is accepted under a payment policy
- In 2023, settlements under False Claims Act exceeded $2.68 BILLION
  - One hospital center paid out $21.6 MILLION for tests deemed "effectively worthless"

13

Medically Necessity

- A physician's determination of medical necessity does not always coincide with the patient's insurance benefits
  - A doctor should determine medical necessity, and someone should pay for that care!

14

PROVE IT!

The Medicare Carriers Manual, Part 3 §2320 reads:

"The coverage of services rendered by a physician is dependent on the purpose of the examination rather than on the ultimate diagnosis of the patient's condition*…when a beneficiary goes to his/her physician for an eye examination with no specific medical complaint, the expenses for the examination are not covered even though as a result of such examination the doctor discovered a pathologic condition."*

15

Things that are NOT medical reasons for a visit

- Comprehensive examination
- Annual eye evaluation
- Annual medical eye evaluation
- Comprehensive eye health evaluation
- Diabetic examination *(you're kidding right?)*

ALL CREATIONS OF OPTOMETERY

NONE MEDICALLY NECESSARY

And others….

- IOP check
- Here for visual field

16

Eye Exams On Diabetic Patients

- No commonly accepted definition for a "Diabetic Eye Exam" exists
- Some vision plans have their own requirements for patients with diabetes
  - Often requires dilation
- My recommended CC "Doctor directed visit for the ocular complications related to…."

17

Dilation in Eye Care

- Major Issue!
- For comprehensive ophthalmological exam codes
  - Usually should be performed, always when medically indicated (what is the chief complaint?)
- For E/M codes
  - When medically indicated

18

Dilation Continued

- If not performed, it should be indicated as to why
  - Reviewing fundus photography is NOT acceptable as a substitute
  - If a patient refuses, must be documented. Careful with frequent patient refusal!
  - If a patient is not dilated, peripheral retinal statements should not be included

19

DOCUMENTATION

Documentation is crucial:

- ✓ It's the only way money is kept in an audit
- ✓ It's the only evidence allowed in court

I see A LOT of charts with lazy/no documentation

20

Diagnostic Codes (ICD-10)

- International Classification of Disease (ICD) – we're now on version 10 – major concept is SPECIFICITY
- These are the keys that unlock the safes of reimbursement – EVERYTHING IS SYMPTOM OR DIAGNOSIS DRIVEN
- This should be no big deal – ***it is your job to make the diagnosis!***

What do the words maybe, possible or probable have in common regarding a diagnosis?

21

Diagnosis Codes

- ✓ Code to highest level of specificity
- ✓ Use eye codes, not systemic (except "code first" diagnoses)
- ✓ If you diagnose it, you must treat it, but you **don't have to code it!**
- ✓ The "primary diagnosis" should correspond with the reason for the visit

22

Diagnosis Codes

- Primary diagnosis – answers the RVF and should be listed first (hence primary)
- Subsequent diagnosis – revealed during the encounter that are not necessarily associated with the RFV. CPT states inclusion of these on the claim form is optional.
- Existing diagnosis – conditions a patient has had in the past not being managed during this encounter. CPT states these should NOT be included

23

ICD 10 Manual "rules"

- Only full codes are valid. Need the full extent of up to 7 characters. AVOID "unspecified" codes.
- If a combination code exists, we must use it
  - Using the code that lists diabetic retinopathy w or w/o mac edema together instead of using a code for retinal hemorrhages and macular edema separately.
- If a condition included laterality, it must be used
- If presenting problem is a complication of care, it must be reported as such
  - Macular edema following cataract surgery, left eye H59.032

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General Rule for Documentation

When documenting a medical record, record every finding you feel should be documented. Record a diagnosis for every ***significant*** clinical findings. You must have a plan for each diagnosis.

25

Ophthalmologic vs EM Codes

This is actually VERY simple!

1. You can ALWAYS use an evaluation and management code – conduct a problem-oriented examination based on the reason for the visit and determine medical decision
2. You can ONLY use an ophthalmologic code when your service meets the definition and description of the code *(Means what? Next slides…)*

26

92002 / 12 Per CPT

*Ophthalmological services: **medical examination** and evaluation with initiation of diagnostic and treatment program; intermediate*

Requires:

The evaluation of a new or existing condition *complicated with a new diagnostic or management problem (?)*

- A medical history
- General medical observation
- Examination of external eye and adnexa

And any other applicable service; may include the use of mydriasis or cycloplegia

27

92004 / 14 Per CPT

*Ophthalmological services: **medical examination** and evaluation with initiation of diagnostic and treatment program; comprehensive, one or more visits. Requires:*

- General evaluation of the complete visual system
- A medical history
- General medical observation
- Examination of external eye and adnexa
- Ophthalmoscopic examination (usually includes dilation)
- Gross visual fields
- Basic sensorimotor exam
- Always includes initiation of diagnostic and treatment programs

EXAMPLES

1. Eye waters?
2. Nevus follow up?
3. Patient with DM?
4. Patient with dry eyes and AMD?

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And the EM Codes?

It's Complicated, Objective, Opinionated, Debated, and Generally a PITA – but you have to understand them!

- Key One – The History
- Key Two – The Examination
- Key Three – Medical Decision Making

29

New Changes Effecting January 2021

- Eliminated 99201
- Choosing the proper level is via medical decision making or time spent with a patient

HOWEVER….traditional billing tenets still apply!

30

Medical Decision Making

Measured by:

- Number of possible diagnosis or number of management options
- Amount and complexity of medical records, diagnostic tests and other information recorded or reviewed
- Risk of complications, morbidity, mortality and comorbidities

Defined as STRAIGHTFORWARD, LOW COMPLEXITY, MODERATE COMPLEXITY AND HIGH COMPLEXITY

31

Here's the Rub

There is NO consensus on what constitutes ***STRAIGHTFORWARD, LOW COMPLEXITY, MODERATE COMPLEXITY AND HIGH COMPLEXITY***

TRUTH: Most doctors over-estimate the complexity of their care according to CPT. 77% denial in Medicare – 90% of those due to upcoding!

32

New Definitions of Medical Necessity

- The reason for the visit or "problem" will establish the medical necessity and help establish the complexity of the decision making
- Problem– something that is evaluated and treated at the encounter. Problems managed by an outside provider with no additional assessment does not qualify
  - Also includes referrals without adequate evaluation

33

Types of Problems in Determining Medical Decision Making

- Minimal problem – may not require a physician
- Self-limited or minor problem – a problem that runs a definite and prescribed course, is transient in nature and not likely to permanently alter health status. NOTE: This could be considered to include a wide range of ophthalmic presentations
- Stable, chronic illness – a problem with an expected duration < 1 year. Stable implies the specific treatment goals are being achieved and not just that the condition itself is stable (ie glaucoma).

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Types of Problems

- Acute, uncomplicated illness or injury – low risk of morbidity and little or no risk of mortality. Full recovery without functional impairment is expected. Could be self-limited/minor problem that is not resolving (ex. Dry eyes, blepharitis, episcleritis).
- Chronic illness with exacerbation, progression or side effects of treatment – chronic illness that is acutely worsening, poorly controlled and requiring additional care

35

Types of Problems

- Undiagnosed new problem with uncertain prognosis – new problem with high risk of morbidity without treatment (corneal ulcer/swollen disc).
- Acute illness with systemic symptoms – An illness that causes systemic symptoms and has a high risk of morbidity without treatment

36

New definitions – New patient

- 99202 – Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making
- 99203 – Office… and low level of medical decision making
- 99204 – Office… and moderate level medical decision making
- 99205 – Office… and high level medical decision

37

Established patient

- 99211 – Office…that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal
- 99212 – Office…straightforward medical decision making
- 99213 – Office… low medical decision making
- 99214 – Office…moderate medical decision making
- 99215 – Office…high medical decision making

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Level 2 E/M codes MUST Qualify 2 of the 3!!!

CPT Code	MDM Level	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data Reviewed and Analyzed	Risk of Complications and/or Morbidity
99202/12	Straightforward	Minimal One self-limiting or minor problem	Minimal to none	Minimal risk of morbidity from additional testing or treatment

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Level 3 E/M Codes

CPT Code	MDM Level	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data Reviewed and Analyzed	Risk of Complications and/or Morbidity
99203/13	Low	Low Two or more self-limiting or minor problems -or- One stable chronic illness -or- One acute, uncomplicated illness or injury	Limited Must meet at least one of the two categories Category One: Test and Documents Any two of: *Review of prior external notes from unique source *Review of results of each unique source *Ordering of each unique test Category Two: Assessment by Independent Historian	Low risk of morbidity from additional testing or treatment

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Level 4 E/M Codes

CPT Code	MDM Level	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data Reviewed and Analyzed	Risk of Complications and/or Morbidity
99204/14	Moderate	Moderate One or more chronic illness with exacerbation, progression or side effects of treatment -or- Two or more chronic illnesses -or- One undiagnosed new problem with uncertain prognosis -or- One acute illness with systemic symptoms -or One acute complicated injury	Moderate Must meet at least one of the three Category One: Tests, documents or independent historian Any combination of three from: *Review of prior external notes form each unique source *Review of results of each unique test *Ordering of each unique test *Assessment requiring an independent historian -or- Category Two: Independent Interpretation of tests *Independent interpretation of test performed by another physician -or- Category Three: Discussion of Management or Test Interpretation *Discussion of management or test interpretation with external physician	Moderate risk of morbidity from additional testing or treatment *Prescription drug management *Decision regarding minor surgery with patient or procedure risks *Decision regarding major surgery without patient or procedure risks *Diagnosis or treatment significantly limited by social determinants of health

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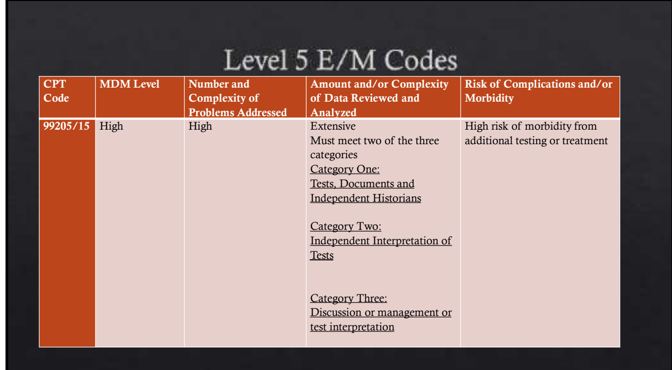

Level 5 E/M Codes

CPT Code	MDM Level	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data Reviewed and Analyzed	Risk of Complications and/or Morbidity
99205/15	High	High	Extensive Must meet two of the three categories Category One: Tests, Documents and Independent Historians Category Two: Independent Interpretation of Tests Category Three: Discussion or management or test interpretation	High risk of morbidity from additional testing or treatment

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Putting it Together

NEW PATIENT	Medical Decision Making	ESTABLISHED PATIENT	Medical Decision Making
		99211	Minimal
99202	Straightforward	99212	Straightforward
99203	Low	99213	Low
99204	Moderate	99214	Moderate
99205	High	99215	High

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Determining Service Level Based on Time

- Have always been able to do this…but BIG changes in how it is done
- Time – total time the physician and qualified healthcare professional spends with the patient, not ONLY the time spend in counseling and coordination of care. It is STILL only the time spent with the patient (excludes waiting time, intake, etc).
  - The requirement that the counseling and coordination be at least 50% of the total time is eliminated
- Must be clearly recorded in the medical record

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Billing E/M on Time

NEW PATIENT	TIME	ESTABLISHED PATIENT	TIME
99202	15-29 MINUTES	99212	10-19 MINUTES
99203	30-44 MINUTES	99213	20-29 MINUTES
99204	45-59 MINUTES	99214	30-39 MINUTES
99205	60-74 MINUTES	99215	40-54 MINUTES

45

Commonly Missed Billing

- Level 4 is billed with one chronic condition with an exacerbation, but no medication is recommended, or surgery discussed
- Level 4 is billed for one chronic, stable condition and medication is prescribed (ie chronic dry eye)
- Two chronic conditions are managed and surgery was discussed but the chief complain indicated "routine exam."

46

Surgical Codes

- Only addressed by Medicare and it is unclear if these rules apply to minor surgeries but most feel a basic surgery report is warranted and would include:
  - Surgery performed
  - Reason for surgery
  - Statement of patient consent – signature?
  - Documentation of anesthesia if applicable
  - Short description of what was done
  - Post-op release instructions

47

Amniotic Membranes (CPT 65778)

- This is a focus of many insurance payor due to high reimbursement
- Rules are not clear
- What IS clear → must established proper medical necessity.
  - +1 SPK for chronic dry eye is likely NOT going to cut it…

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Keys to Success

- For amniotic membranes or any advanced procedure…
  - Medical necessity!!
  - Must be supported by exam documentation
  - Indications in the HPI/Assessment on the instability of a condition is critical

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Modifiers Made Easy

Modifiers are attachments to the procedure codes that tell the payor you are doing something different or additional for a reason. That reason may go against the payors determination of what is medically necessary but the modifier SOMETIMES allows you to override the payors restrictions.

There are VERY FEW modifiers you will use as an optometrist.

50

Modifiers in Eye Care

"Identifying" Modifiers

RT, LT - Right eye, Left eye

E1-E4 - Eyelid location

GY – Non-covered modifier (for Optomaps, refractions,etc – optional use)

51

Over-use of -59 and -25 Modifiers

-59 Modifier

- The catch all / break all rules modifier – ultimately way abused
- THE most audited modifier in Medicare
- Lots of opinions on this one…lots of folks giving out poisonous information. No matter what anyone tells you, use the -59 modifier and you WILL get audited and you WILL lose the appeal

52

-25 Modifier

THE SECOND MOST COMMON MODIFIER AUDIT TARGET IN MEDICARE!!!

When to use:

1. When a patient presents (RFV) for one issue (ex. glaucoma follow up) and you find something in the exam (ex. trichiasis)that necessitates surgery on the same day
2. When you determine you must perform an evaluation and management service to determine the need for surgery (BE VERY CAREFUL HERE! Likely lose every appeal!)

53

Modifiers in Eye Care

26 & TC - Describes the technical vs the interpretive component of some services (usually radiological). In our case, applies to a-scans, b-scans

24 & 79 - For a service performed during a Global surgery fee period unrelated to the surgery. -24 goes with the office visit and -79 with tests

What about co-management?

54

A moment on Co-management

- Mostly allowed only with Medicare
- Recent focus on optometry's relationship with ophthalmology – specifically co-management
- You must SET and COLLECT your own fees

55

Modifiers in Eye Care

52 Modifier

Used to tell the payer that you are performing a test on only ONE eye even though the test is paid as if you did both eyes.

You can bill only for the eye where the test was medically necessary. There are some exceptions to this (rare – glaucoma is most common)

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A Few Other Issues
Documentation of Interpretation / Reports

- Every diagnostic test must have an associated interpretation and report
- Without an interpretation and report, an auditor can deny reimbursement for the test
- Here's the rub…CPT did not bless us with directions on what should be included in an interpretation and report

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Documentation of Interpretation / Reports

What many suggest

- Statement of reason test was run
- Brief summary of results
- Statement of reliability of the data
- Statement of cooperation of the patient
- Diagnosis associated with the test or statement of how the results will assist in diagnosis and management of condition

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Orders for Diagnostic Tests

- CPT says that for every diagnostic test…
  - It must be clear to the auditor from the medical record why you performed the test

    -OR-
  - The record must include a physician "order" for the test
- The second is best!

59

Three Places for Orders

- In the plan of the previous examination (that the auditor does not have!)
- In the reason for visit for the current examination
- In the plan of the current examination or in an order section noting the test is to be performed that day

All OK… but suggest #1 (for others's sake) AND #2 or #3 (for the auditor's sake)

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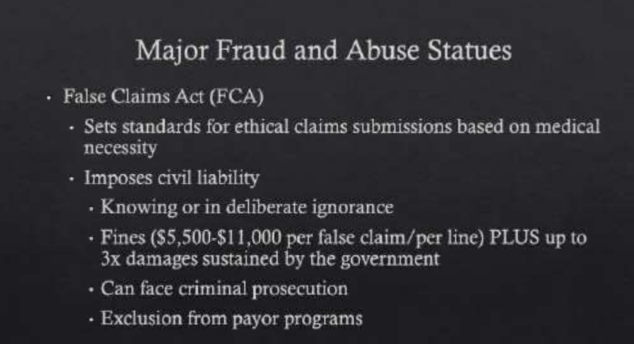

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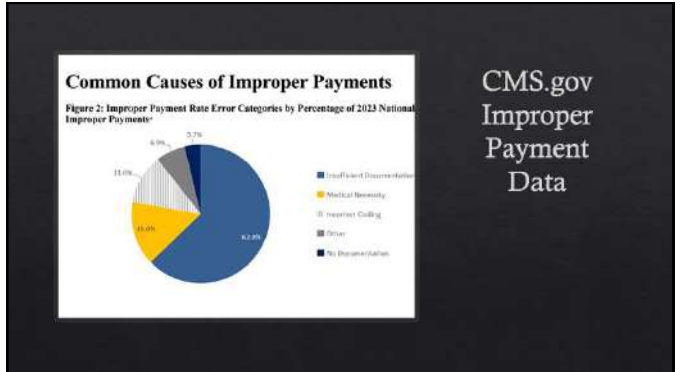
This is a BIG Focus

- 2023 Medicare improper payment rates
  - 7.38% totaling $31.23 BILLION

62



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More Data..

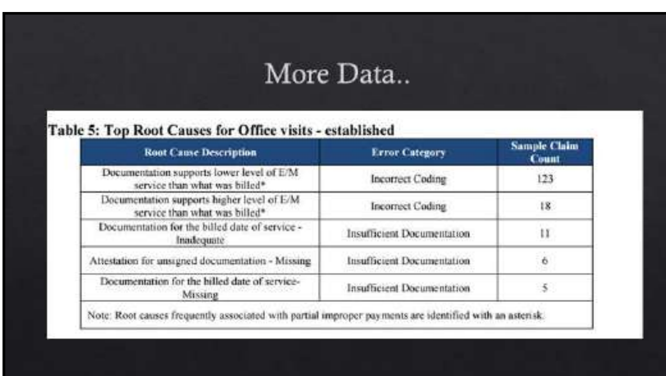

Table 5: Top Root Causes for Office visits - established

Root Cause Description	Error Category	Sample Claim Count
Documentation supports lower level of E/M service than what was billed*	Incorrect Coding	123
Documentation supports higher level of E/M service than what was billed*	Incorrect Coding	18
Documentation for the billed date of service - Inadequate	Insufficient Documentation	11
Attestation for unsigned documentation - Missing	Insufficient Documentation	6
Documentation for the billed date of service- Missing	Insufficient Documentation	5

Note: Root causes frequently associated with partial improper payments are identified with an asterisk.

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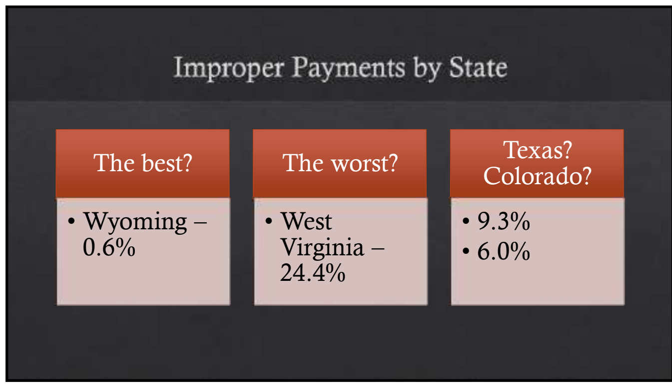
It's getting better?

- Improper Payment Rates over time
  - 1996 – 13.8%
  - 2010 – 10.5%
  - 2014 – 12.7%
  - 2021 – 6.26%
  - 2023 – 7.38%

65

Improper Payments by State



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More statistics

- Improper payment rate of orthopedic footwear – 100%
- Improper payment rate Ophthalmology – 3.3%
- Improper payment rate Optometry – 8.5%...
  - Estimated repayment of $76.5 million
- Chiropractic was highest at 39.3%
- Most erroneously billed code across healthcare…99214

67

We can do better ODs!

Provider Types Billing to Part B	Improper Payment Rate	Claims Reviewed	Percentage of Provider Type Improper Payments by Type of Error				
			No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other
Optometry	8.5%	66	0.0%	63.9%	0.0%	32.9%	3.2%
Ophthalmology	3.3%	300	0.0%	81.6%	0.0%	18.4%	0.0%

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Major Fraud and Abuse Statues

- Anti-Kickback Statute (AKS)
  - Defines criminal offense to knowingly and willfully offer, pay, solicit or receive any remuneration directly or indirectly that induces or rewards referrals of items or services reimbursable by a Federal health care program.
    - Courts may decide to apply this to non-Federal funds
    - Civil penalties up to 3x the amount of kickback
    - Possible criminal penalties including fines and imprisonment

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Major Fraud and Abuse Statues

- Physician Self-Referral Law (Stark Laws)
  - Prohibits making referral to an entity in which the physician has ownership or a compensation arrangement unless an exception applies (Safe Harbors).

70

The Age of Audits

- All payers have dramatically increased the number of audits performed (medical and vision)
  - Gov't is broke
  - Healthcare reform has placed a major emphasis on uncovering fraud and abuse
  - Ignorance cannot be used as an excuse!!
  - Qui Tam – Whistleblower Act – unhappy patients can report who they think are fraudulent and will get paid for it!
    - Paid out 349 million in 2023 to whistleblowers in 712 lawsuits
  - Medicare has hired Recovery Audit Contractors (RACs) who are paid based on the amount of money they get back

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The Age of Audits

- Ophthalmology (includes optometry) was specifically called out in a report by the Office of the Inspector General about health care fraud…..
- Payors conducting the most Audits
  - Medicare
  - Aetna
  - VSP (extra evil)
  - BCBS
  - EyeMed

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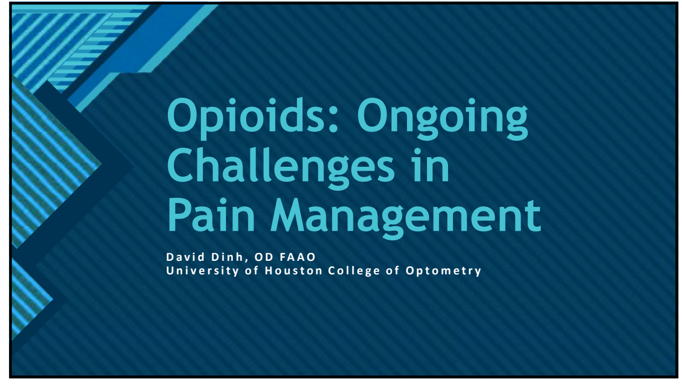

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No Financial Disclosures

University of Houston College of Optometry – CE Team
- Amanda Johnson
- Christian Loayza
- Carlos Cole
- Lorellye Graham

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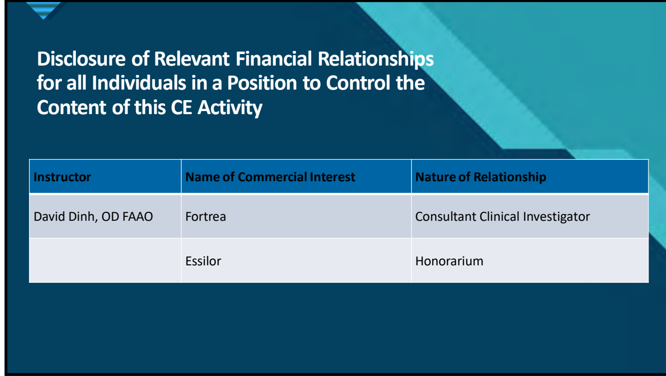


Disclosure of Relevant Financial Relationships for all Individuals in a Position to Control the Content of this CE Activity

Instructor	Name of Commercial Interest	Nature of Relationship
David Dinh, OD FAAO	Fortrea	Consultant Clinical Investigator
	Essilor	Honorarium

3

Today's Goals

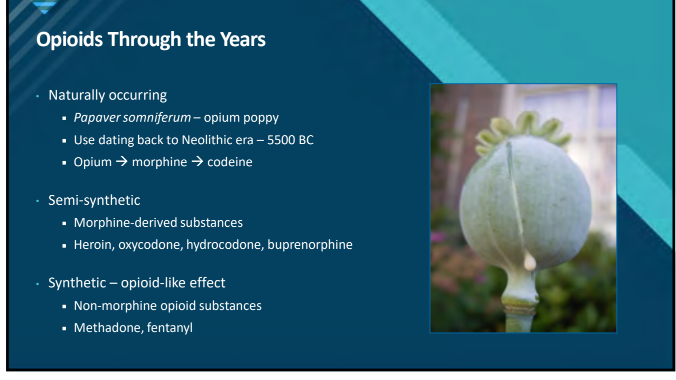
History
What are opioids? What's the big deal?

Clinical Impact
How does this influence patient care?

Alternative Options
What other choices in our toolbox?

Optometric Goals
Applying concepts to everyday scenarios

4



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Opioids - Who? What? Why?

- *"analgesic to treat pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate"*
- Common opioids:
  - Morphine
  - Heroin
  - Fentanyl
  - Hydrocodone
  - Hydromorphone (Dilaudid®)
  - Methadone
  - Codeine
  - Oxycodone (Oxycontin®)
  - Percocet® (oxycodone + acetaminophen)

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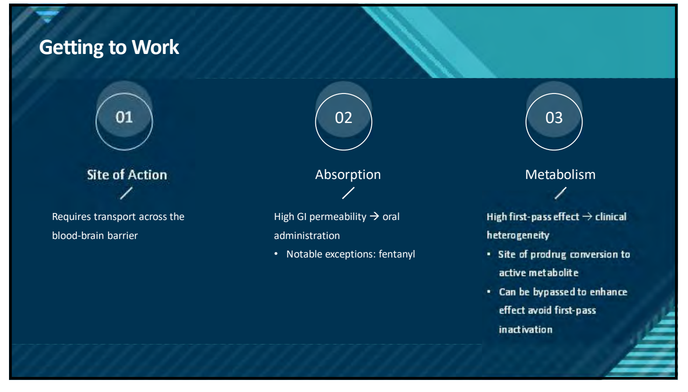

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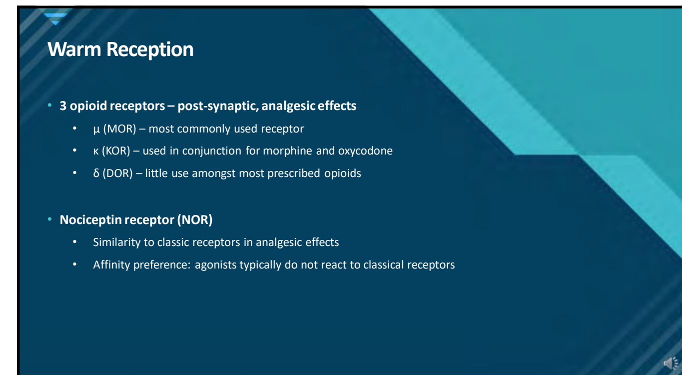

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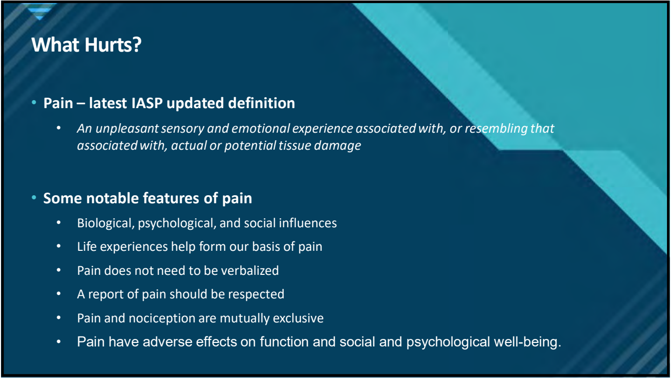

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Biopsychosocial Model

Biological Factors

Psychological Factors

Social Factors

PAIN

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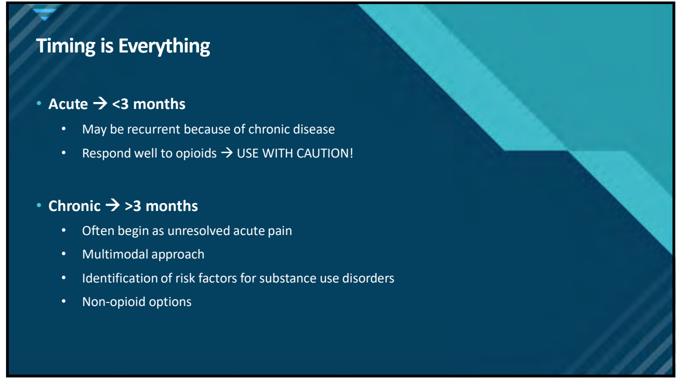

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On the Origin of Pain

- **Nociceptive**
  - Secondary to actual or potential tissue damage
  - Typically acute
  - Examples: stubbed your toe, burned your hand on the stove
- **Neuropathic**
  - Dysfunction within the nervous system
  - Acute or chronic
  - Examples: postherpetic neuralgia, diabetic peripheral neuropathy

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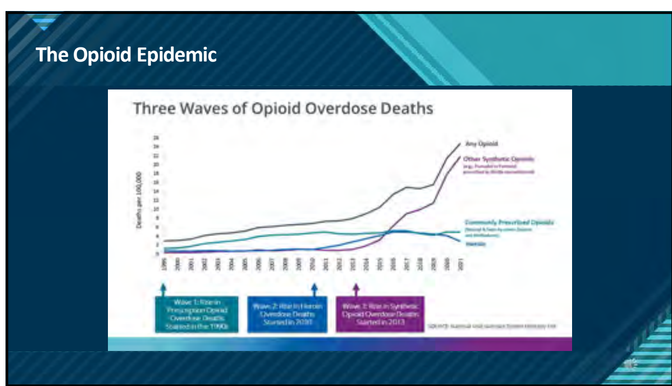

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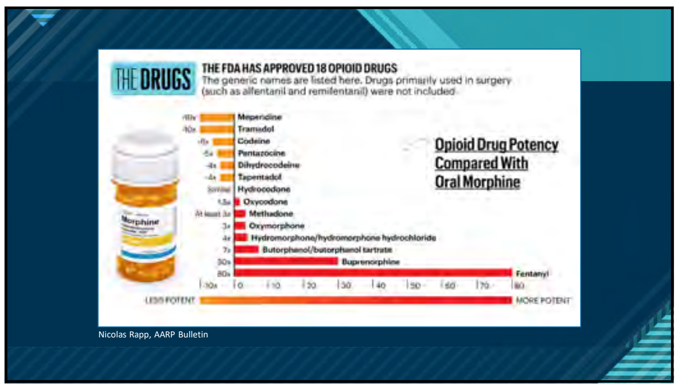

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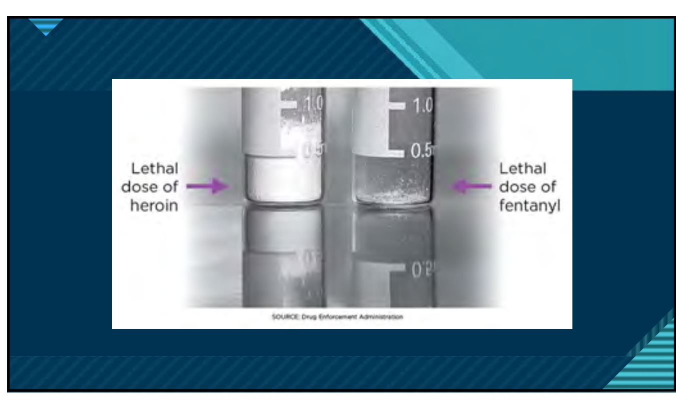

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Attempts at Control

Aggregate Production Quota for Opioids (grams)	2016	2024	Overall
Fentanyl	2,300,000	731,360	-68%
Hydrocodone (for sale)	86,000,000	27,143,545	-68%
Hydromorphone	7,000,000	1,951,801	-72%
Morphine (for sale)	62,500,000	20,805,957	-67%
Oxycodone (for sale)	139,150,000	53,658,226	-61%
Oxymorphone (for sale)	6,250,000	464,464	-93%
Overall Decline:	**303,200,000**	**106,069,975**	**-65%**

Source: Established Aggregate Production Quotas for Schedule I and II Controlled Substances and Assessment of Annual Needs for the List I Chemicals Ephedrine, Pseudoephedrine, and Phenylpropanolamine for 2024

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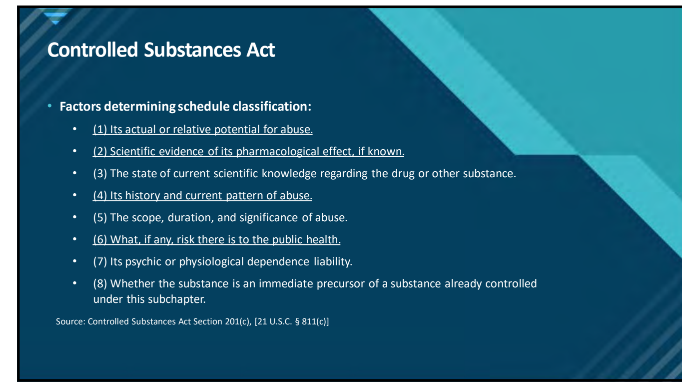

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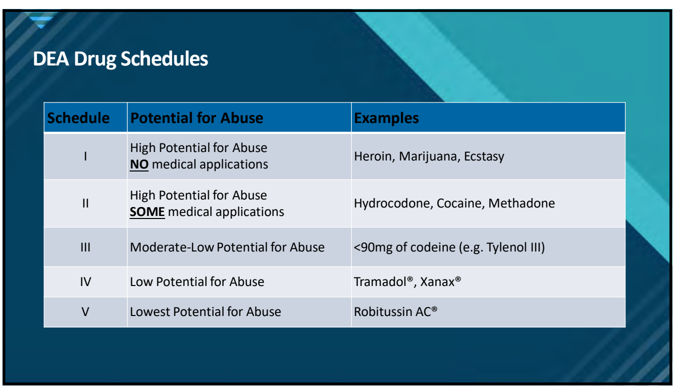

Schedule	Potential for Abuse	Examples
I	High Potential for Abuse **NO** medical applications	Heroin, Marijuana, Ecstasy
II	High Potential for Abuse **SOME** medical applications	Hydrocodone, Cocaine, Methadone
III	Moderate-Low Potential for Abuse	<90mg of codeine (e.g. Tylenol III)
IV	Low Potential for Abuse	Tramadol®, Xanax®
V	Lowest Potential for Abuse	Robitussin AC®

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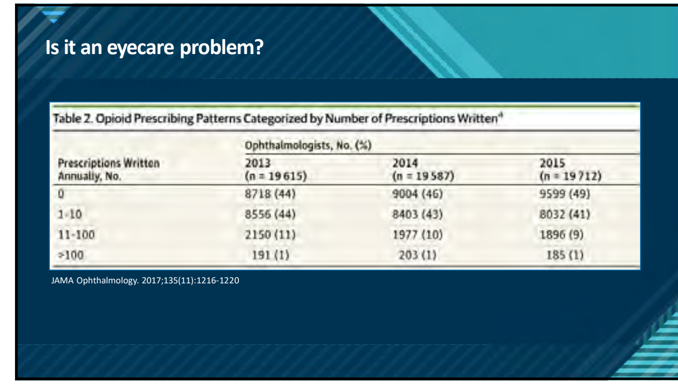

Table 2. Opioid Prescribing Patterns Categorized by Number of Prescriptions Written[a]

Prescriptions Written Annually, No.	Ophthalmologists, No. (%) 2013 (n = 19 615)	2014 (n = 19 587)	2015 (n = 19 712)
0	8718 (44)	9004 (46)	9599 (49)
1-10	8556 (44)	8403 (43)	8032 (41)
11-100	2150 (11)	1977 (10)	1896 (9)
>100	191 (1)	203 (1)	185 (1)

JAMA Ophthalmology. 2017;135(11):1216-1220

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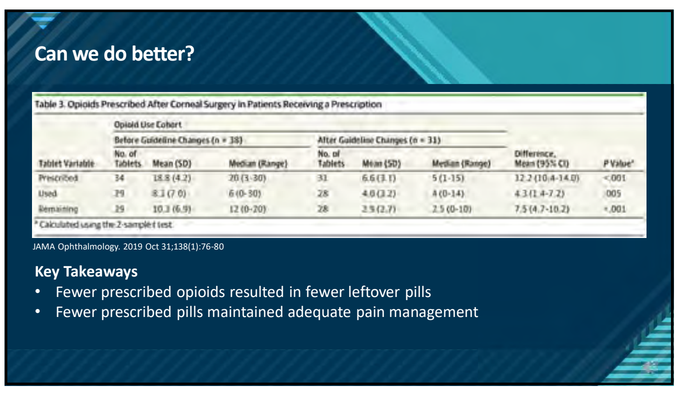

Table 3. Opioids Prescribed After Corneal Surgery in Patients Receiving a Prescription

Tablet Variable	Opioid Use Cohort: Before Guideline Changes (n = 38) No. of Tablets	Mean (SD)	Median (Range)	After Guideline Changes (n = 31) No. of Tablets	Mean (SD)	Median (Range)	Difference, Mean (95% CI)	P Value[a]
Prescribed	34	18.8 (4.2)	20 (3-30)	31	6.6 (3.1)	5 (1-15)	12.2 (10.4-14.0)	<.001
Used	29	8.1 (7.0)	6 (0-30)	28	4.0 (3.2)	4 (0-14)	4.3 (1.4-7.2)	.005
Remaining	29	10.3 (6.9)	12 (0-20)	28	2.5 (2.7)	2.5 (0-10)	7.5 (4.7-10.2)	<.001

[a] Calculated using the 2-sample t test

JAMA Ophthalmology. 2019 Oct 31;138(1):76-80

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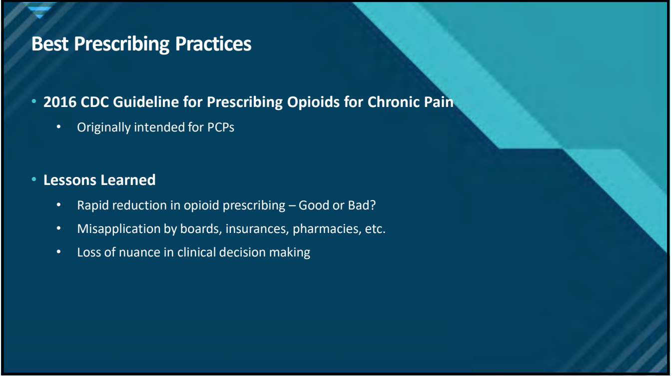

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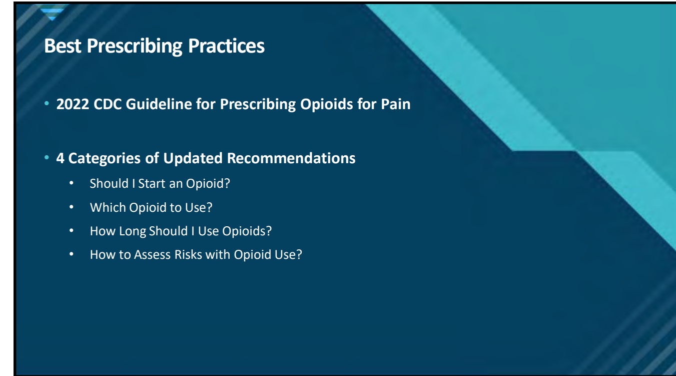

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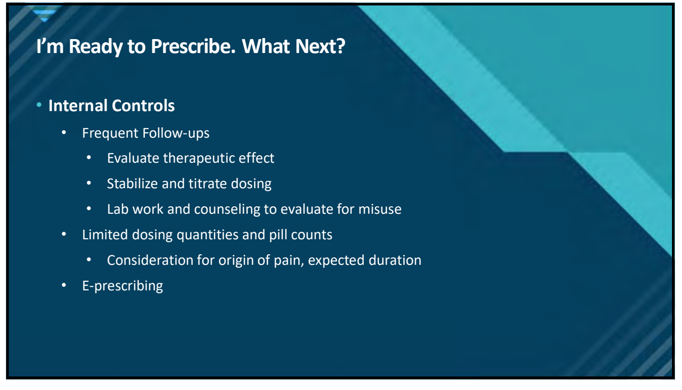

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I'm Ready to Prescribe. What Next?

- **Internal Controls**
  - Patient Education
    - Set realistic expectations
    - Situations for discontinuation → Patient Contracts
      - Risks outweigh benefits
      - Evidence of misuse → Urine Drug Screening
  - DEA Drug Disposal Sites
  - Provider Education
    - Education at all levels

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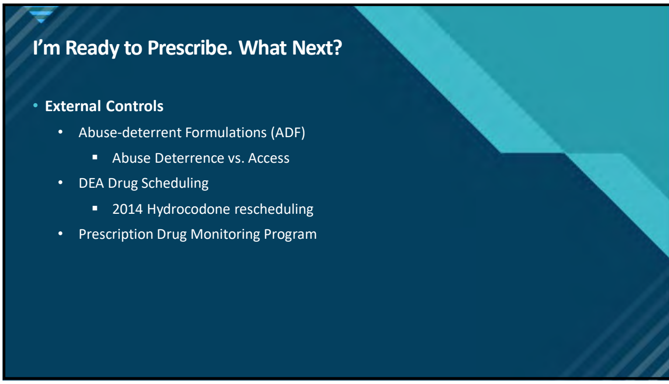

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Prescription Drug Monitoring Program

- **Goals**
  - Prevent doctor shopping
  - Enhance tracking among different state/federal organizations
  - Allow for insight on prescribing habits to identify outliers
- **Key Features**
  - Pharmacy updates after filling controlled substance
  - Prescriber access to patient filled drug history

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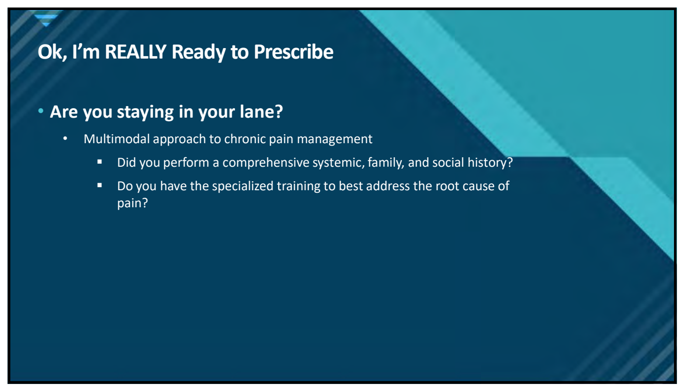

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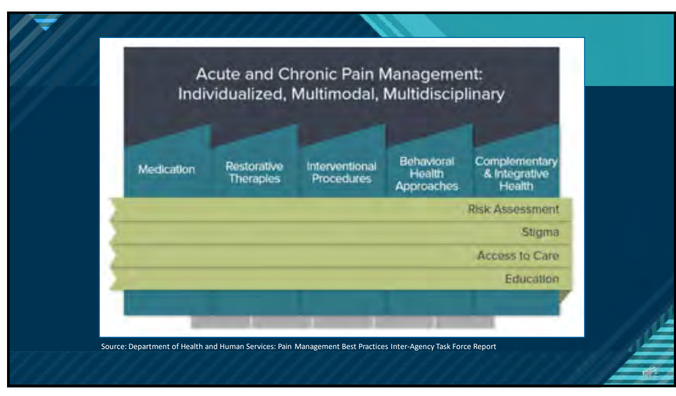

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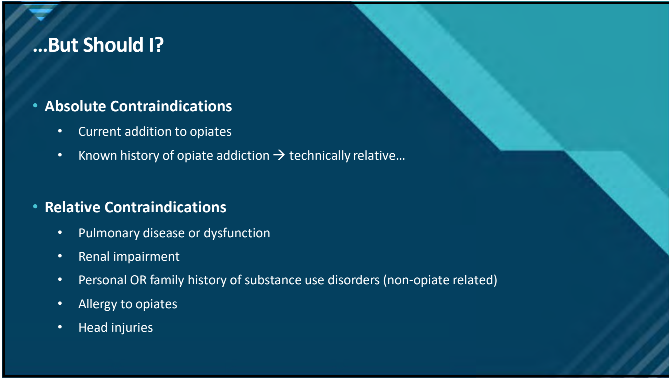

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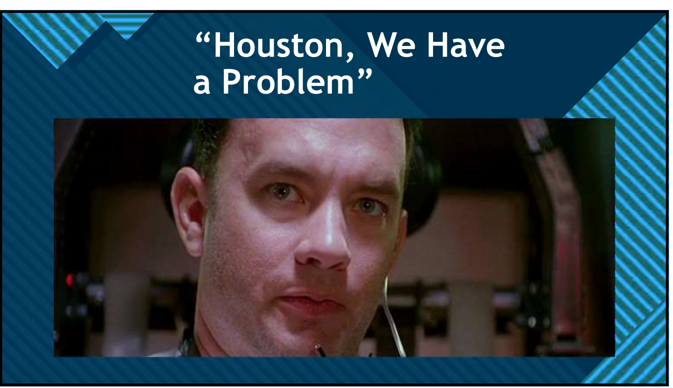

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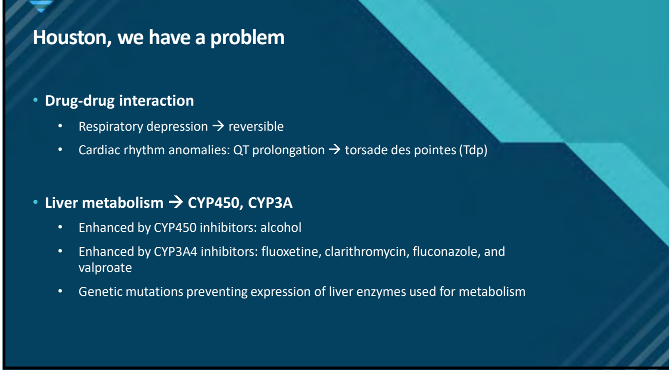

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Expecting the Unexpected

- **Short-term Side Effects**
  - sedation, dizziness, nausea, vomiting, constipation
- **Long-term Side Effects**
  - physical dependence, tolerance, and respiratory depression

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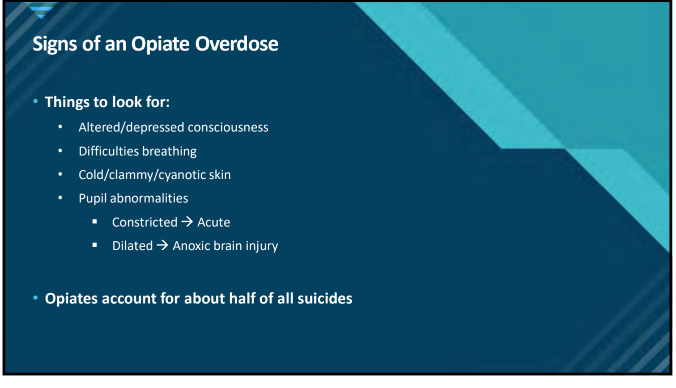

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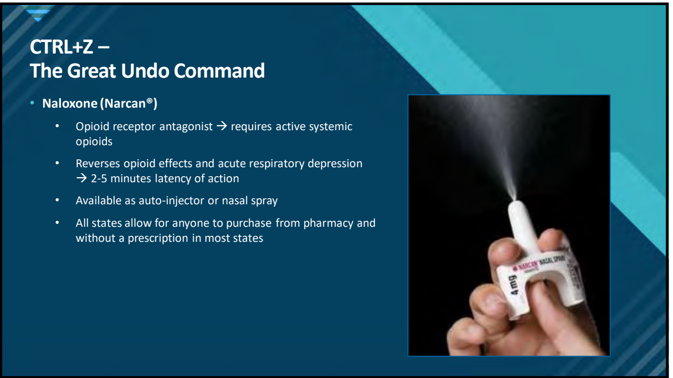

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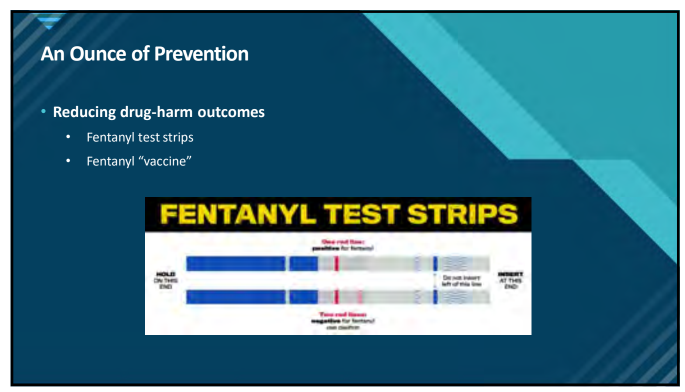

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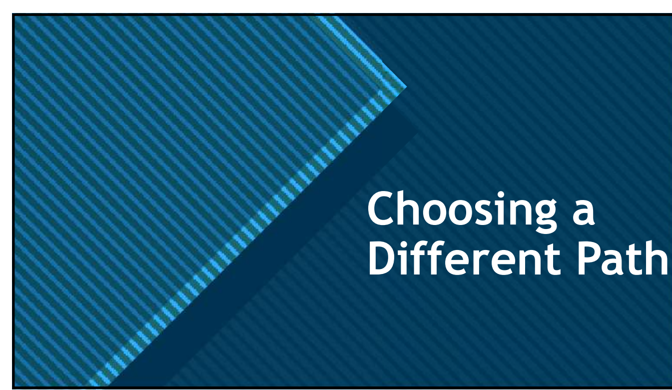

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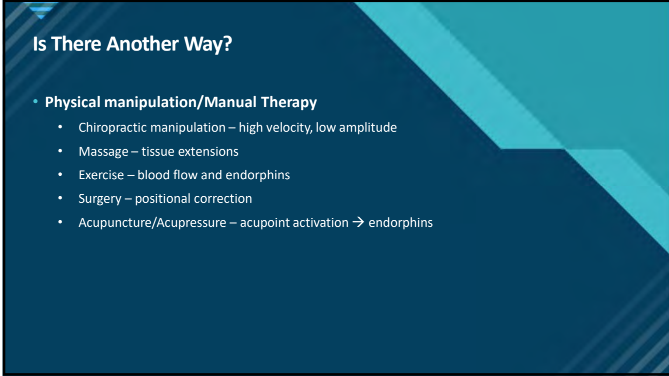

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And Does It Work?

- **Manual Manipulation → Neurophysiological results**
  - Interaction of inflammatory mediators and nociceptors
    - Decrease in cytokine concentration
    - Increase in serotonin and endorphins
  - Decreased cortical activity in pain centers of the brain

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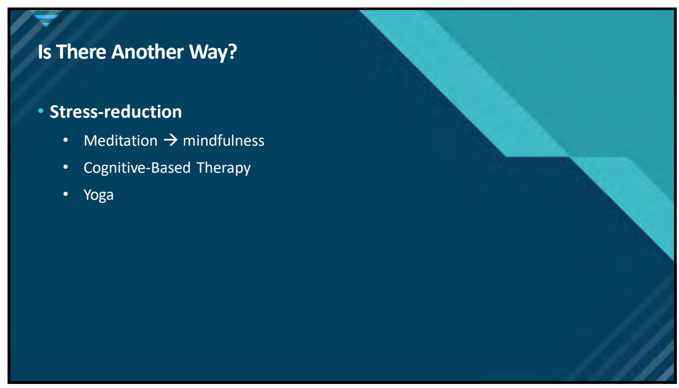

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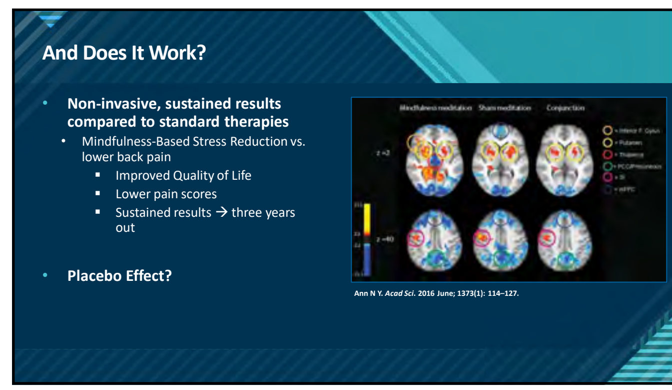

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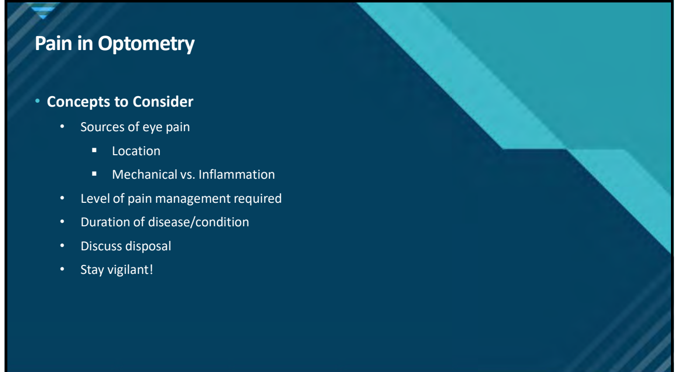

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Pain in Optometry

- **Common non-opiate options**
  - Medications
    - Corticosteroids
    - Topical/Oral NSAIDs
    - Immunomodulators
    - Acetominophen/Ibuprofen
  - Mechanical coverage
    - Bandage Contact Lens
    - Amniotic Membranes

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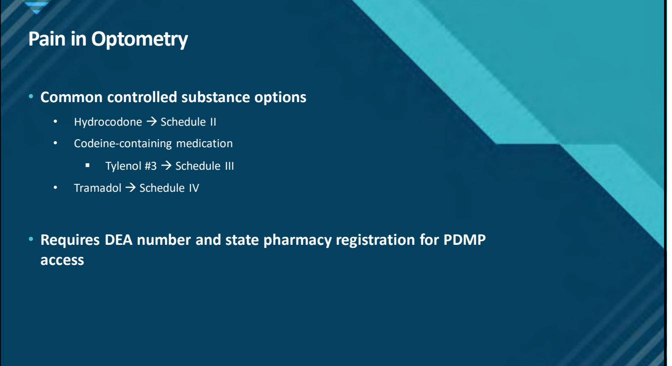

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Take Home Points

- **Understand and implement best practices:**
  - Risk-Benefit Analysis
  - Multimodal approach
  - Non-opiate options
- **How important is all of this?**
  - Over the course of this CE, 12 more Americans have died of an opioid-related overdose

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2024 Texas Professional Responsibility Course

UNIVERSITY OF HOUSTON COLLEGE OF OPTOMETRY
ANDREW KEMP, OD, FAAO
PRESENTER

Welcome to the 2024 Professional Responsibility Course sponsored by the University of Houston College of Optometry. As you know, this course is a requirement for Texas license holders. What you may not know is that ***all*** fees associated with this course are devoted to permanent projects that are important for ***the future of the profession***.

Thank you for choosing UHCO for your continuing education.

The development and production of the 2024 Professional Responsibility Course is underwritten by the Harris Lee Nussenblatt Lecture Series Endowment. This endowment was established in 1992 by the Nussenblatt Family in memory of former Associate Professor Harris Nussenblatt, OD. The Lecture Series focuses on issues related to professional ethics, public health and practice administration

The following activity planners and speaker have no relevant financial interests in this lecture:

Dr. Andrew Kemp, UHCO Speaker

Amanda Johnson, UHCO

Carlos Cole, UHCO

Cristian Loayza, UHCO

Lorellye Macomber, UHCO

Preface

The content of the Professional Responsibility Course is at the discretion of the Texas Optometry Board. This year, the Board set an aggressive agenda. **Some of the items are presented based on our knowledge of the subject matter as of January 1, 2024 and may change over the course of the year.**

Pay attention to any updates from TOB and TOA.

AGENDA – TEXAS OPTOMETRY BOARD

- Statutory address requirement
- CE Broker update
- CPR/BLS CE requirement
- Professional identification requirements (again…)
- Initial examination of a patient – in detail
- Remote care and initial examination of the patient – where are we?
- Review of HB1696 – Vision Plan Bill

Statutory Address Requirement
Tex.Occ.Code 351.351 – License Holder Information

(a) A license holder shall file with the board:
- *(1) the license holder's mailing address;*
- THIS WOULD BE YOUR PREFERRED MAILING ADDRESS
- **USED FOR COMMUNICATIONS FROM THE BOARD**
- *(2) the address of the license holder's residence;*
- WHERE YOU LIVE
- *(3) the mailing address of each office of the license holder; and*
- MAYBE LESS CLEAR – THIS REFERS TO THE MAILING ADDRESS OF THE OFFICE WHERE YOU PROVIDE PATIENT CARE TO TEXAS PATIENTS
- *(4) the address for the location of each office of the license holder that has an address different from the office's mailing address.*
- PHYSICAL ADDRESS OF THE OFFICE WHERE YOU PROVIDE PATIENT CARE TO TEXAS PATIENTS IF THAT ADDRESS IS DIFFERENT FROM THE MAILING ADDRESS
- **#3 AND #4 USED BY THE BOARD FOR INSPECTION PURPOSES**

This information would be included in your initial application for licensure. We are focusing on CHANGE to that information.

Statutory Address Requirement
Tex.Occ.Code 351.351

LICENSE HOLDER INFORMATION

THIS IS THE BIG ONE….because change happens!

(b) Not later than the 10th day after the date of a change in the information required to be filed with the board under Subsection (a), the license holder shall file with the board a written notice of the change

Some Specifics

- This includes **ALL** the information in the previous slide
- Special instructions related to short-term fill-in work (see next slide)
- Primary updates can be made directly at https://tob.texas.gov/optometrists/update-contact-information/
- To report secondary addresses, email to info@tob.Texas.gov

OK…what about the temporary thing

For licensees who are in an office routinely and provide ONLY fill-in (temporary) services

If you are in a particular office routinely, report that office as your primary business location

If you see patients at multiple locations in a given year, provide the location where **you see the MOST patients** as your primary location (update online) and supply other locations to the Board (by email) as described in the previous slide

If you are not in any office on a routine basis and see a minimal number of patients, report "No primary address – fill-in work only" in the business address field

NOTE FOR EVERYONE: The Board is actively reviewing all aspects of the inspection process they are mandated to make by Texas law. Look for notices in 2024 from the Board for any changes applicable to this information.

Statutory Address Requirement
Tex.Occ.Code 351.351

While this may seem like a minor issue, it is imperative that the Board be able to contact every license holder and know where they provide patient care.

Any failure to receive essential / legal information from the Board based on you not keeping contact information up to date is **TOTALLY on you** and there is no allowed excuse.

CE Broker – Deeper Dive

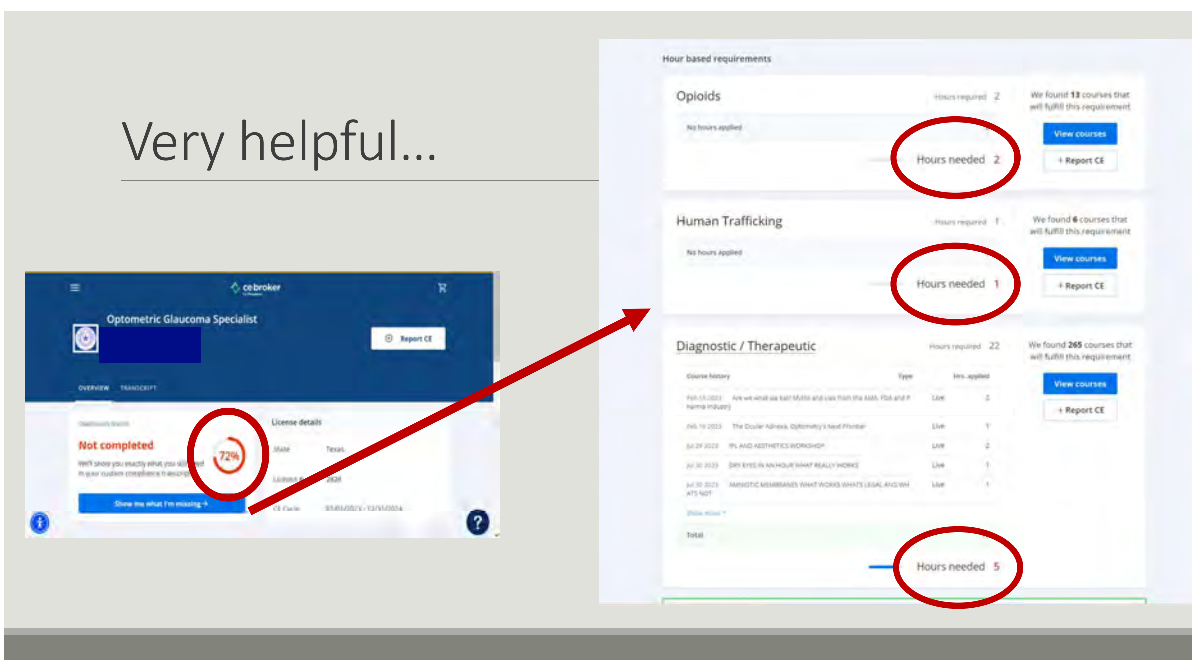
Key Points

- CE Broker is the official / only CE tracking system for the Board
- CE Broker Basic Account is FREE – you can sign up for an upgraded account ($39 a year) that provides more information, if you wish
- CE hours can ONLY be reported through CE Broker – **NOT the Board**

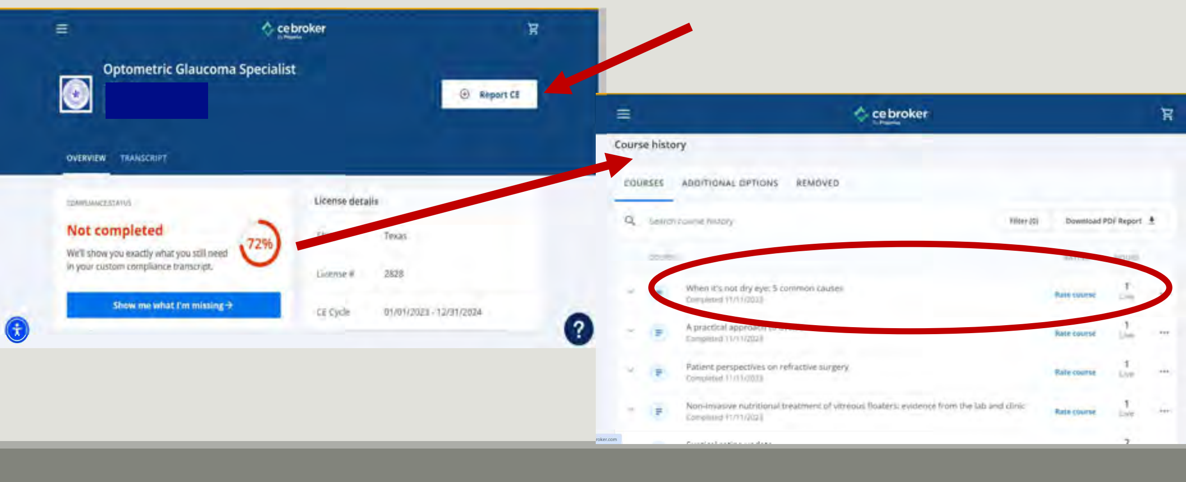
NOTE: **EVERYTHING** CE happens through CE Broker – do not call the Board asking about your hours, asking if a course is approved, asking to approve a course, etc. etc. etc.

CE Broker

- Everyone should already have a CE Broker account. For new grads or anyone who has never gone through renewal process, simply go to https://cebroker.com and create an account – VERY easy
- Knowing your CE is recorded with CE Broker is **YOUR** responsibility
  - Make sure any CE you expect credit for is going to be recorded with CE Broker **BY THE ENTITY PRESENTING THE CE**
  - You CAN upload CE to your account yourself – a somewhat painful process
  - **There is NO retro-active approval – CE must be approved BEFORE you attend**



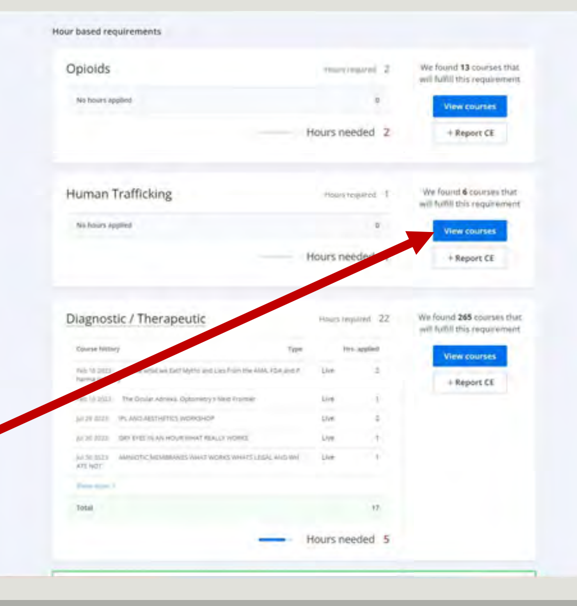
Once you get it, it's pretty cool…



More help…

CE Broker provides a "Course Search" feature (also free) to find courses needed to help with license renewal. Access at https://courses.cebroker.com/search/tx – select profession and search away! Or look on your account page

NOTE: These are all online courses – remember you are limited to 16 online credit hours per renewal cycle



Some of the features I showed are not available with the basic plan…here is a breakdown

BASIC PLAN – FREE

- ✓ Connect with TOB
- ✓ Complete course history
- ✓ Can report hours manually
- ✓ Check your status any time
- ✓ Take recommended courses

PROFESSIONAL PLAN - $39/YR

- ✓ Everything in Basic Plan
- ✓ Detailed view of missing compliance
- ✓ Details of when each requirement was met
- ✓ Can track multiple licenses
- ✓ Personalized compliance transcript
- ✓ Onsite storage of training certificates

CONCIERGE PLAN ALSO AVAILABLE…PRETTY PRICEY

CPR Requirements

Board Rule 273.17

Everyone who applied or renewed in 2023 had to have this…everyone applying or renewing in 2024 will have to provide this!

(a) Definitions.

(1) Cardiopulmonary resuscitation (CPR) is an emergency lifesaving procedure performed when the heart stops beating. A certification in CPR includes training and successful course completion in cardiopulmonary resuscitation, AED and obstructed airway procedures for all age groups according to recognized national standards.

(2) Basic Life Support (BLS) is a basic level of pre-hospital and inter-hospital emergency care and non-emergency medical services care. A certification in BLS includes training and successful course completion in airway management, cardiopulmonary resuscitation (CPR), control of shock and bleeding and splinting of fractures, according to recognized national standards.

(b) Requirement for Initial License. Commencing effective January 1, 2023, all applicants for initial licensure shall provide proof of successful completion of a CPR or BLS certification prior to receiving a license.

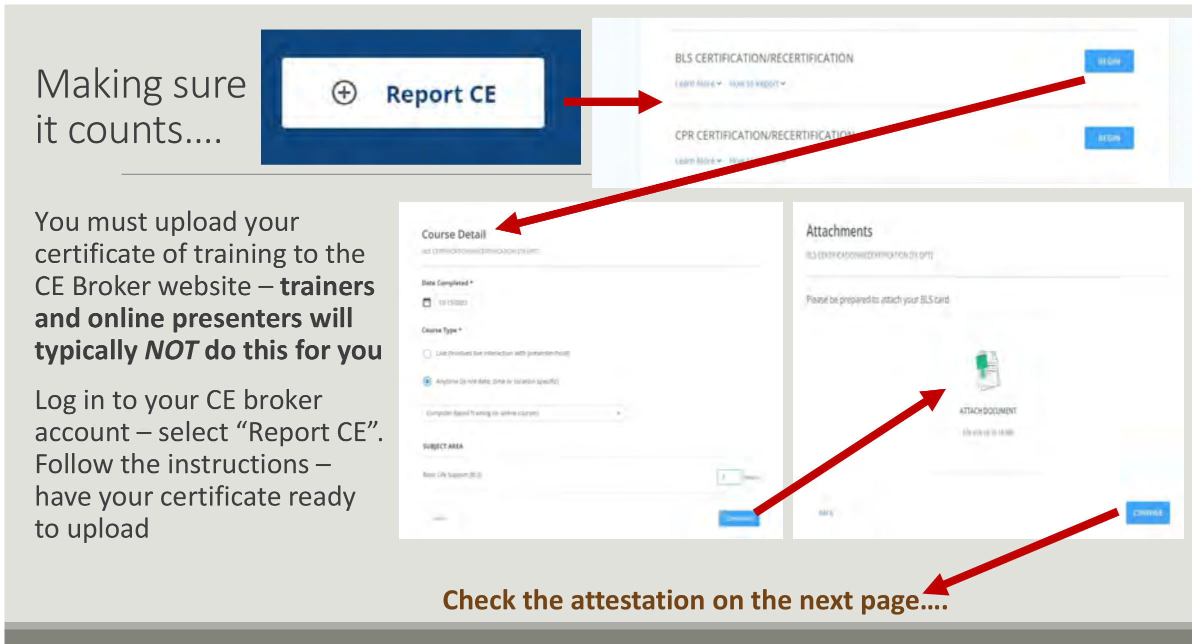
(c) Requirement for Renewal of License. Effective January 1, 2023, all active licensees shall provide proof of successful completion of a CPR or BLS certification for renewal of a license each renewal cycle. Licensees may be credited two general hours of continuing education for CPR certification and four general hours of continuing education for BLS certification.

CPR Requirements

Board Rule 273.17

Break it down….

- This requirement was established by Board Rule 2022 – required for all licensee renewals after January 1, 2023
- **CPR** is the basics and entry-level training – **BLS** offers more areas of training for emergency preparedness. Both are allowed for certification – BLS is more applicable to healthcare settings (opinion)
- Courses may be taken live or online – online courses can take less than an hour…advanced live courses can take 2-4 hours
- Courses are readily available – online, certified trainers, fire department, put a group together, extended staff meeting. NOT expensive!!!



Professional Identification

Same as seven other PR courses…

<u>Section 351.362 NAME OF PRACTICE</u>

(a) An optometrist or therapeutic optometrist may practice under a trade name, an assumed name, or the name of a professional corporation or association.

(b) An optometrist or therapeutic optometrist practicing in this state shall display the **<u>actual name</u>** under which the optometrist or therapeutic optometrist **<u>is licensed by the board</u>**, so that the name is visible to the public before entry into the optometrist's or therapeutic optometrist's office reception area.

Professional Identification

Same as seven other PR courses…

<u>Rule 279.10</u>

(a) To **protect the public health** and **provide a means for the patient to identify a licensee** in a complaint filed with the Board, §351.362 of the Act requires an optometrist or therapeutic optometrist to display the doctor's name so that the name is visible to the public before entry into the office reception area. This requirement does not apply to an optometrist or therapeutic optometrist practicing at a location on a temporary basis, as defined in subsection (b) of this section.

(b) Temporary basis is defined as the practice of optometry or therapeutic optometry at an office for no more than two consecutive months. For example, an optometrist or therapeutic optometrist practicing at a location one day per week during a three month period is not at that location on a temporary basis, and the doctor's name must be displayed as required in §351.362 of the Act.

(c) Section 351.458 of the Act prohibits the display of an optometrist or therapeutic optometrist's professional designation if the intent of the display is to mislead the public that the named optometrist or therapeutic optometrist owner regularly practices at that location. Therefore an optometrist or therapeutic optometrist practicing at an office in which the doctor has no ownership interest, must display the doctor's name as licensed by the Board, regardless of the percentage of time spent at that office, unless the doctor's practice meets the definition of temporary basis in subsection (b) of this section.

Professional Identification

Break it down…

This is a **STATE law** – Occupations Code 104. In effect since 1999.

Optometrists (me as an example) may identify as:

- Joe DeLoach, Optometrist
- Joe DeLoach, Therapeutic Optometrist
- Doctor Joe DeLoach, Optometrist
- Joe DeLoach, Doctor of Optometry
- Joe DeLoach, OD

Key Points

Intent of the law:

- Individuals cannot mislead the public regarding the licensure/credentials of a healthcare provider
- Doctors cannot mislead the public into thinking they **do or do not** practice at a particular location (cannot put name on door unless you practice there – including owners). **WORKS BOTH WAYS!**

Professional Identification

Key point..often misunderstood. ***"Temporary basis"***

Does not apply to practice at a location on a temporary basis – defined as the "practice of optometry or therapeutic optometry at an office for no more than two consecutive months". KEY WORD IS **CONSECUTIVE**

EXAMPLES

1. Doctor works at practice full or part-time for two or more consecutive months – NAME ON DOOR
2. Doctor works only one day every week for two or more consecutive months – NAME ON DOOR
3. Doctor fills in full or part-time for six weeks – NO requirement for name on door

Minimum Competency and Remote Eye Examinations

This information is current as of January 1, 2024. Various parties are involved in challenging the law and rules related to Section 351.353.

Information presented **IS** in effect at the time the course was written. It could change at any time.

If this directly applies to you, it is very important you stay aware of any potential changes in the information that will be forthcoming from the TOB, should/when they occur.

Section 351.353 – Initial Examination of Patient
Back to the beginning – 1956!

(formally adopted as law in 1969 after being upheld by the SCOTUS and only a few changes since then)

INITIAL EXAMINATION OF PATIENT.

To ensure adequate examination of a patient for whom an optometrist or therapeutic optometrist signs or **causes to be signed an ophthalmic lens prescription**, in the **initial examination of the patient** the optometrist or therapeutic optometrist shall make and record, **if possible**, the following findings concerning the patient's condition:

First three issues – #1

Causes to be signed an ophthalmic lens prescription

Minimum competency only applies if the examination results in issuing a glasses or contact lens prescription.

In many cases – how would you know beforehand?

Another thought….apply logic

Patient presents with medical emergency - new patient with a corneal ulcer from CL overwear and no glasses. Would this be a logical exemption from 351.353? Law is law and usually rigidly interpreted. You can only trust, and having been there I do, that your colleagues on the Board can understand when it doesn't apply (wouldn't recommend playing games here!).

First three issues – #2

Initial examination of a patient

Current interpretation is initial means the first complete eye examination you conduct on that patient (no specific time limitation like Medicare)

First three issues - #3

If possible

Intent IS - a unique situation results in not being able to perform the service.
- patient refuses autorefractor (or ***any*** element of the care)
- cannot perform tonometry because of uncontrollable nystagmus
- cannot adequately perform internal examination due to mature cataracts
- cannot perform biomicroscopy examination because patient is obese

Intent is NOT – the patient and the doctor just don't happen to be in the same place at the same time

KEY TO "NOT POSSIBLE" IS DOCUMENTING WHY!

And what is required? 1-5
With the addition of points from Rule 279.3

(1) case history - ocular, physical, occupational, and other pertinent information;
KEY POINT: "*Pertinent*" – left to the discretion of the provider
(2) visual acuity;
KEY POINT: Left to the discretion of the provider
(3) results of biomicroscopy examination, including lids, cornea, and sclera;
KEY POINT: Rules add "*using a binocular microscope*"
(4) the results of an internal ophthalmoscopic examination, including an examination of media and fundus;
KEY POINT: Rules add "*using an ophthalmoscope or biomicroscope with fundus condensing lenses*"
(5) the results of a static retinoscopy, O.D., O.S., or autorefractor;
KEY POINT: None – left to discretion of provider

And what is required? 6-10
With the addition of points from Rule 279.3

(6) subjective findings, far point and near point;
KEY POINT: None – left to the discretion of the provider
(7) assessment of binocular function;
KEY POINT: None – left to the discretion of the provider
(8) amplitude or range of accommodation;
KEY POINT: None – left to the discretion of the provider
(9) tonometry; and
KEY POINT: None – left to the discretion of the provider
(10) angle of vision, to right and to left.
KEY POINT: None – left to the discretion of the provider

Other "Key Points" – Rule 279.3

- The optometrist must "*personally make and record*"
  - Biomicroscopy (external) exam
  - Ophthalmoscopic (internal) exam
  - Subjective findings, far point and near point (refraction)
- The optometrist may either personally make and record or authorize an assistant present in the same office with the optometrist to make and record the remaining seven required findings
- **Videos and photographs do not fulfill the internal ophthalmoscopic examination requirement – *YOU MUST LOOK IN THE EYE WITH YOUR OWN TWO EYES!***

"*personally make and record*"

The current TOB interpretation of "*personally*" means the doctor performed the test. This rule IS currently in effect.

The board has submitted a rule change changing the language to "***in person***" – NOT in effect at the time this course was published. This would make it clear that the doctor is **IN THE ROOM WITH THE PATIENT**.

The terms "personally" or "in person" do not apply to telehealth services outside of the requirements of Section 351.353. The Board has an entire section on Rules related to telehealth services (Rule 279.16) – those rules do state that telehealth services must provide the **same level of care as an in-person visit.**

Few other points…

Section 351.359. Prescription. (a) *An ophthalmic prescription must include:*
(1) the signature of the optometrist or therapeutic optometrist…

UNLESS PRACTICING UNDER DELEGATION, THE DOCTOR WHO PERFORMED THE EXAMINATION MUST SIGN ANY PRESCRIPTION THAT IS THE RESULT OF THE EXAMINATION. THE BOARD POSITION IS THE DOCTOR THAT SIGNED THE PRESCRIPTION PROVIDED THE SERVICE AND IS RESPONSIBLE FOR COMPLIANCE WITH ALL ASPECTS OF 351.353.

Rule 279.2

(o) *an optometrist or therapeutic optometrist may not sign, or cause to be signed, an ophthalmic lens prescription without first personally examining the eyes for whom the prescription is made*

SELF-EXPLANATORY

The Penalty – Rule 279.3

*The willful or repeated failure or refusal of an optometrist or therapeutic optometrist to comply with any of the requirements in the Act, §351.353 and §351.359, shall be considered by the board to constitute **prima facie evidence that the licensee is unfit or incompetent by reason of negligence** within the meaning of the Act, §351.501(a)(2), and shall be sufficient **ground for the filing of charges to cancel, revoke, or suspend the license.** The charges shall state the specific instances in which it is alleged that the rule was not complied with. After the board has produced evidence of the omission of a finding required by §351.353, the **burden shifts to the licensee to establish that the making and recording of the findings was not possible.***

Are some optometrists exempt from all this?

Back to the Act – Section 351.005(a)(2) & (b)

(a) This chapter does not:

(2) prevent or interfere with the right of a physician licensed by the Texas Medical Board to:

(A) treat or prescribe for a patient; or

(B) direct or instruct a person under the physician's control, supervision, or direction to aid or attend to the needs of a patient according to the physician's specific direction, instruction, or prescription;

(b) A direction, instruction, or prescription described in Subsection (a)(2)(B) must be in writing if it is to be followed, performed, or fulfilled outside the physician's office

WOW…that is a bunch of words. Is it even possible to break this one down?

What is FACT.

A physician licensed to practice medicine in Texas under the Physicians Medical Practices Act has broad authority to *"delegate to a qualified and properly trained person acting under the physician's supervision any medical act that a reasonable and prudent physician would find within the scope of sound medical judgment to delegate…" (TOTALLY open ended!)*

When an optometrist is under delegation of a physician per the terms of Section 157.001 of the Medical Practices Act which means the physician signs the medical record and the prescription, the optometrist is operating under the PHYSICIAN'S license and IS NOT bound by the Texas Optometry Act. Refer back to Slide 32 – if you sign it, the service was provided by you and you are under the Texas Optometry Law and Board rules.

WOW…that is a bunch of words. Is it even possible to break this one down?

More FACT

Delegation is NOT the same as direction, instruction or prescription.

Optometrists simply employed by, contracted with (legally or illegally), under the direction of, or who receive a paycheck signed by a physician are NOT operating under delegation unless they have a written delegation order from the physician.

NOTE: Texas optometrists have NO legal delegation authority.

WOW…that is a bunch of words. Is it even possible to break this one down?

Sure…we can look to precedent issued in 2023 by a Texas Administrative Law Judge (ALJ) and resultant rulings adopted by the Texas Optometry Board.

Texas Optometry Board Conclusions

The Board has affirmed that licensees must comply with the Act even if acting under the direction of a medical doctor unless that direction is sufficiently specific, addressed to the optometrist, and aids the needs of the patient. If the optometrist signs the prescription, that licensee must comply with the required 10 findings under Section 351.353 during an initial examination when a prescription will be written **even if the examination is conducted in a remote setting**.

NOTE: The Judge ruling in the case concluded *"the optometrist and employer created the* ***'impossibility' of making the required 10 findings under Section 351.353 when they decided to operate remotely."***

What now?

What NOW is what the last two slides said!

What will happen going forward is in the hands of the courts, as the actions of the State and TOB are being challenged as not legal. The outcome of said challenge will likely take time. In the meantime, **the conclusions of the State ALJ and the TOB are IN FORCE.**

Stay tuned!

And last….

A review of HB1696 – the Vision Plan Bill. What it did, where it is and where it's going.

Let's Start With What It Did

- ✓ Prohibits plans from the identifying and tiering of in-network ODs based on discounts on non-covered services, amounts spent on products, or brands or sources of products utilized by the OD.
- ✓ Prohibits plans from steering patients towards any particular in-network OD, any retail location owned by or affiliated with the plan, or any internet site or virtual provider owned by or affiliated with the plan.
- ✓ Requires plans to provide direct, immediate, electronic access to complete in-network and out-of-network plan benefits to the patient and OD.
- ✓ Requires plans to accept standardized claim submission forms and processes, and reimburse doctors via electronic funds.

Let’s Start With What It Did

- ✓ Prohibits improper chargebacks to reimbursements when the plan is not supplying the materials (cost of goods) for a patient.
- ✓ Prohibits plans from calling services and products "covered" when the reimbursement amount to the OD is considered "de minimus" in nature. De minimis means of nominal or very small value.
- ✓ Prohibits plans from calling services and products as "covered" when zero reimbursement of the service or product comes from the plan to the OD.
- ✓ Prohibits plans from using or offering reimbursement rates that are different from another OD based on the OD's particular practice and business decisions, such as what lab they choose to use or what products they choose for a patient.
- ✓ Requires plans to give 90-day notice to any provider contract changes.

Let’s Start With What It Did

- ✓ Prohibits plans from requiring an OD provide a covered product or service at a loss.
- ✓ Prohibits plans from requiring that an OD receive reimbursement by a virtual credit card.
- ✓ Prohibits plans from requiring an OD to use any particular EHR.
- ✓ Prohibits plans from requiring an OD to use any particular clearinghouse or claim filing service.
- ✓ Prohibits plans from requiring unneeded and unrelated patient information to file a claim or receive reimbursement for a wellness eye exam, including glasses/contact lens prescriptions, unique anatomical measurements like PD, or facial photographs.
- ✓ Prohibits vision plans from using extrapolation as a method to complete an audit. This provision does not apply to medical plans.
- ✓ Requires that the provisions of the bill are to be enforced by the Texas Insurance Commissioner.

WOW!

So, what's going on now…

Several entities are doing everything in their power to stop this law from making changes in the system

- ☹ Restraining orders
- ☹ Injunctions
- ☹ Law suits
- ☹ Forcing contract renewals

THEY DO NOT LIKE WHAT THE STATE OF TEXAS DID!

When does this law change things? Some specifics

1. If you are under operating under a contract you signed or renewed prior to January 1, 2024, that contract is in force under the terms as written. WATCH FOR #2!!!

2. Any contract signed after January 1, 2024, renewed after January 1, 2024 **or CHANGED after January 1, 2024** – the conditions and terms of the new law are in **FULL FORCE**

WATCH FOR ANY NEW CONTRACT OR CHANGE IN YOUR CONTRACT – this will trigger all the stipulations under HB1696

So what should I do?

This law, in whatever form emerges from the legal war, is just like other practice enhancements – therapeutics, managed care plan access, telehealth. They are all resources / choices.

The TOB nor the TOA can tell you what decision to make or how conduct your practice inside the legal aspects of the law.

Each licensee ultimately has to decide how they interact and cooperate with vision plans, or all managed health plans for that matter.

TOA Has Stepped Up As A Significant Resource for Texas Optometrists

TOA managed care general resource webpage
https://texas.aoa.org/advocacy/managed-care-plan-laws-resources-for-texas-optometrists?sso=y

TOA partner law firm for managed care contract review:
https://texas.aoa.org/Affiliates/TX/Documents/Advocacy/2023/2023-24%20Enoch-Announcement-v4.pdf

TOA complaint submission form:
https://texas.aoa.org/advocacy/managed-care-plan-laws-resources-for-texas-optometrists/manage-care-plan-concerns-form?sso=y

TDI complaint webpage:
https://www.tdi.texas.gov/hprovider/providercompl.html

Thank you for your attention and have a great 2024

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Human Trafficking Training for Health Care Providers

Natalie Pirrone
Education and Outreach Director

Provided By The Poiema Foundation, ©2023

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Conflict of interest and disclosures

- The presenter has no financial relations with commercial interest(s) to disclose
- Statistics in this presentation should be viewed through a critical lens
- No standards currently exist for reporting human trafficking

Trigger warning:

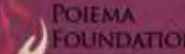
- Violence, sexual assault, and sexual abuse are discussed. This may be triggering or upsetting for some participants

2

Learning Objectives

Participants will:

1. Understand Human Trafficking as defined by the TVPA 2000.
2. Learn vulnerability factors for victims.
3. Learn how traffickers recruit victims.
4. Identify potential signs of human trafficking while providing services for patients.
5. Discover immediate health care needs of identified victims
6. Develop ability for a trauma-informed response
7. Identify who should participate in a multi-disciplinary care model
8. Learn about available resources for trafficking survivors' services



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Human Trafficking

Human trafficking is a modern form of slavery.

It involves selling another person's body or labor in exchange for something of value.

TVPA 2000-The United States Department of Justice generally classifies human trafficking into two major categories: sex trafficking and labor trafficking.

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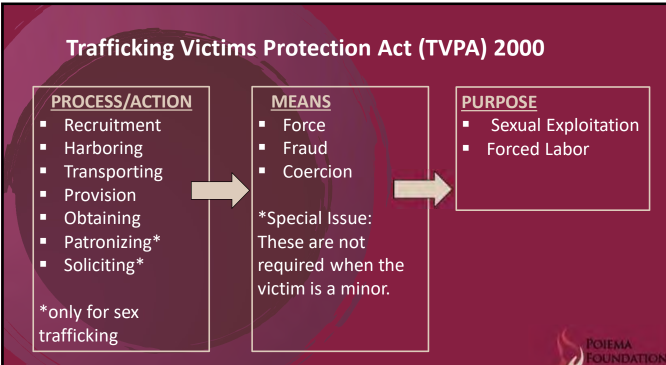

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Trafficking Vs. Smuggling

Trafficking

- ❖ Crime against a person
- ❖ Done without consent
- ❖ Exploitation; transportation not required
- ❖ No border crossing required

Smuggling

- ❖ Crime against a state
- ❖ Done with consent
- ❖ Requires transportation
- ❖ Must cross an international border

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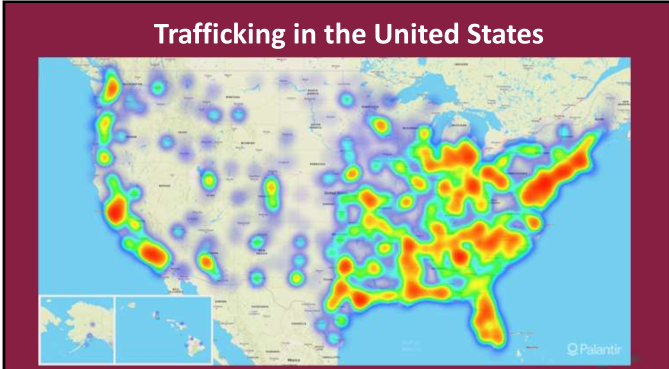

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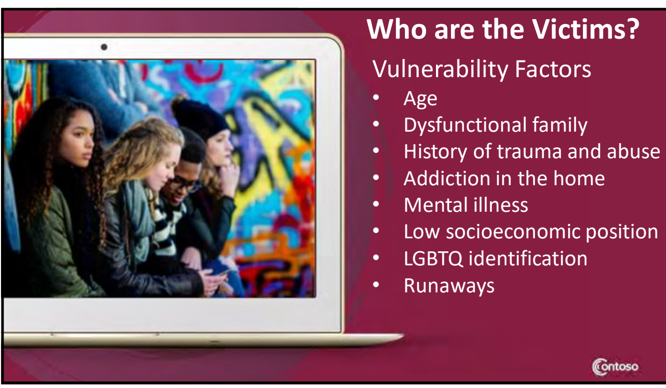

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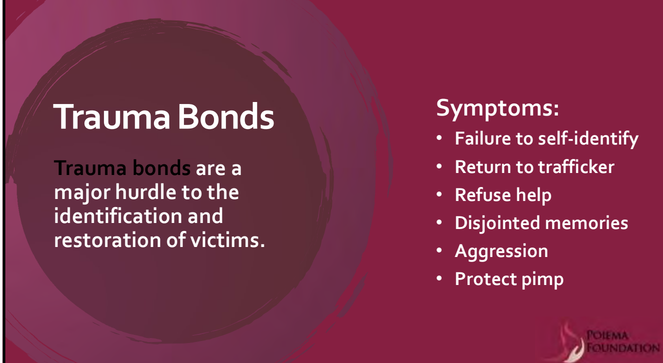

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Trauma

DISREGULATED NERVOUS SYSTEM

- Hyperarousal:

Anger, panic and phobias, irritability, hyperactivity, frequent crying and temper tantrums, nightmares and night terrors, regressive behavior, increase in clinging behavior, running away.

- Hypoarousal:

Daydreaming, inability to bond with others, inattention, forgetfulness, shyness.

Physical symptoms can include: eyes widen, pale skin, complaints of being cold, flat affect.

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Characteristics of "The Life"

Impact on Physical Health/Clinical Settings

- Malnutrition
- HIV/AIDS
- STD's
- Hepatitis
- Effects of drug abuse
- Pregnancy/abortions
- Broken bones/bruises
- Dental injuries/cavities
- Cigarette burns
- Head/face trauma
- Exhaustion/sleep depravation
- Skin Conditions
- Concussions, traumatic brain injuries
- High blood pressure
- Untreated diabetes
- Substance abuse

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Characteristics of "The Life"

Impact on Emotional/Behavioral Health

- Nervous/anxiety/panic attacks
- Depression
- Suicidal ideation
- Dissociation
- Avoids eye contact
- Unable to answer questions
- Substance abuse
- Complex PTSD

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Characteristics of "The Life"

Other Indicators of Trafficking:

- Inappropriate clothing for the weather
- Accompanied by an older, controlling boyfriend or woman
- The adult with them doesn't let them answer questions
- Lives in an overcrowded home
- Lives at their place of employment
- Has tattoos indicating ownership/branding
- Disorientation-doesn't know their address
- May have multiple hotel keys or cell phones

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Trauma Informed & Patient Centered Approach

If you suspect your patient is a victim of human trafficking:

- Build trust by asking permission before you do a procedure
- Explain what you are doing during the exam (oral/physical trauma)
- If possible, try to provide a space to speak privately with the patient
- Use your authority to separate the patient from anyone who may have accompanied them to the clinic
- Have protocol in place; limit the number of staff involved
- Safety is of primary importance for everyone; equip your staff to understand the importance of confidentiality

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Trauma Informed & Patient Centered Approach

If you suspect your patient is a victim of human trafficking:

- Use a professional interpreter if possible (It is tempting to use their family member, but this could be their trafficker or their manager)
- Strive to minimize re-traumatization
- Maintain a nonjudgmental attitude

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Trauma Informed & Patient Centered Approach

Questions you may ask a potential victim of human trafficking:

- What type of work do you do?
- What are your work hours?
- Are you being paid?
- Are you able to come and go as you please?
- Where do you eat and sleep?
- How many people stay there?
- Do you owe money to your employer?

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Trauma Informed & Patient Centered Approach

Questions you may ask a potential victim of human trafficking:

- Have you ever been asked to work in an environment that is unfair, unsafe, or dangerous?
- Do you feel pressure to do something you don't want to do?
- Have you been physically hurt?
- Has your family been threatened?

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Trauma Informed & Patient Centered Approach

If you suspect your patient is a victim of human trafficking:

- Provide the patient with options for services, reporting, and resources
- If the patient is in immediate, life-threatening danger, follow your institutional policies for reporting to law enforcement. Whenever possible, try to work with the patient in the decision to contact law enforcement.
- Don't make promises you cannot keep!
- Multidisciplinary approach

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Multidisciplinary Team

This team may include 3-5 people from different organizations such as:

- Law enforcement
- Attorneys/legal experts
- Anti-human trafficking nonprofits
- Human trafficking task force members
- Domestic violence/sexual assault programs
- Local shelters

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Mandatory Reporting

TEXAS LAW

Anyone who thinks a child, or person 65 years or older, or an adult with disabilities is being abused, neglected, or exploited must report it to DFPS.

Texas Department of Family and Protective Services

Report Abuse, Neglect, or Exploitation

Contact DFPS

Report Abuse

- By Phone: 1-800-252-5400
- Online: Texas Abuse Hotline

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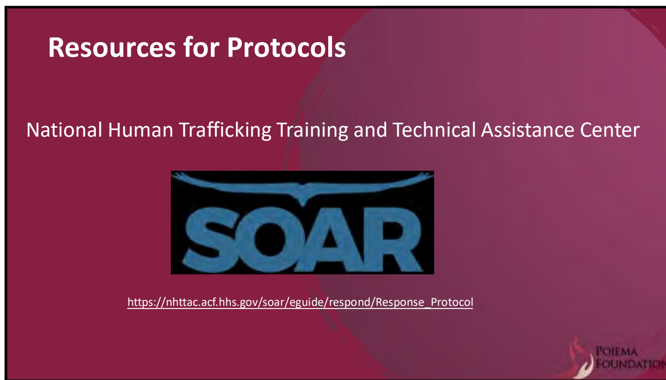

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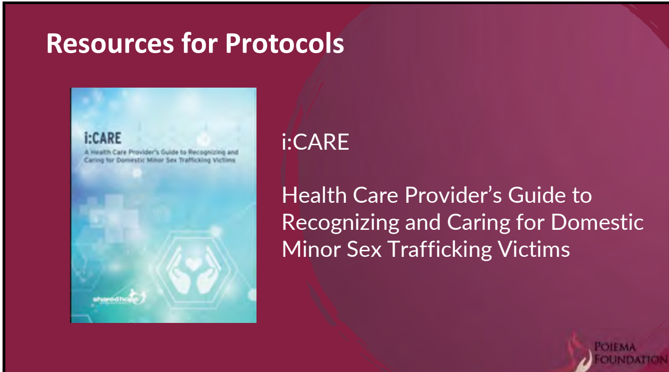

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National Human Trafficking Resource Center (NHTRC)

1-888-3737-888

email: NHTRC@PolarisProject.org

TOLL-FREE | 24 Hours/day, 7 Days/week

Confidential | Interpreters available

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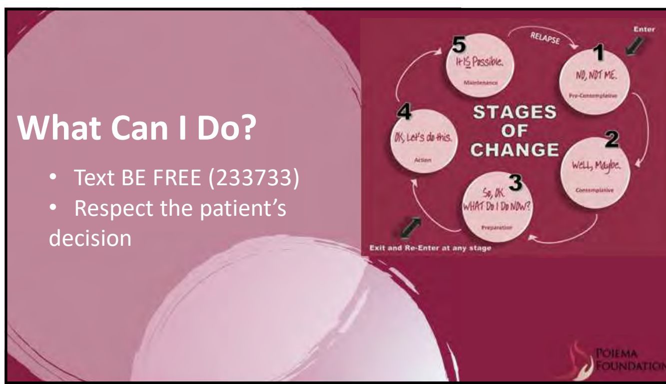

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