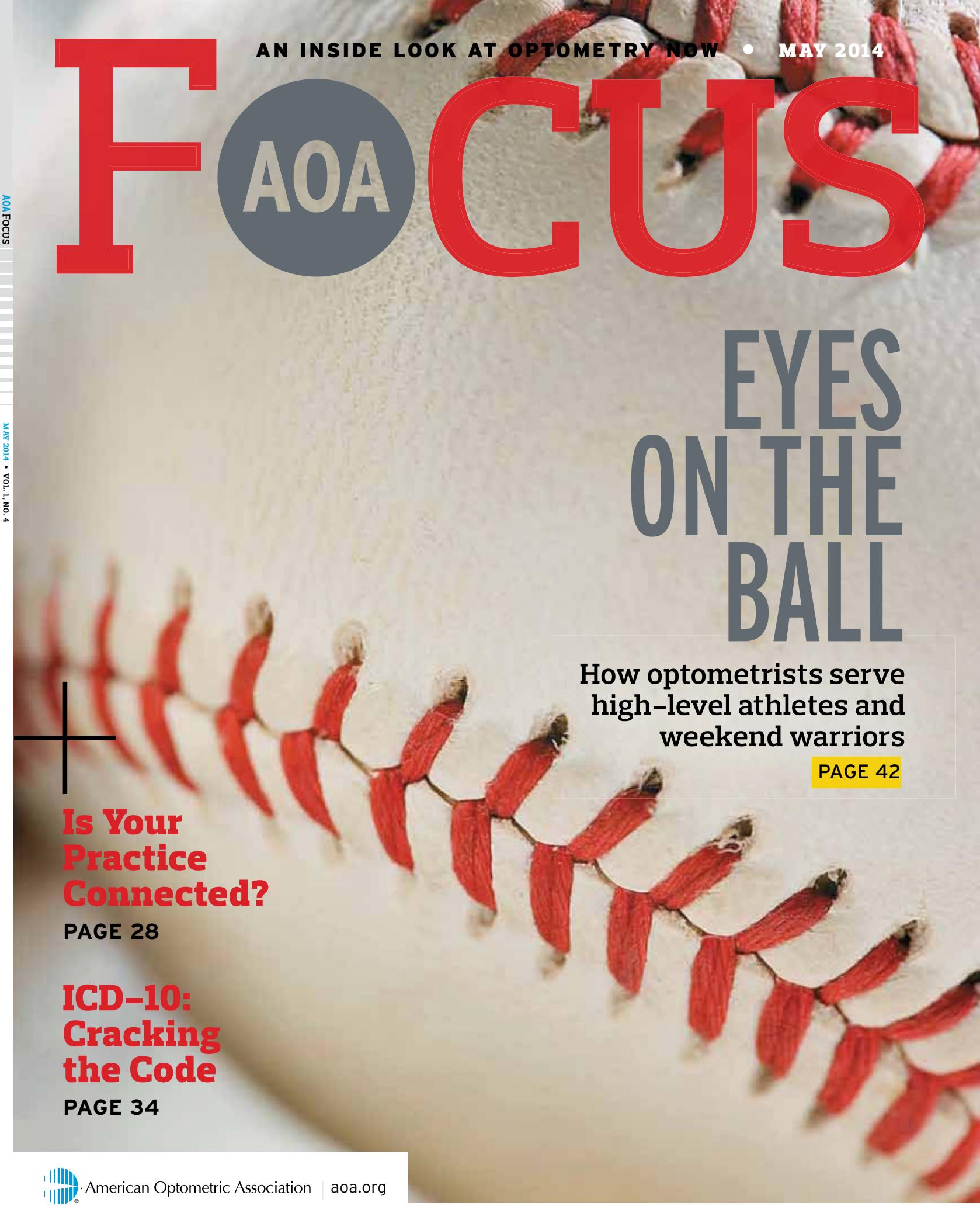


# FOCUS



AOA

EYES  
ON THE  
BALL

How optometrists serve  
high-level athletes and  
weekend warriors

PAGE 42

Is Your  
Practice  
Connected?

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ICD-10:  
Cracking  
the Code

PAGE 34



1-DAY ACUVUE® MOIST® Brand Contact Lenses for ASTIGMATISM  
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FOR ASTIGMATISM

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# FOCUS

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### > CORRECTION:

On page 45 of the April issue, the American Optometric Student Association's web address was listed incorrectly. The correct URL is [theaoa.org](http://theaoa.org). The editors of *AOA Focus* regret any confusion this error caused.

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# FOCUS

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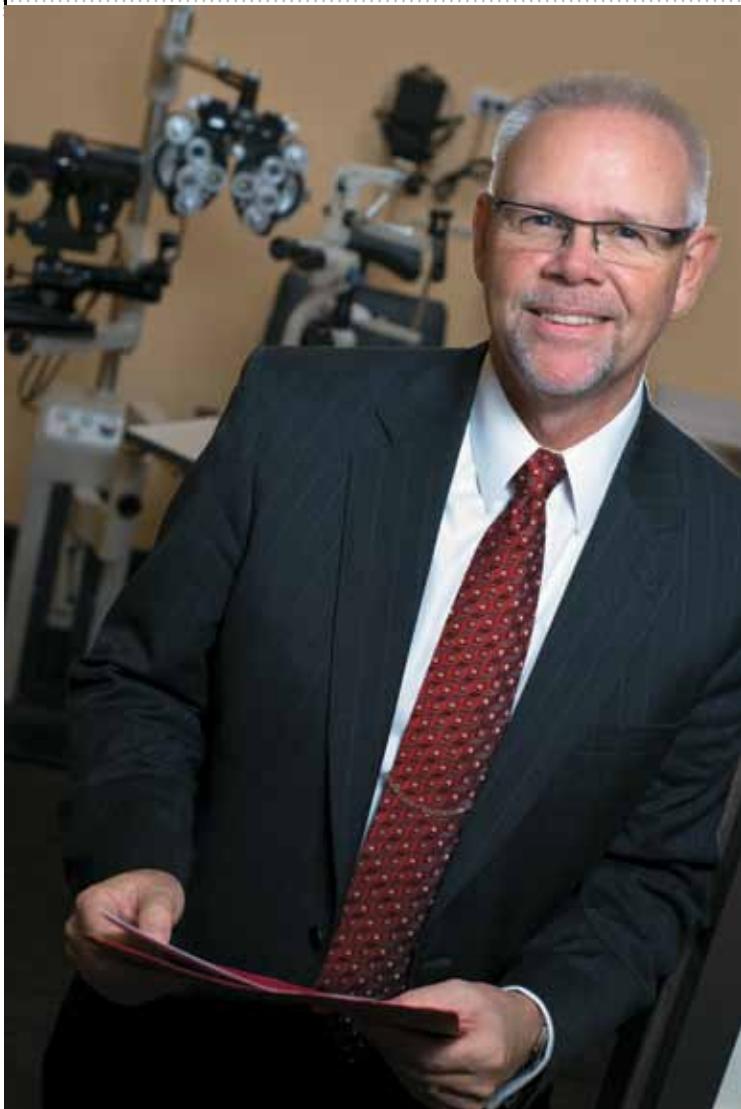
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## FROM THE PRESIDENT



Mitchell T.  
Munson, O.D.,  
AOA President

# THE NEW ERA OF HEALTH CARE

Is our profession ready for the changes that are coming?

**H**ealth information technology, Stage 2 meaningful use, ACOs, quality improvement, HIPAA compliance; all are buzzwords for the new age of health care, which is already upon us. While many health care professionals still exchange information by fax or emails, the constraints that will fall upon us to become secure and compliant will cause all of us to make significant changes in the way we store and transfer patient data.

Since the passage of the Affordable Care

Act (ACA) in 2010, we have now seen the creation of integrated delivery models, known as Accountable Care Organizations (ACOs), which will be tasked with providing "shared care" to patients to reap "shared savings." In order to provide coordinated care among the various providers, interconnectivity will become essential. And whether an optometrist chooses to remain independent or become part of an ACO, he or she must also adapt and become connected to this new world of compliant electronic information sharing—all in the

name of providing better quality of care and better patient outcomes.

The new focus on value-driven health care has even gone so far as to create "quality rankings" for health care providers.

The increasing demands for accountability and information technology have caused a sharp increase in the number of medical registries in recent years. A medical registry is defined as a systematic collection of a clearly defined set of health and demographic data for patients with specific health characteristics. While medical registries can be used as a resource for epidemiological research, they also will be used as a tool to monitor and improve the quality of care and, in some cases, allow providers to participate in government incentives that are tied to quality of care.

In light of the changes we have already seen, the foresight of the AOA to anticipate what the future of health care would look like for optometry has been remarkable. From the creation of the essential pediatric vision benefit to the ongoing efforts to build a registry for optometry and the recent creation of OcuHub by AOAEexcel™ to provide the necessary connectivity component for the exchange and storage of health information, our members need go no further than the AOA to stay informed, compliant and successful in this new era of health care reform.

# AOA NEWS

EYE CARE ADVANCES

## 4 PATIENT QUESTIONS ABOUT GOOGLE GLASS

**A**s Google Glass gears up for public release, optometrists studying the device are wondering: Will this negatively affect eyesight?

Glass is a small, wearable computer that uses an optical head-mounted screen to display a smartphone-like interface above the wearer's upper-right field of vision. Fitted to glasses frames, the device is activated through voice commands or head gestures.

Optometrists are concerned that Glass will cause computer-related eye strain symptoms, could increase dry eye, and might be difficult for presbyopes to use with the screen mounted close to the face—though the display is designed to appear as if it were about two feet away. Field of vision is another concern as the 1/4-inch arm of the device might obstruct parts of the vision field.

Bruce Morgan, O.D., professor at the Michigan College of Optometry at Ferris State University, and student Elyse Kleifgen are working with faculty to test the clinical and educational uses of Glass after Kleifgen was accepted into the Glass' Explorer beta test. She plans to see how her field of vision changes over time with use.

Lori Roberts, O.D., chair of the AOA New Technology Committee, is

also looking to test the device. Dr. Roberts signed up for an Explorer test, and should her bid be accepted, she plans to share the device with the committee for scrutiny. Although the committee doesn't endorse products, it could develop practice guidelines for members.

"We want to try [Google Glass] out, get our hands on them," Dr. Roberts says. "The more hands on them, the better."

As Google announces new prescription-lens-ready frames that are adaptable to Glass, optometrists likely will receive more questions about corrective lens availability. Here are four patient questions and how to answer them:

### 1. Can I drive while wearing Glass?

Just as you wouldn't text and drive, you shouldn't use the device while driving.

### 2. I have poor vision in my right eye. Can I wear Glass?

Optometrists who have used Glass say it's probably best to wear the screen over the dominant eye. However, Glass is only available with a right-eye-positioned screen.

### 3. I've been diagnosed with dry eye. Will Glass make it worse?

Looking up repeatedly to access the Glass screen could exacerbate dry eye, some optometrists speculate, but symptoms could be less pronounced with a glance as opposed to a prolonged stare.

### 4. Can you fit me with prescription lenses for Glass?

Currently, Glass is mounted to a specially designed frame with nonprescription lenses. However, Google announced prescription lenses may be fit to the frames with help from eye care providers.

—Heather Boerner

► See the Jan./Feb. *AOA Focus* to learn more. Visit [support.google.com/glass](http://support.google.com/glass) for FAQs about Glass.

HATTANAS KUNCHAI/SHUTTERSTOCK



INSIDE OPTOMETRY

# VISION PLAN REEVALUATES WEB PORTAL FOR ORDERING LENSES



**A** vision plan is rethinking its new online arrangement for ordering contact lenses after hearing concerns about the impact the system would have on optometrists.

Superior Vision's plans were set to roll out an online portal for ordering elective contact lenses by May 1. Under this system, ODs would no longer be able to fulfill contact lens orders that are covered by the Superior Vision benefit. ODs would receive a fee for fitting lenses, but they would not be able to sell lenses directly to patients, says Stephen Montaquila, O.D., chair of the AOA Third Party Center Executive Committee.

The change prompted a wholesale contact lens distributor to withdraw from its agreement with Superior Vision to fulfill lens orders. ABB Optical Group in a

statement says it never authorized or agreed to these specific terms.

"From what we saw, Superior was instituting a new policy that would have utilized a Web portal to fulfill covered contact lens orders. Essentially, this would have removed an OD's ability to sell any covered lenses to patients utilizing the portal," Dr. Montaquila says. "ODs voiced significant opposition to this. Concern was expressed about the impact that this policy change would have on their practices."

The news has national implications. It's an indicator of how plans are viewing their role and the overall delivery of vision care services.

Superior Vision recently merged with Block Vision. The merged company will cover more than 8.5 million members nationwide with a provider network surpassing 55,000 access points. —*Jennifer Lubell*

**"Essentially, this would have removed an OD's ability to sell any covered lenses to patients utilizing the portal."**

SEAN JUSTICE/THINKSTOCK

INSIDE OPTOMETRY

## NEW DIPLOMATES ANNOUNCED

**T**he American Board of Optometry (ABO) has announced 1,035 ODs as new Diplomates. In January, 1,112 doctors qualified to take the ABO's Board of Certification Examination. The 93.2 percent who passed the exam represent 49 states, two provinces in Canada, and Australia. The ODs will be added to the board-certified optometrist locator on the ABO website.

Registration is open for the next board certification exam, July 1–31, 2014, at Prometric Test Centers worldwide.

Visit [americanboardofoptometry.org](http://americanboardofoptometry.org) for more information.



99 TO 100%

The amount of UV-A and UV-B radiation sunglasses should block

PRACTICE MANAGEMENT

## EMPHASIZE UV AWARENESS WHEN RECOMMENDING SUNGLASSES

May is Ultraviolet Awareness Month, and as the days get longer and brighter, sunglasses become an essential accessory. Only 30 percent of Americans say UV protection is the most important factor when purchasing sunglasses, according to the AOA's 2014 American Eye-Q® Survey. That's why it's important to let patients know that your office is the best place to shop for shades.

The AOA, in partnership with the Opticians Association of America and with support from Luxottica and The Vision Council, created the SUN Initiative, a program that provides tools and free continuing education (CE) to help optometrists better inform patients about sun-related risks and guide sunglass purchasing decisions. Three CE courses—Protect, Prescribe, Present—are available online free to members. Here are some of those

tips on how to present outdoor eyewear to patients this summer—and boost revenue in your practice.

### Build on trust

Patients are trusting, loyal and more receptive to discussing the importance of your recommendations. When it comes to outdoor eyewear, patients become consumers who want to look as good as they are able to see.

- **Provide them with plenty** of stylish, fashionable eyewear options
- **Create a positive experience**, from reception to exam, and end with a purchase that satisfies

### Outshine the competition

Patients choose to purchase eyewear from their OD because they believe that he or she offers the best in care and products. To ensure a patient comes to you for quality, protective outdoor eyewear:

- **Provide a comfortable** and comprehensive retail experience
- **Make a strong case** for the importance of outdoor eyewear
- **Offer cost-effective lens** options and frame choices that treat all the visual needs your patients require—not just one aspect of their daily lives

### See to believe

Patients will quickly realize that their OD's office is the best place to buy sunglasses as long as the practice is presented that way.

- **Set up appealing displays** of your merchandise so patients know right away what options are available to them
- **Offer several forms** of information, whether in print or online, that can help them make a smart selection —Lesley Grissum

Visit [eyearn.aoa.org](http://eyearn.aoa.org) (member login required) for three courses—**Protect, Prescribe, Present**—available only to members. Purchase informational products to share with your patients through **AOA Marketplace**.

# NEW TOOL HELPS WITH HIPAA REVIEWS

**A** new tool helps ODs and other providers conduct risk reviews on protected patient information.

The Health Insurance Portability and Accountability Act (HIPAA) requires that certain “covered entities” do regular reviews or risk assessments on the safeguards they use to ensure the security of this information. ODs who transmit any information in an electronic format—such as transferring a claim to Medicare or other payers—are considered “covered entities” under HIPAA. A security risk assessment is also required of providers participating in the Medicare and Medicaid EHR Incentive programs. To assist smaller and medium-sized practices with these reviews, the U.S. Department of Health and Human Services (HHS) recently released a new security risk assessment (SRA) tool.

The tool takes providers through each of HIPAA’s requirements, asking more than 150 questions. According to the SRA’s website, a “yes” or “no” answer will indicate if a provider needs to take corrective action on a particular requirement. A risk assessment helps avoid potential breaches in patient health data and other adverse security situations by detecting vulnerabilities in a provider’s security system or policies. Providers can apply for the tool online, and there is no charge to apply or use it.

Not many ODs fully understand the significance of risk assessment—or where to start.

Jason Miller, O.D., a partner in a three-doctor private practice in Powell, Ohio, sees the tool as a positive development. Dr. Miller has consulted with the AOA as one of the “Coding Experts” on coding and medical records concerns and HIPAA issues.

Not many ODs fully understand the significance of risk assessment—or know where to start, he observes. “Many believe a breach will never happen to them.” In his view, educational tools and online resources could help save ODs some time and make the process easier to figure out. The SRA website specifically offers tutorial videos and a user guide for providers.

With so many offices adding computers and changing companies they do business with each year to comply with meaningful use certification of EHR requirements, “this SRA needs to be evaluated and continually tested to ensure our patient’s data is protected at the highest level,” he says.

Doctors have been grappling with the need to have a record of completing an SRA in the event they get audited. The tool helps solve this issue by producing a report that can be given to auditors.  
— Jennifer Lubell

**Apply for the tool online at [healthit.gov/providers-professionals/security-risk-assessment](http://healthit.gov/providers-professionals/security-risk-assessment).**



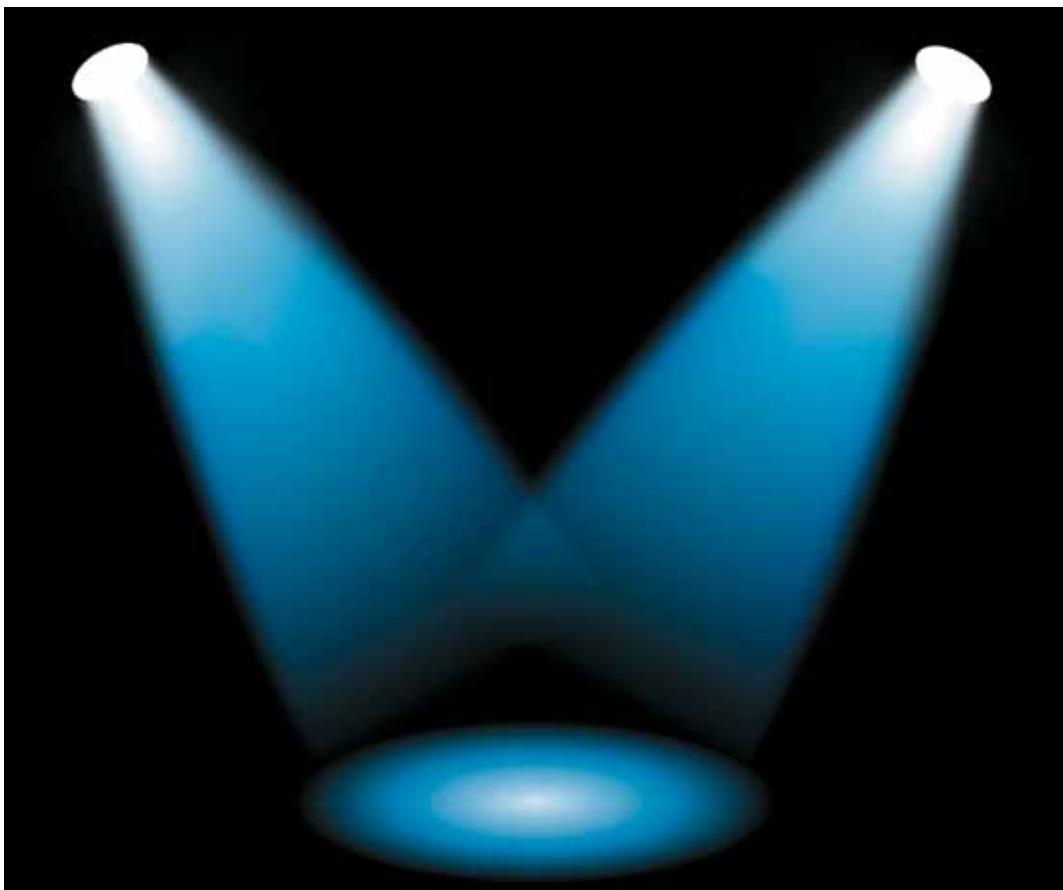
## ADVOCACY

### What the “Sunshine Act” Means for Your Practice

The “Sunshine Act” is shining a light on transparency in industry-doctor relations—and optometrists have an important role to play.

The Affordable Care Act authorized Sunshine Act rules to make the public aware of any financial transactions taking place among certain members of the health care industry. The Centers for Medicaid and Medicare Services (CMS) is

**“It certainly behooves ODs to review what’s being made available to the public.”**



overseeing this “Open Payments” reporting system.

Any gifts, payments or other transfers of value made to physicians (including ODs) and teaching hospitals by the manufacturers of pharmaceuticals, medical devices and medical supplies now require public reporting.

Certain Group Purchasing Organizations (GPOs) must report ownerships or investments held by physicians or their immediate family, in addition to payments and other transfers of value from the GPO to a physician with an ownership or investment interest in the GPO.

The goal is to inform the public of potential conflicts of interest, says Chris Wroten, O.D., a member of the AOA’s Federal Relations Committee.

The burden of tracking and reporting falls on manufacturers or GPOs. But ODs and other physicians have the opportunity to review and correct any information in these reports about gifts or payments they received.

ODs in these situations would most often be dealing with manufacturers, but some will be affected by GPOs—and not be aware of it, Dr. Wroten says.

# ON THE HILL

## 1. Why you should get proactive

Patients and the general public will be able to view these reports.

"If there's been a legitimate transfer of value of a significant amount, the appearance could be that there's some form of external influence on the doctor's decision-making," Dr. Wroten notes. "It certainly behooves ODs to review what's being made available to the public and to their own patients to ensure its accuracy and address any concerns."

## 2. What can be reported—and when

"Transfers of value" can take many forms. They may include lunches a pharmaceutical or contact lens company holds in an OD's office for staff or certain continuing education events sponsored by manufacturers. Other transactions may involve travel expenses, charitable contributions from industry, food and beverages, consulting fees and speaker honoraria. Gifts under \$10 are not reportable, Dr. Wroten says.

CMS required manufacturers to begin collecting data Aug. 1, 2013. They must report their data to CMS annually by March 31 of each calendar year. The first group of reports under the Open Payments program are scheduled to be available to the public on CMS's website on Sept. 30, 2014.

## 3. How to find out if you're in a report

CMS is anticipating a 45-day

window for practitioners to review reports for accuracy. This window will occur after reports have been posted for review but before they go public.

The AOA has been encouraging ODs to register with CMS's Enterprise Portal. Doing so will allow them to receive electronic notifications when relevant data has been posted for review. The alternative is to manually check the CMS website, but that comes with a risk of missing the review period, Dr. Wroten cautions.

## 4. How to change errors

If there's a discrepancy between transfers of value and what has been reported, an OD must contact the manufacturer involved to correct the error. That manufacturer will then need to amend its report to CMS.

For example, if an OD lectures on behalf of a pharmaceutical company or contact lens manufacturer, the value transferred in the form of honoraria, travel or other related expenses is reportable. If the manufacturer over-reports what was actually paid, the OD should inform the manufacturer of the error.

Ultimately, it's up to the two parties to discuss and resolve any discrepancies, Dr. Wroten says.

—Jennifer Lubell

► Get helpful advice in "Sunshine Act: Impact on Optometry" at [aoa.org/sunshine-act](http://aoa.org/sunshine-act). Sign up for notifications on the CMS portal at [1.usa.gov/1mICUuw](http://1.usa.gov/1mICUuw).

## ODs: Make Your Voice Heard About Narrow Networks

> The National Association of Insurance Commissioners (NAIC), at its annual meeting at the end of March, conducted an initial review of its model law to ensure networks offer enough choices for consumers. In the wake of the Affordable Care Act, insurers have been trending toward narrower networks, shutting ODs out of limited networks and limiting access to patients. If the NAIC—which sets policy for insurance commissioners—reverses the trend on narrow networks, it could open up more choices for both ODs and patients. The AOA encourages members to contact their respective state insurance commissioners and health reform task forces about supporting the broadening of networks.

## AOA Warns Public about Online Eye Exams

> The AOA is warning consumers about possible risks associated with online refractive eye exams. In a statement, AOA President Mitchell T. Munson, O.D., said the association has received an increasing number of questions about the safety and validity of this type of online test. The AOA contends that such tests are no substitute for an in-person comprehensive eye exam by an optometrist or ophthalmologist. The AOA is calling for a thorough evaluation of online eye-testing sites, and how they might affect patient health, and also plans to monitor these sites and play an active role in fact-checking their claims.

## Get Answers to Your Questions on ACA Implementation

> In April, the AOA's Third Party Center (TPC) hosted a webinar on Affordable Care Act implementation. "ACA Implementation—The First 100 Days—Implications for ODs" is now available to members online. ODs can get the latest information on issues the AOA has been working on since last September's combined Super Advocacy Meeting in Washington, D.C., including narrow provider networks, the current status of the Harkin law and how it can be enforced, and what health and vision plans are doing in response to ACA implementation. The webinar is a follow-up to one the TPC hosted in December 2013, which attracted 400 members and discussed ACA implementation and coverage expansion opportunities for ODs. View it at [aoa.org/ACA100days](http://aoa.org/ACA100days) (member login required).



## HEALTH CARE REFORM

# A Tale of “Meaningful Use” in Two Cities

Where an optometrist lives can determine how easy—or challenging—it is to comply with “meaningful use” electronic health record (EHR) requirements. For example, access to support and bandwidth may vary based on location.

### The rural OD

Roger Jordan, O.D., who practices in Gillette, Wyo., knows the challenges ODs face in remote, rural areas.

Dr. Jordan, who chairs the AOA’s Federal Relations Committee, foresees problems for doctors in areas without ready access to IT support companies to help prepare their office for compliance. Although he personally has more than one health IT vendor for support, ODs in smaller towns around the state may not.

“Unless you’re very computer-based, it’s very difficult to do on your own as an office,” he observes.

Even in Dr. Jordan’s hometown of Gillette, not a small town by Wyoming’s standards, staying up-to-date has its difficulties—especially

with respect to cost, upgrades and IT support. For example, his practice’s system uses a standard server, which is more expensive to maintain than a cloud-based system.

His office has met meaningful use requirements. However, he notes a challenge: “There’s one Internet line to the whole city, and if that goes down, I go down, too.”

The federal government has taken steps to ease the burden of compliance in Medicare’s EHR Incentive Program. For example, ODs who face barriers can apply for certain exceptions this July to avoid penalties in 2015. The CMS lists a number of circumstances for hardship exceptions. Eligible providers might live in remote areas and lack sufficient access to the Internet. Or they could face vendor certification issues. EHRs need to be certified for the Medicare incentives program.

### The urban OD

Some ODs in urban areas, where Internet access is plentiful, haven’t

needed such exceptions.

“I have to say I’m one of the success stories of meaningful use,” says Gregory Foley, O.D., who practices in Washington, D.C., and has taken on the task of compliance in his office.

The practice just finished year two in Stage 1 meaningful use. Dr. Foley says meeting requirements wasn’t that difficult, but it did require diligent upkeep.

“A lot of the software companies have a reporting system that lists all of the meaningful use requirements,” he says. “You can populate those reports as you go along for each of the doctors, to make sure those counts are correct for each of the items that you need.”

That’s where the upkeep comes into play. Dr. Foley regularly runs reports and informs the other ODs in his practice of what they need to do to meet meaningful use quotas. Without such diligence, “it would have been a disaster,” Dr. Foley says.

### Gearing up for Stage 2

Dr. Foley admits he’s more concerned about meeting Stage 2 requirements, which include digital communication with patients.

“Most software companies are still working on a version of software to meet a lot of the requirements for Stage 2,” he observes.

As part of Stage 2, ODs must make a portal available to patients so they can access their medical records. Whether they live and work in Gillette or Washington, D.C., “I think that’s going to be a huge challenge for ODs across the country,” Dr. Jordan says.

—Jennifer Lubell

► Get resources to tackle meaningful use at [aoa.org/ehr-meaningful-use](http://aoa.org/ehr-meaningful-use) (member login required).

## ADVOCACY

# Georgia OD Fights for Patient Relationships

**G**eorgia optometrist Steven Wilson, O.D., had a simple reason to go several rounds with a vision plan in state court: preserving longtime patient relationships.

Dr. Wilson's case arose several years ago when Spectera Eyecare Networks, part of UnitedHealthCare (UHC), revised its contract with independent ODs. The revision required use of its own optical labs to provide eye care services and materials to covered patients. Previously, ODs had been allowed to use their own optical labs or those from other sources to provide services and materials.

Dr. Wilson, and colleagues at Wilson Eye Center in Valdosta, Ga., sued the vision plan. They alleged that Spectera's actions violated the state's Patient Access to Eye Care Act. The law states that insurers can't preclude covered patients from seeking eye care services directly from a licensed provider who's on the insurer's network.

*Spectera, Inc. v. Wilson et al.* eventually made its way to the Georgia Supreme Court. In state court documents, Spectera said the new agreement was "more cost-effective for its insureds who seek eye care from independent eye care providers."

However, according to the high court's interpretation, Spectera could not force ODs to use its labs exclusively. In an interview, Dr. Wilson discusses the decision's impact on vision plan policies in Georgia, and why he sees this as a win for optometry.

**In 2010, Spectera terminated its former contract—known as a "Patriot contract"—with this new agreement requiring that you obtain eye care services and materials from the plan's lab. How was this going to affect your business?**

The Patriot contract allowed me to prepare lenses, eyeglasses and contact lenses directly for the patient. This is how we operated from 1986 until the new contract was sent out to all providers in the United States. It wasn't just in the state of Georgia.

At the time, Spectera had the state employee contract. There were more than 78,000 enrollees in the state of Georgia under UHC, and over 50 percent were taking out the Spectera vision insurance. We have a small university here, a prison, teachers in the public school system, and other state employees. They'd been patients of mine since the 1980s. I had a relationship with them.

I knew if I dropped out of the program due to the fact that I didn't want the new contract that precluded me from preparing eyeglasses and contact lenses, I'd lose them. This was never

"This was never an issue of money. It was about service—I wanted to have control over that service."

an issue of money. It was about service—I wanted to have control over that service.

### What was your main argument?

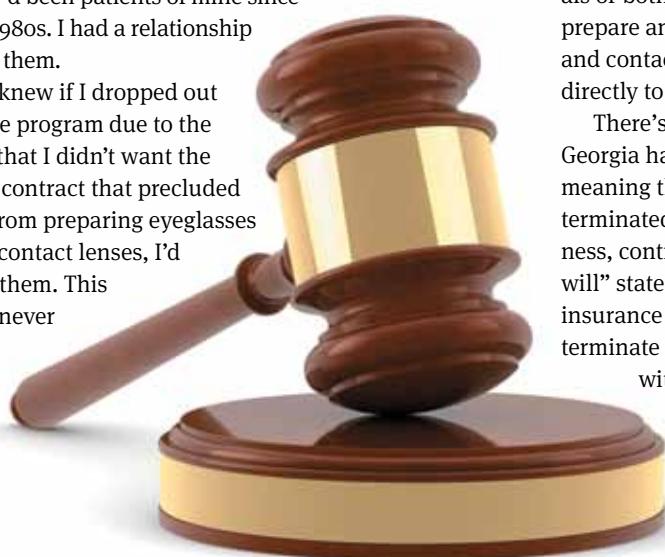
Let's say that UHC opened a glaucoma clinic in Atlanta and said to all UHC providers, "You can see the patient for the exam, but if you think they have glaucoma, you can no longer do visual fields, OCT [Optical Coherence Tomography], etc. You're going to be required under this new contract to send them to UHC's glaucoma clinic in downtown Atlanta. We're going to provide that eye care service."

That's against [state] law because that would be precluding the patient from getting eye care service—i.e., glaucoma testing—directly from the provider.

### What important outcomes came out of this ruling?

As a result of this litigation, all insurance companies in the state of Georgia have complied with the Supreme Court ruling. They have amended their contracts or manuals or both to allow a provider to prepare and supply eyeglasses and contact lenses from their lab directly to the patient.

There's another important part. Georgia has been an "at will" state, meaning that anybody can be terminated without cause in business, contracts, etc. It's now an "at will" state with an asterisk to it. An insurance company can no longer terminate an eye care provider without cause. [Spectera] tried to do that to us three times in the case, but the judges didn't want to be a part of it. —Jennifer Lubell



SUCCESS STORY

# ACTIVE-DUTY OD

**Navy Cmdr. Margaret**

**"Marrie" Read, O.D.,**

stationed at Naval Health Clinic Quantico in Virginia, talks service to her country and the profession through the Armed Forces Optometric Society (AFOS).

## JOINT TASK FORCE

"AFOS links us back to AOA and issues optometry as a whole is facing. Sometimes we become very immersed in our federal service optometry, but AOA helps keep us connected back to the big picture. AOA has been very supportive of AFOS and its members."

## NOT YOUR EVERYDAY JOB

Advice for aspiring AFOS ODs: "When you join, you don't have to commit to a 20-year career because that's not for everyone. But take advantage of the three- to four-year commitment and experience as much as possible. If you only do a tour, you still served your country and learned a great deal along the way. You might find you love it and 20 years later wonder where all the time went."

## BROAD HORIZONS

"The Armed Forces opens the door to a variety of experiences. We're able to practice full-scope optometry at duty stations all over the world, including humanitarian missions and deployments. We have the opportunity to receive extra training through residencies and programs such as aerospace optometry. As active-duty optometrists, we have the opportunity to be a part of something bigger than ourselves."

PHOTOGRAPH BY SUSANA RAAB



# Doctors may now enroll staff as AOA associate members

All non-ODs working for AOA member ODs may now become AOA associate members at no cost.

Among the many benefits of membership to help unlock your optometric staff's potential are:

- Online continuing education (CE)
- Billing and coding training
- Access to member-only web pages
- Discounted fees for paraoptometric education materials
- Reduced registration fees for Optometry's Meeting®

## To enroll staff:

**Visit [www.aoa.org/enroll-my-staff](http://www.aoa.org/enroll-my-staff)**

(You will need your AOA OD member ID and password to enroll staff)

## For questions or assistance:

**Paraoptometric Resource Center**

**prc@aoa.org**

**or call 800-365-2219, ext. 4108**



Q&A

## VISION FOR THE UNDERSERVED

### ZAKIYA NICKS, O.D.

Through HEHP grants, Zakiya Nicks, O.D., leads outreach for those who go without eye care.

Zakiya Nicks, O.D., wants more children in underserved communities in her native city of Memphis, Tenn., to get eye exams. And she doesn't want the homeless people who live in the streets to go without glasses. Better vision could help them get a job and a new lease on life.

To help in both cases, Dr. Nicks coordinates community outreach programs at The Eye Center at Southern College of Optometry. For example, she oversees "Project Homeless Connect: Focus on Vision Care," which serves the homeless in Memphis and Shelby county.

One tool she has found effective in extending her reach is the Healthy Eyes Healthy People® State Association Grant (HEHP), a program of Optometry Cares®—the AOA Foundation and the AOA.

HEHP grants seek more comprehensive approaches to the vision and eye health care needs of the American population. AOA members have been encouraged to use these grants to help improve vision

PHOTOGRAPH BY TREY CLARK

care in community settings.

The Project Homeless program, which received a \$4,000 HEHP grant in 2013, aims to improve access to comprehensive eye health and vision care so that homeless individuals can get the services they need for uncorrected vision problems. To date, the program through various events has administered 341 eye exams, dispensed 110 reading glasses and ordered 176 prescription glasses.

Recently, Dr. Nicks applied for another HEHP grant to help fund the “See to Read” vision awareness program in Memphis. It is a joint project of the Southern College of Optometry and the Memphis Public Library and Information Center. Through interactive educational events, the program aims to increase the number of children in high-poverty areas who get eye exams from an OD.

In an interview with *AOA Focus*, Dr. Nicks discusses the instant rewards that come from giving a homeless person a new pair of glasses, and how a day at the zoo can teach children new things about their vision.

### What's the biggest challenge in treating the homeless through the Project Homeless Connect Program?

There are different reasons why someone may be homeless. Someone might not be able to get a job because they can't see. Proper eye care could change their situation.

At these events, we set up a vision area and we actually deliver eye care there. At the end of the event, if we decide someone needs glasses, we have reading glasses

that are donated, as well as optical fitting for some types of prescription glasses.

We're able to give them a pair of reading glasses on the spot. They put them on and realize they can actually see at that point. That's one of the biggest rewards. That gives them instant gratification.

### Why do so many children in underserved areas go without proper vision care?

A lot of times it's just a lack of education. A lot of them just don't realize the importance of the eye exam. Parents are not aware that a child may not be performing well in school or has behavioral problems. They don't have the attention span to sit there because they don't see the same thing another child may see. If a parent has never had to wear glasses before, they're just not aware of it.

### An HEHP grant helped fund another children's program, "Eye Spy: A Day at the Zoo." Tell us about the program.

We've partnered with the Memphis Zoo to host vision-related events at the zoo. The idea is to educate parents and children on different aspects of children's vision. Similar to the “See to Read” Program, we set up different stations and try to incorporate it with different aspects of the zoo.

When the children come into the zoo, they receive a passport. Each station has an interactive activity. For example, there's an optical illusions station, or a binocular vision station where we talk about eye movement or see things in 3-D. We have a UV station where they make bracelets

with beads that change colors with UV rays. Another station is a “bird's eye view,” which involves different magnifiers.

At the last [Eye Spy] event in June 2013, we had over 530 children register.

### What do you hope to achieve with the “See to Read” program?

We requested a \$5,000 Healthy Eyes Healthy People State Association Grant. If our application is accepted, funding will include an educational program for parents; vision and eye health station activities for children; and eye exams through the S.A.V.E (School Advocates for Vision & Education) mobile unit at the Whitehaven Branch and Raleigh Branch of the Memphis Public Library and Information Center.

We will provide different activities for the children that focus on awareness for visual conditions. We'll let them try on different types of prescription glasses to see what someone else's vision might be like. We'll have 3-D vision activities, things like that. This helps educate children that vision isn't just about wearing glasses or seeing 20/20. There are other components to it like eye muscle movement, binocular vision.

The tentative dates for the events are in August and September. If this works out well, we hope to expand to different branches.

—Jennifer Lubell

► [View the 2014 HEHP grant winners and learn more about the program at \*\*aoafoundation.org/hehp/\*\*.](http://aoafoundation.org/hehp/)

# WHAT MEMBERS ARE DOING

## Like Mother, Like Child

Mothers pass along plenty of wisdom to their children—and sometimes even a career path. Because May is a time for celebrating mothers, *AOA Focus* asked for your stories and photos about mothers and children who share more than just family; they share the profession of optometry.

➲ **Janet Kohtz, O.D.**, has been in practice for more than 40 years in Riverside, California. Daughter **April Spurling, O.D.**, is a 2013 graduate of the College of Optometry at Western University of Health Sciences. Dr. Spurling is currently working on a fellowship at the Padula Institute of Vision Rehabilitation in Guilford, Connecticut.



➲ **Brenda Heinke Montcalvo, O.D.**, immediate past president of the Ohio Optometric Association and 1985 graduate of Pacific University College of Optometry, comes by her passion for the profession naturally. Her mother, **Marilyn Heinke, O.D.**, is a 1945 graduate of Northern Illinois College of Optometry who practices in Wisconsin.



➲ **Mary Beth Emmick, O.D.**, followed mother **Rosemary Emmick, O.D.**, in her choice of career and in the education that led to that career. Dr. Rosemary Emmick graduated from the University of Houston College of Optometry in 1985, and Dr. Mary Beth Emmick graduated from the same school in 2013. The two practice in Hawesville, Kentucky.



➲ With four generations in the profession, this family is going strong. From left to right, **Sarah Moser Frugé, O.D.**, mother **Rhonda Fink Moser, O.D.**, and **Rebecca Moser, O.D.**, are all optometrists. But the family's connection to eye care goes back even further to grandmother **Ruby Brady Fink, O.D.**, and great grandmother **Mattie L. Langley, O.D.**

## WHAT MEMBERS ARE SAYING



Shaping the future of eye care by collaborating with colleagues from around the country.

**Texas Optometric Association, @TexasOptometric**



It's nice to catch up with colleagues that I normally don't get to see too often.

**Maria Nunez-Imholtz,  
O.D., @mandarin831**



# WHAT IS YOUR FAVORITE PART OF OPTOMETRY'S MEETING®?

Looking forward to the poster session this year!  
**Leslie E. O'Dell, O.D.,  
@HelpMyDryEyes**



### JOIN THE CONVERSATION

Want to see your name in print? Share your thoughts on social media. Find us here:



@aoaconnect



American Optometric Association

Get ready for Optometry's Meeting 2014, June 25–29 in Philadelphia, at [optometrysmeeting.com](http://optometrysmeeting.com).

## We Fund Your Vision.

Take your practice to the next level with financial backing from industry experts.

When it comes to practice financing, anyone can lend you money. But what you really need is a trusted lending advisor with over 30 years of experience in financing the optical market.

Healthcare Professional Funding has the unique working knowledge to advise licensed medical professionals and help them make the right choices for their practice.

To learn more about equipment financing, start-up financing, purchasing a practice and improvement/expansion financing, visit [ExcelOD.com/Practice-Finance](http://ExcelOD.com/Practice-Finance).

Or, call 855-944-2265 to speak to a representative.



## HEALTHCARE PROFESSIONAL FUNDING

A Subsidiary of The Bank of Maine

# EYE CHART

## OPTOMETRY'S ADVOCATES

From staff to volunteers, the AOA is hard at work on Capitol Hill and around the country, fighting to make optometry's voice heard where policy decisions are made.

### KEYS TO SUCCESS

30+  
YEARS  
of the  
AOA's Federal  
Keypersons program

420  
ODS WHO SERVE  
AS KEYPERSONS,  
contacting and  
working with  
legislators on behalf  
of the profession

535  
MEMBERS  
OF CONGRESS—  
meaning the AOA seeks  
more Keypersons to  
cover all legislators

50  
NUMBER OF  
STATES, PLUS D.C.,  
covered by  
Keypersons

CHERKAS/THINKSTOCK; BUBONE/THINKSTOCK; MA\_RISH/THINKSTOCK

### GATHERING MOMENTUM

Rough  
number of  
attendees  
at AOA  
advocacy  
conferences a  
decade ago

200

650+

Rough number of ODs  
and students who attended  
the 2013 AOA Congressional  
Advocacy Conference

600  
ODs and students  
who took to  
Capitol Hill on  
"Lobby Day"  
in 2013



### ACTION FIGURES

5,000  
ROUGH NUMBER OF  
policy-related letters  
sent by the AOA's online  
legislative action center

60+  
AOA MEMBER  
volunteers on advocacy-  
and policy-related  
committees

2  
AOA-BACKED BILLS  
seeking full recognition  
for optometry in the  
National Health Service  
Corps (HR 920, S 1445) and  
Medicaid (HR 855)

3  
TIMES THE AOA  
has defeated organized  
medicine's "Sullivan-  
Bucshon" bill (now HR 1427),  
designed to control whom  
the public can consider a  
doctor or physician

# 2014 AOA AWARD WINNERS

Congratulations to the 2014 AOA award winners, whose accomplishments will be highlighted at the 2014 Optometry's Meeting® Opening General Session on Wednesday, June 25, in Philadelphia. Read more about the winners at [aoa.org/awards2014](http://aoa.org/awards2014).



## Optometrist of the Year Award

### Peter M. Agnone, O.D.

Peter M. Agnone, O.D., of Michigan, is the 2014 Optometrist of the Year. Dr. Agnone is a graduate of the Illinois College of Optometry and currently serves on the AOA Executive Third Party Committee.

Dr. Agnone is an active member in the Michigan Optometric Association (MOA), serving as president in 2003. He developed and executed a plan for success in third-party advocacy, serving a key role in the reThink Eyecare campaign. In advocating for the profession, he has helped thousands of auto industry employees and retirees gain access to optometrists for medical eye care.



## Young Optometrist of the Year Award

### M. Rob Pate, O.D.

M. Rob Pate, O.D., of Alabama, is the 2014 Young Optometrist of the Year. Dr. Pate is a 2007 graduate of the University of Alabama at Birmingham School of Optometry.

Dr. Pate is an active member in the Alabama Optometric Association (ALOA) and was recently elected to the ALOA Board of Directors. He has served ALOA in numerous leadership roles, including legislative keyperson and InfantSEE® Committee chairman. He has traveled across the state visiting local optometric societies to lecture on the InfantSEE program and provide ideas on implementing the program within all optometric offices.



### Optometric Educator of the Year Award

#### Gilbert E. Pierce, O.D., Ph.D., F.A.A.O.

Gilbert E. Pierce, O.D., of Ohio, is the Optometric Educator of the Year. Dr. Pierce is a 1989 graduate of The Ohio State University College of Optometry and serves his alma mater as a professor of clinical optometry. Dr. Pierce served as president of the Ohio Optometric Association (OOA) and regularly visited with Ohio state legislators on behalf of OOA. He also has led the Ohio State Student Delegation at the annual AOA Legislative Conference in Washington, D.C. In service to the AOA, Dr. Pierce has volunteered for the AOA's Publications and Education Committee and Faculty Relations Committee.



### Paraoptometric of the Year Award

#### Roberta Beers

Roberta Beers, CPOT, of Pennsylvania, is the 2014 Paraoptometric of the Year. Beers has a long history with the Pennsylvania Paraoptometric Association, beginning her service as treasurer in 1988. She went on to serve as vice president of education, president-elect, and president in 2000. Beers received the Pennsylvania Paraoptometric of the Year award in 1997 and again in 2012. She also co-authored the third edition of the Pennsylvania Paraoptometric Manual. Beers has volunteered her time promoting the InfantSEE® program at health fairs, in addition to volunteering with Special Olympics Opening Eyes and as coordinator of Northwestern Pennsylvania Opening Eyes.



### Distinguished Service Award

#### Paul C. Ajamian, O.D., F.A.A.O.

Paul C. Ajamian, O.D., of Georgia, is the winner of the 2014 Distinguished Service Award. Dr. Ajamian is a 1980 graduate of the New England College of Optometry.

Dr. Ajamian founded the first optometric co-management and referral center, Omni Eye Services of Atlanta. Dr. Ajamian helped pioneer the referral center concept and engaged community optometrists to share in the post-surgical care of their patients.

Dr. Ajamian is an active member of the Georgia Optometric Association, serving as president from 2000 to 2001. He has held several leadership positions within the AOA, including chair of the Task Force on Radial Keratotomy.



### Apollo Award

#### Bernard Maitenaz

Bernard Maitenaz, of Paris, France, is the winner of the Apollo Award, the highest award presented to the general public by the AOA. It honors individuals or organizations for distinguished service to the visual welfare of the public.

With an educational background in optical science and engineering, Maitenaz has made a significant impact on the optometric profession by inventing the Varilux lens. In 2012 alone, 20 million progressive addition lenses were prescribed and dispensed in the United States.

Maitenaz has received numerous accolades for his contributions to optometry, including an honorary doctorate of ocular science from the New England College of Optometry.

# 2014 Optometrist of the Year Nominees

Congratulations to all of AOA's 2014 Optometrist of the Year nominees.

Read more about their achievements at [aoa.org/awards2014](http://aoa.org/awards2014).



**AFOS**  
**Angela Nabors Musick,  
O.D., F.A.A.O.**  
Armed Forces Optometric Society



**Alabama**  
**Duane Mohon, O.D.**  
Alabama Optometric Association  
InfantSEE® Provider



**California**  
**Tommy Lim, O.D.**  
California Optometric  
Association  
InfantSEE Provider



**Colorado**  
**Kent Yount, O.D.**  
Colorado Optometric Association  
InfantSEE Provider



**Georgia**  
**John Whitlow, O.D.**  
Georgia Optometric Association



**Illinois**  
**Leonard Messner, O.D.**  
Illinois Optometric  
Association



**Indiana**  
**James Haines, O.D.**  
Indiana Optometric  
Association



**Kansas**  
**Sharon Michel Green, O.D.**  
Kansas Optometric  
Association



**Kentucky**  
**Julie Metzger Aubuchon, O.D.**  
Kentucky Optometric Association  
InfantSEE Provider



**Maryland**  
**John Burns, O.D.**  
Maryland Optometric Association  
InfantSEE Provider



**Minnesota**  
**G. Troy Mork, O.D.**  
Minnesota Optometric  
Association



**Missouri**  
**Wesley Kemp, O.D.**  
Missouri Optometric Association  
InfantSEE Provider



**Nebraska**  
**Robert Vandervort, O.D.**  
Nebraska Optometric Association



**New Hampshire**  
**Mark Harris, O.D.**  
New Hampshire Optometric Association  
InfantSEE Provider



**New Jersey**  
**George Veliky, O.D.**  
New Jersey Society of Optometric Physicians  
InfantSEE Provider



**New Mexico**  
**Alissa Irons, O.D.**  
New Mexico Optometric Association  
InfantSEE Provider



**New York**  
**Denise Whittam, O.D.**  
New York State Optometric Association  
InfantSEE Provider



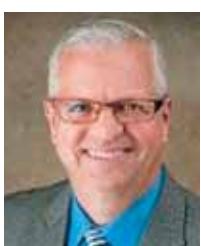
**North Carolina**  
**Jerry Ellington Jr., O.D.**  
North Carolina State Optometric Society



**Ohio**  
**Bruce Manning, O.D.**  
Ohio Optometric Association  
InfantSEE Provider



**Oklahoma**  
**Michelle Welch, O.D.**  
Oklahoma Association of Optometric Physicians



**Oregon**  
**David Wolf, O.D.**  
Oregon Optometric Physicians Association  
InfantSEE Provider



**Pennsylvania**  
**Melvin Lilly, O.D., F.A.A.O.**  
Pennsylvania Optometric Association  
InfantSEE Provider



**South Carolina**  
**Philip Flynn, O.D.**  
South Carolina Optometric Physicians Association  
InfantSEE Provider



**Texas**  
**Thomas Lucas Jr., O.D.**  
Texas Optometric Association



**Virginia**  
**Shannon Franklin, O.D.**  
Virginia Optometric Association  
InfantSEE Provider



**Washington**  
**Christopher Barry, O.D.**  
Optometric Physicians of Washington  
InfantSEE Provider



**West Virginia**  
**William Ratcliff, O.D.**  
West Virginia Association of Optometric Physicians  
InfantSEE Provider



**Wisconsin**  
**Richard Ames, O.D.**  
Wisconsin Optometric Association  
InfantSEE Provider

# 2014 Young Optometrist of the Year Nominees

Congratulations to all of AOA's 2014 Young Optometrist of the Year nominees. Read more about their achievements at [aoa.org/awards2014](http://aoa.org/awards2014).



**AFOS**  
**Tara Jayne, O.D.**  
Armed Forces  
Optometric Society



**Colorado**  
**Tara Peterson, O.D.**  
Colorado Optometric Association  
InfantSEE® Provider



**Georgia**  
**Benjamin Casella, O.D.**  
Georgia Optometric Association



**Illinois**  
**Matthew Jones, O.D.**  
Illinois Optometric Association



**Indiana**  
**L'Erin Garner, O.D.**  
Indiana Optometric Association  
InfantSEE Provider



**Kansas**  
**Dawn Williams, O.D.**  
Kansas Optometric Association  
InfantSEE Provider



**Maryland**  
**Nina Nghi Doyle, O.D.,  
F.A.A.O.**  
Maryland Optometric Association  
InfantSEE Provider



**Minnesota**  
**Randy Kempfer, O.D.**  
Minnesota Optometric Association  
InfantSEE Provider



**Mississippi**  
**Greg Loose, O.D.**  
Mississippi Optometric  
Association  
InfantSEE Provider



**Missouri**  
**Sally Bodenhamer, O.D.**  
Missouri Optometric Association



**Nebraska**  
**Christopher Wolfe, O.D.**  
Nebraska Optometric Association



**New Jersey**  
**Eliot Milsky, O.D.**  
New Jersey Society of Optometric  
Physicians



**New Mexico**  
**Sarah Bortz, O.D.**  
New Mexico Optometric  
Association

Read more  
about  
winners and  
nominees  
at [aoa.org/  
awards2014](http://aoa.org/awards2014).



**North Carolina**  
**Suzanne Parker, O.D.**  
North Carolina State  
Optometric Society



**Ohio**  
**Rachel Bostelman, O.D.**  
Ohio Optometric Association  
InfantSEE Provider



**Oklahoma**  
**Lynsey Bigheart, O.D.**  
Oklahoma Association of  
Optometric Physicians  
InfantSEE Provider



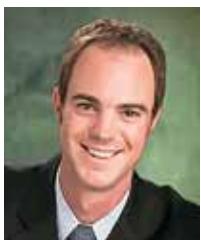
**Oregon**  
**Ashley McFerron, O.D.**  
Oregon Optometric Physicians  
Association  
InfantSEE Provider



**Pennsylvania**  
**Michelle Beachkofsky, O.D.**  
Pennsylvania Optometric  
Association



**Texas**  
**Jonathan Cargo, O.D.**  
Texas Optometric Association  
InfantSEE Provider



**Virginia**  
**Brent Segeleon, O.D.**  
Virginia Optometric  
Association



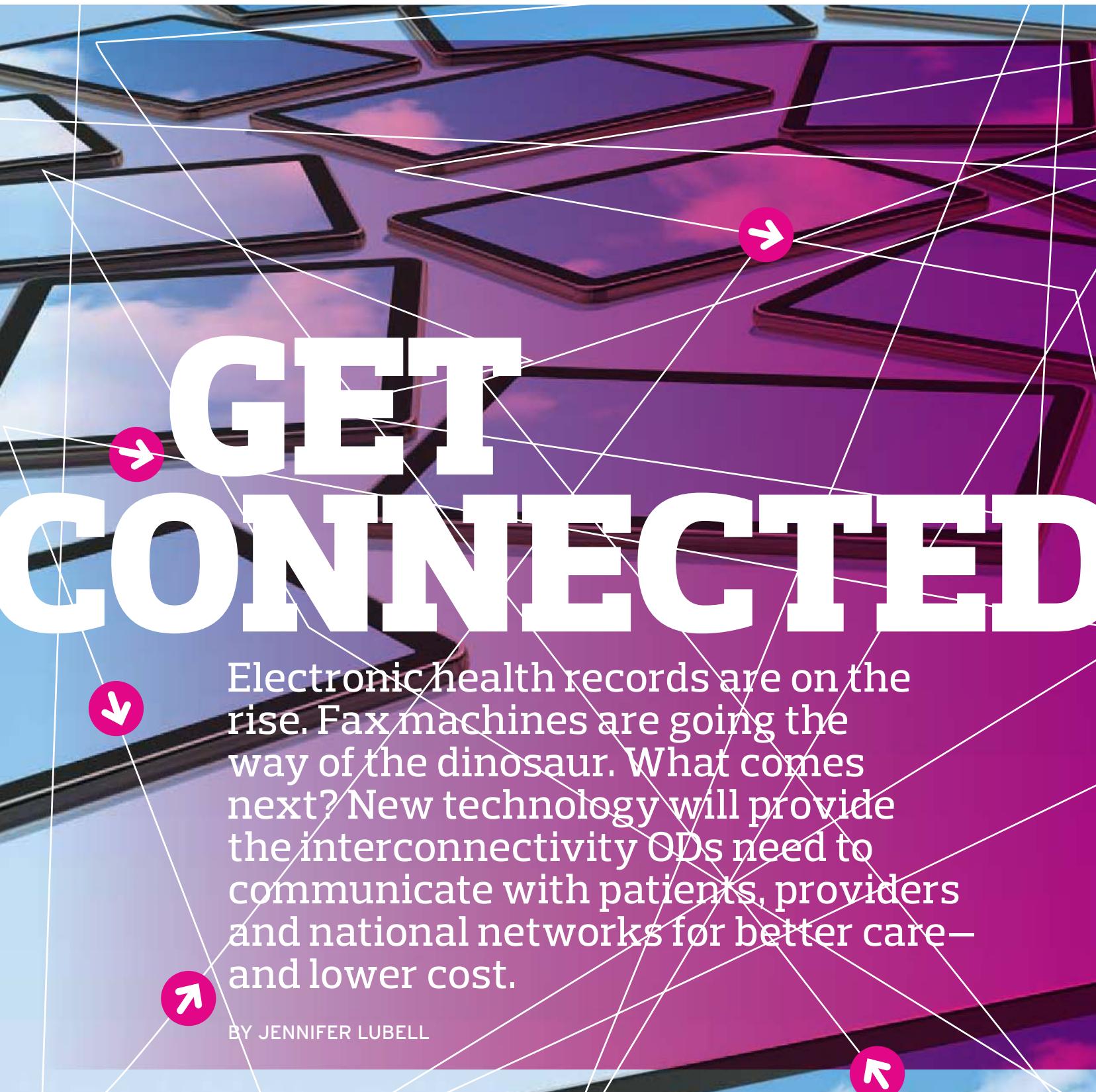
**Washington**  
**David Kading, O.D.**  
Optometric Physicians of  
Washington  
InfantSEE Provider



**West Virginia**  
**Brad Lane, O.D.**  
West Virginia Association of  
Optometric Physicians



**Wisconsin**  
**David Hammes, O.D.**  
Wisconsin Optometric Association  
InfantSEE Provider



# GET CONNECTED

Electronic health records are on the rise. Fax machines are going the way of the dinosaur. What comes next? New technology will provide the interconnectivity ODs need to communicate with patients, providers and national networks for better care—and lower cost.

BY JENNIFER LUBELL



DABOOST/VEER

## I

Imagine a future where optometrists sign on to a customized health information exchange, where they can easily communicate with other doctors throughout the country.

They will be able to submit patient data through secure channels to optimize care. They will have access to apps that will lower the cost of practice and ease their own workflows.

Technology hasn't gotten there yet, but the tools are being built. They couldn't come at a timelier moment. Optometrists will need this ability to interconnect with other health care entities to thrive in a changing health care environment.

Health IT tools are no longer just a convenience; they're a necessity.

The AOA has strongly urged members to adopt these tools for several reasons, says Rodney Peele, AOA's assistant director for regulatory policy and outreach. For one thing, they lead to better patient care and integration with the local medical community.

They also provide a way "to demonstrate that optometry is at the forefront of medical delivery," Peele says.

There are plenty of other reasons, too.

For example, lawmakers have recognized that incentives to implement electronic health records (EHRs) could generate private and public sector spending, with a fringe benefit of helping corral the rapid rise of health care costs. Thus, meaningful use was born.

According to Peele, the AOA believes the best way to make EHRs helpful, and to make implementation worthwhile for practices and patients, is to focus on features that doctors want rather than unnecessary advanced functions. For example, optometrists would readily use EHRs to communicate securely with other health care providers, share patient data, and easily add to or pull from the data—based on their role.

"Let pediatricians focus on reporting which children have received their vaccinations," he says. "Let the internists identify contagious disease threats. For eye care, EHRs could improve referrals and handing off patients between primary care and specialty care,



replacing antiquated tools such as faxes and, yes, even email."

This year, optometrists and other providers began the second stage of participation in Medicare and Medicaid's meaningful use EHR incentive programs. Stage 2 will require EHR connectivity to meet core requirements. A participating OD must be able to communicate with patients through a secure electronic messaging system—and provide them the option of viewing, downloading and transmitting their health

Dr. Barresi recently became the CEO of OcuHub, a company with a new technology platform that will help optometrists comply with federal IT requirements and support the connectivity needed for care coordination.

"It's a highly fragmented environment for care," Dr. Barresi says. "When you look at the role the Internet has played in other industries, it's dramatically different. It's only been in the last couple of years with the Health Information Technology for

in Salem, Ohio, says her practice has been getting ready for Stage 2. "We are in the process of staff training, attending webinars, and staying up-to-date with the workflow changes that are going to occur in our practice to meet Stage 2," she says.

Salem Eyecare has all of the ingredients of a technology-savvy practice. Her office uses EXAM-WRITER, an EHR produced by Eyeinfinity/Officemate, which is one of many EHR systems ODs commonly use. Compulink, Maxim-Eyes and Revolution EHR are other popular choices, Dr. Lippiatt says.

The office also has a practice management system, integrated diagnostic equipment, and an integrated scanning solution, which allows the practice to operate in an efficient and seamless manner, Dr. Lippiatt says.

As an example, "Patient insurance information is scanned directly to the electronic patient record, which reduces errors during the billing process. The EHR is integrated with the practice management system, which allows seamless viewing of patient demographics and other pertinent information, such as occupation, other family members, etc.," she says.

Others may not be as prepared. Kim Castleberry, O.D., president and CEO of Plano Eye Associates in Plano, Texas, is concerned that many ODs will be blindsided by coming changes.

Right now, interconnectivity for many practices consists of snail mail, fax machines and nonsecure email, Dr. Castleberry says. Stage 2 meaningful use "effectively eliminates the fax machine and email for patient communications in lieu of more secure communications."

Stage 2, for example, requires

## "WE HAVE TO HAVE TOOLS FOR THIS INTERCONNECTIVITY. IF WE LEAVE IT TO OTHERS, THEN WE RISK BEING SHUT OUT AT THE PRESS OF A BUTTON."

—IAN LANE, O.D.

information online safely.

All of these developments require EHR "interconnectivity" in a practice: the method by which providers, patients, labs and hospitals will communicate with one another in a health IT environment.

"We have to have tools for this interconnectivity," says Ian Lane, O.D., a health information technology consultant. "If we leave it to others, then we risk being shut out at the press of a button."

### IT use rates are high, but efficiency is low

The need for interconnectivity and better care coordination is clear, says Barry J. Barresi, O.D., Ph.D., former executive director of the AOA.

Economic and Clinical Health Act that you've seen a huge investment in electronic health records."

Optometrists have ranked fairly high on EHR adoption compared with other medical specialties. The AOA's educational efforts have helped boost adoption rates, Dr. Barresi notes. "Right now we know that 19,000 optometrists and ophthalmologists attested to meaningful use Stage 1 in 2013."

However, ODs often have struggled to implement requirements into their practices. They remain eager to connect their EHRs to people they work with in their community—from primary care providers to ophthalmologists, Peele notes.

Lorie Lippiatt, O.D., president of the Salem Eyecare Center, Inc.,

Read about how ODs are preparing for ICD-10 implementation on page 34.

## EHRs in Action

According to the AOA's 2012 New Technology and EHR Survey, nearly half of ODs have adopted an EHR, and others have plans to do so:

49%

of ODs have adopted an EHR

**42%** use e-prescribing technology

**35%** reported plans to acquire an EHR

**16%** had no plans to acquire an EHR

eye care practices to provide a summary of care document for 50 percent of their referrals and transitions of care. Creating such electronic documents will be a challenge—and sending them will be an even bigger one, he says.

Dr. Castleberry is planning some upgrades of his own to prepare for Stage 2. Like Dr. Lippiatt, he currently uses ExamWRITER. In his situation, the vendor for this system didn't get adequate certification for Stage 2, he explains. This would mean going to multiple vendors at an increased cost to stay with ExamWRITER.

His plan is to transition to another system, Uprise by Vision-Web, to prepare not only for Stage 2 but, more important, for ICD-10, he says. ICD-10 refers to the International Classification of Diseases, Tenth Revision, a more expansive system for reporting medical conditions on insurance claims and in patient records. ICD-10 implementation is scheduled to take effect in October 2015.

What this platform brings to the table is "complete EHR certification," Dr. Castleberry says. It makes purchase of additional software for patient portal, secure communications, eRx, customer service and business analysis functions unnecessary, as they are all included. "I like their one-vendor solution, and it will lower my costs by over 50 percent compared to what I am currently paying," he notes.

### Exchanges have excluded optometrists

On a national level, there's another barrier to true interconnectivity. Ophthalmic software has not been the focus of state and regional health information exchanges (HIE), says David Jaco, O.D., clinical consultant to OcuHub.

HIEs allow for the sharing of health information through electronic channels. These organizations have typically focused on connecting with hospitals, multi-provider groups and enterprise software groups that are typically not in the eye care arena, Dr. Jaco says.

"If we were not careful, optometry was going to have a difficult time getting connected," he adds.

Hospital-based physicians have benefited from IT technology deployed by their affiliate hospital systems, according to Dr. Barresi. "There's a high degree of access to primary care physicians and hospital-based physicians to communication technology that helps coordinate care across multiple electronic health records. We don't have that in eye care."

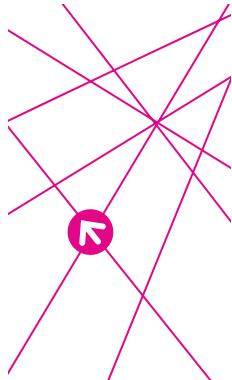
The AOA began floating a potential solution back in 2012. The result was OcuHub, which arose from a business relationship between AOAExcel™, a for-profit subsidiary of the AOA, and two major health IT companies, Covisint and AT&T ForHealth.

In March, Toronto-based TearLab Corporation purchased OcuHub's technology platform from AOAExcel. This means OcuHub will now be a fully owned subsidiary of TearLab. As a term of the sale, AOA members will be able to buy the OcuHub core technology products at a discount.

Given the high rate of IT adoption over the past couple of years in the field, Dr. Barresi estimates a healthy level of interest in OcuHub. For those who have already invested in an EHR and used its great functionality in their practice, "I still think most would say, 'Wouldn't it be nice if a practice is better connected so I can take full

**"IF WE WERE NOT CAREFUL,  
OPTOMETRY WAS GOING TO HAVE A  
DIFFICULT TIME GETTING CONNECTED."**

—DAVID JACO, O.D.



advantage of what this technology can do?" Dr. Barresi says.

In the short term, the motivator for an OD to buy OcuHub is to improve care coordination with other providers. In the long term, it's to make sure they don't lose access to patients.

ODs don't want a local accountable care organization (ACO) or other care group in the community to say, "We don't want to work with you because you're not connected," Dr. Barresi says.

#### Help with IT compliance

OcuHub will give optometrists the ability to connect through "Direct" messaging, a recent requirement of the Office of the National Coordinator (ONC), Dr. Jaco says. "We're currently working with states to connect our HIE and our direct messaging to states so optometrists can not only communicate with other optometrists, but with other disciplines as well."

He explains how this system would help an OD comply with

Stage 2 meaningful use: "Let's say a patient needs a retinal specialist, and I send out my consult notes to that referral doctor. In the past, I'd either send that information by snail mail or by fax. Now with Stage 2, they expect that to be sent at least 10 percent of the time electronically." Through OcuHub, an OD would be able to send progress notes to a referral doctor through a direct, secure email that complies with federal privacy regulations.

The referral doctor must have an ONC Direct messaging account, as well. The system would also enable patients to communicate with optometrists in a secure, electronic manner.

The system will seem familiar to anyone with a Gmail or Yahoo Mail account, with one key difference. "It's a secure email, and the email is set up so that each doctor who uses it is a known and trusted entity," says Dr. Lane, who helped create the roadmap for OcuHub. The system ensures that if an OD sends patient information to another physician, it gets to the right physician, he notes.

At some point OcuHub will also create a registry for PQRS data. Optometrists not only will be able to view their numbers but also compare—anonymously—how they rate against other doctors locally and nationally.

## Incentives to Get Connected

Although the EHR is just one part of interconnectivity, it's a vitally important part. ODs also can earn money for participating in Medicare's EHR Incentive Program. As of November 2013:

- **13,468** ODs have registered to participate
- **9,264** ODs have received an incentive bonus

**\$160,154,365**  
in Medicare incentive bonuses have  
been issued to ODs

The AOA also estimates ODs have earned an additional \$3 million under the Medicaid EHR incentive program.

## **Creating a national exchange**

A national HIE is the ultimate goal of OcuHub. The reason: A national HIE will make it as easy and cost effective as possible for providers to communicate, Dr. Jaco says.

Instead of having an ophthalmic software company work out negotiations with 50 states or 100 HIEs, EHR vendors would be able to go through just one connection with OcuHub. OcuHub would be responsible for establishing and maintaining all necessary connections.

Developers are aiming to officially unveil the system in the second quarter of 2014. Building the system has taken several years, and the select testing of OcuHub began in June 2013 in fewer than 100 practices.

"We're rolling it out to make sure we get the kinks and early bugs worked out before we open it up to the masses," Dr. Jaco says.

The plan is to get HIEs in Kentucky and Tennessee—two states where personal contacts had already been established—on board first with OcuHub, then expand.

This means an OD in Kentucky with a diabetic patient could send that patient's information—saying "here's what we found today"—to a primary care physician in the state who's also connected to OcuHub.

Connecting to the system will be just as easy as creating an Amazon account. It will require a username, password and some demographic information to get started, he says.

## **The iPhone of optometry**

Eric Donnenfeld, M.D., chief medical officer of OcuHub, expects this platform "will do for eye care delivery what the iPhone has done for personal communication."

Dr. Donnenfeld is a founding partner of Ophthalmic Consultants of Long Island and Connecticut, a large practice with 13 offices and 35 ophthalmologists and optometrists. The challenge his practice faces is similar to what many others are dealing with: "To provide timely sharing of information in a HIPAA-compliant fashion that improves patient care."

He believes OcuHub will be the solution to this information exchange problem. He and colleagues plan to use it to build a closer relationship with the practice's referring optometrists and ophthalmologists.

OcuHub—and electronic portals similar to it—will be vital to everything from Stage 2 compliance to provider connectivity, Dr. Castleberry contends.

*Jennifer Lubell is a content producer for the AOA, based in Washington, D.C.*



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# CRACKING THE CODE

More than 69,000 diagnosis codes make up ICD-10, but only 5 percent have an exact ICD-9 match. With the transition deadline for the new code set now slated for October 1, 2015, ODs are making the most of the extra time to prepare for the new system.

BY WILL PINKSTON

It's an action-movie scene all too familiar: Time ticks away as the hero attempts to break the code. Cue the dramatic orchestra, the inevitable beads of perspiration flicked away in a moment of concentration. The clock counts 3... 2... 1... 'click,' and the hero saves the day, just in the nick of time.

The transition to International Statistical Classification of Disease and Related Health Problems, Tenth Revision, (ICD-10) codes from the predecessor ICD-9

PHOTOGRAPH BY JILL HUNTER



Peter Cass, O.D.

**“It’s serious enough that if you don’t take it seriously, it could put you out of business.”**

—Peter Cass, O.D.

code set isn’t an edge-of-your-seat thriller; but on a much grander scale, the parallels are uncannily similar.

The deadline for all HIPAA-covered entities—even those that do not deal with Medicare claims—to permanently switch to ICD-10 is slightly more than a year away. Practitioners can expect a complete shift from ICD-9 to ICD-10 codes no earlier than Oct. 1, 2015. There’s no easy one-to-one switch, and although many optometrists are familiar with ICD-9, ICD-10 is drastically different with tens of thousands of new codes. And come transition, if practices are not entering the proper ICD-10 codes, their claims will not be processed. Preparation is key, and through AOA member benefits and expert help, practitioners can successfully navigate these uncharted waters.

PHOTOGRAPH BY JILL HUNTER

## "A total shift in paradigm"

Full implementation of ICD-10 has been a long time coming. Proponents of the transition point out ICD-9 is decades old—other nations have used ICD-10 since the '90s—and limited in description; ICD-10 will provide greater specificity and more accurate billing. The perks of ICD-10 derive from

its comprehensive exactness. But therein also rests its bad rub.

There are nearly 19 times as many procedure codes with ICD-10-CM/PCS (Clinical Modification/Procedure Coding System) and nearly five times as many diagnosis codes over ICD-9-CM, according to the Centers for Disease Control and Prevention (CDC).

"It's huge," says Rebecca Wartman, O.D., AOA Third Party Center Executive Committee member and a presenter on the AOA's "Ask the Coding Experts" ICD-10 webinar series. "Other than the procedure codes we use, the other code we need is the diagnosis code and it's a total shift in paradigm. We're having so many more codes, and so many codes that have to be coded along with another code. You have to be conscious of which eye the condition is in, any systemic implications, if it's viral or infective in origin, and certainly with injuries, it gets really complicated."

And there's a code for it all, hence the specificity. Practitioners are now able to code for relative location, subsequent encounters and diagnoses related to other conditions, making for a very thorough, 1,000-page reference guide.

More than 69,000 alphanumeric diagnosis codes make up ICD-10, detailing everything from the commonplace to downright rare, and in a very specific manner. For instance, reading ICD-10 in one setting is a sure-fire cause of H53.10 (eye strain) and exponentially increases the chances for W45.1XXD (paper cut, subsequent encounter), but both are beside the point if you leave the window open and find yourself W61.43XA (pecked by turkey, initial encounter).

All levity aside, the enormous scope of codes can be overwhelming considering only 5 percent of ICD-9 codes have an exact match in ICD-10. The comprehensive nature helps cut down on claims fraud and helps provide comprehensive patient documentation but drastically increases the chances a good-intentioned coder could accidentally submit the wrong code.

## 5 STEPS TO PREPARE FOR ICD-10 TRANSITION

The transition to ICD-10 after Oct. 1, 2015, cannot be something practitioners take lightly, but it's also not a cause for panic. Consider taking incremental steps that will help your practice meet compliance, say Rebecca Wartman, O.D., and Peter Cass, O.D.:

### 1 Basic training

Now is the time for practices to prepare for the ICD-10 transition. Familiarize the practice with what is changing and why. Incorporate an educational component into regular staff meetings, and form a team to help conduct training in the months ahead, Dr. Cass recommends. Use the free "Ask the Coding Experts" webinars available at AOA EyeLearn™.

### 2 Time to update

Five times as many ICD-10 diagnosis codes with few parallels to ICD-9 mean now is also the time to bring practice systems up to date. Contact EHR vendors to see how they plan to handle updates. Can the EHR import a narrowed list of optometry-specific codes into the software, or can it switch between code sets if necessary? Review superbills for most frequent ICD-10 codes.

### 3 Check and double-check

Practices' preparation will ensure smooth transition from within, but what about the claims process down the line? Check with intermediaries to inquire about their software compatibility for the transition, and ask payers about their readiness. Dr. Cass says if 40 percent of a practice's income comes from one payer, "you better make a phone call."

### 4 Improve your documentation

Maintaining proper documentation is a necessity in the health care industry, and it becomes even more critical with ICD-10. Make sure your practice is in the habit of filling out all the necessary documentation required, and coders are prepared to handle the specificity and standardization called for in ICD-10.

### 5 Practice makes perfect

Practice ICD-10 with your staff until everyone is familiar. Take the opportunity to periodically rehearse ICD-10 and compare notes to find common mistakes or to gauge understanding, Dr. Wartman says.

Dr. Wartman uses the example of hypertensive retinopathy—currently one code (362.11) by ICD-9 standards. Under ICD-10, however, the practitioner must code retinopathy per eye, then code hypertension along with the retinopathy and specify tobacco usage, if relevant, in a third code.

Visit [eyearn.aoa.org](http://eyearn.aoa.org) (member login required) for free access to the ongoing "Ask the Coding Experts" ICD-10 coding webinars.

ICD-10 can get even more confusing, such as when dealing with infections. In another example, Dr. Wartman points out a retinopathy code will not be appropriate if the condition is due to toxoplasmosis, because that code would then be found under the infection section.

"It can get quite complex, and ODs will have to understand both the alphabetical index and the tabular list to really come up with the code," Dr. Wartman says, referencing how certain conditions might not appear necessarily where the coder would naturally assume.

### Serious business

Given the track record that ICD-10 implementation has been extended multiple times—most recently on March 31 when Congress moved the deadline from Oct. 1, 2014, to Oct. 1, 2015, as part of the Protecting Access to Medicare Act—practitioners might not see the purpose in early preparation, and that's a "dangerous" attitude to have, says Peter Cass, O.D., a private practitioner in Beaumont, Texas,

chair of the Texas Optometric Association's Health Information Technology Committee and health IT consultant.

There remains hesitancy on the part of the health industry to transition, and for good reason. The transition to ICD-10 means post-implementation date, abso-

lutely no one is an experienced user, and it could take some time before learning if claims were filed incorrectly and denied. There's also concern that insurers might not be up to par on the code set, as well.

"This is the Y2K of health care," Dr. Cass says. "If everything goes smoothly, it will be an unpleasant change, but we can make it through. If you're not prepared and something goes wrong with billing or coding, it could be enough to hurt your business."

Should a link in the chain between clinicians, electronic health record (EHR) software, intermediaries and payers be broken in the process, it could hinder payment. Dr. Cass says that can be particularly harmful considering "most [practices] are 95 percent insurance, and unless you can get by on 5 percent of your income, you better get it right between now and Oct. 1, 2015."

To cover all bases, both Drs. Cass and Wartman suggest taking precautionary steps in the event a link fails during the transition. Dr. Wartman says providers should be prepared to have extra funds on hand in case claims don't flow back readily.

The transition will make it equally important for billing and coding staff to express compe-

tency within the new code sets. Professional billing and coding staff are the last line of defense for ensuring claims leave the office with no mistakes, and in turn, help keep the practice's bottom line from bottoming out due to denied claims. Practitioners need to prepare for the ICD-10 transition from a coding, financial and staffing standpoint.

"It's serious enough that if you don't take it seriously, it could put you out of business," Dr. Cass says. "But at the same time, at the most basic level it's really not that hard. Just change the codes, understand those codes, make sure your intermediary and payer can handle it, and you'll probably be OK."

### Putting it into practice

Despite the complexity of the new code sets, it is manageable with training and repeated practice. And while concerns about ICD-10 cannot be alleviated entirely, groundwork can ensure practitioners and staff know their office is confidently equipped for compliance.

Robert Hamp, O.D., a partner in an eight-doctor group practice with locations around Charlotte, N.C., says office preparations for ICD-10 compliance started as a formality several months ago, knowing that the conversion was ultimately coming down the line, and it was not something the group should avoid.

"We've been planning for months now, but as it gets closer, we realized not only do we have to know what we're doing on our end, but there's a very real possibility that the payers might not be fully prepared on their end," Dr. Hamp says. "We've learned that it's best to have a contingency plan. We expect it to affect our revenue streams, for sure."



Robert Hamp, O.D.,  
and office manager  
December Bean

Referencing a difficult EHR conversion at the practice, Dr. Hamp says the experience became an impetus to start training early for the ICD-10 transition. Doctors and staff alike are encouraged to attend continuing education (CE), webinars and tutorials. Training occurs whenever there is time—in between patients, after hours or during CE at conferences.

PHOTOGRAPH BY PETER TAYLOR

Coding is a team effort in Dr. Hamp's practice, as doctors' claims documentation is reviewed by billing and coding staff in a checks-

**“We’re trying to prepare ahead of time to hit the ground running.”**

—Robert Hamp, O.D.



and-balances approach, making it important for all staff—right down to the front-desk checkout staff—to know ICD-10. Currently, Dr. Hamp says the group conducts coding trials to ensure accuracy.

"We'll take a given chart and recode it from ICD-9 to ICD-10. Then we have doctors paired up to double-check each other's charts, and we'll go through them to make sure we're all on the same page," Dr. Hamp says. "We're trying to prepare ahead of time to hit the ground running. On our end, we will be OK."

Wilbert Stock Jr., O.D., a practitioner in Kirksville, Mo., says his practice, including four staff, has also taken the opportunity to participate in mock coding sessions through the Centers for Medicare & Medicaid Services. The office conducted a test week with Medicare solely using ICD-10 codes.

Dr. Stock says the practice has

and-balances approach, making it important for all staff—right down to the front-desk checkout staff—to know ICD-10. Currently, Dr. Hamp says the group conducts coding trials to ensure accuracy.

Johnson expresses a bit of worry over the ICD-10 transition, considering all the coding lands on her desk with input from Dr. Stock but feels she will be ready to meet compliance.

"Now is really the time to go to as many training sessions as you possibly can and to start reviewing the codes and what is going to be different in ICD-10 versus ICD-9," Johnson says.

With the exception of several diagnoses that were difficult or, in some cases, impossible to find a related code, Dr. Stock also feels confident the practice will take the transition in stride with help from AOA resources.

"It shouldn't be a problem," Dr. Stock says. "Sure, mistakes are

Purchase the ICD-10 code book at a reduced member price and find other coding resources at [aoa.org/marketplace](http://aoa.org/marketplace).

primarily relied on the AOA's ICD-10 webinar series to learn the nuances of the new code set and would continue to do so in the months ahead. Melanie Johnson, the practice's primary billing and coding specialist, says the AOA training has been helpful, and she looks forward to using additional AOA resources.

Currently, Johnson says she's working to put together a superbill quick-reference list of frequently used codes. Although, given the detailed nature of ICD-10, the bill will not be able to list specific codes related to incidences of injuries, as they are individualized to specific cases.

going to be made and it's going to be a learning process, but we're hoping by Oct. 1, 2015, we'll be able to submit clean claims."

### Deciphering the code book

The resources available for AOA members to learn the new code sets mean meeting ICD-10 compliance does not have to be a daunting task nor break the bank if practitioners plan accordingly.

Members are taking advantage of coding training, such as the "Ask the Coding Experts" webinars presented monthly at no cost for members. A single ICD-10 webinar in February attracted nearly 1,000 registrants—many whom had multiple staff listening in, as well. All sessions of the webinar are available for members to review online at AOA EyeLearn™.

"The training is available online and can be broken down into hour-long or less chunks to make it easier," Dr. Wartman says.

Since 2010, AOA has provided another useful resource for coding with the website AOACodingToday.com. The website will provide coders a digital toolbox for reviewing ICD-10 codes, and it also includes complete volumes of Current Procedural Terminology (CPT®) and ICD-9 codes.

The AOA's ICD-9 "Codes for Optometry 2014" also includes a first-of-its-kind ICD-10 Coding Primer for Optometrists and is available for order on AOA Marketplace. Members can purchase the ICD-10 code book also on AOA Marketplace at a reduced member price.

The AOA Paraoptometric Resource Center (PRC) also offers

opportunities for certified paraoptometric coders (CPOC) to learn the basics in EHR and billing and coding. Paraoptometric staff also can find billing and coding resources on AOA Marketplace.

Dr. Wartman suggests that members may benefit from participating in World Health Organization (WHO) ICD-10 tutorials for eye care to help understand the nomenclature involved in the transition. Optometrists should be aware, however, that the WHO ICD-10 code set is not the adapted version developed for the United States.

This year's Optometry's Meeting® in Philadelphia will also feature "Ask the Coding Experts" CE sessions pertaining to billing and coding principles.

With the training and conversion resources available to optometrists, the transition period will not be something that is impossible for practices that are ready to meet the challenge. Even at the conclusion of some of his ICD-10 presentations, Eric Botts, O.D., trustee for the Illinois Optometric Association who also started his own billing consultant company, says many doctors express a collective, "That's it?"

"It's easier than what they think, and it's going to be very doable," Dr. Botts says.

Becoming comfortable and familiar with the code set months in advance is a target to aim for, Dr. Botts says, as it allows time before the transition. He suggests transferring documentation

by June 1, 2015, and creating a superbill for reference. Dr. Botts also suggests practitioners code to the most specific code available to ensure a speedy claims process, as opposed to selecting the "unspecified" code.

"Getting familiar with the new codes is not going to be that difficult, but ICD-10 is something new, and new can often be a challenge," Dr. Botts says. "However, there's no doctor who's incapable of learning these codes."

*Will Pinkston is a content producer for the AOA, based in St. Louis, Mo.*

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ICD-10, get helpful webinars  
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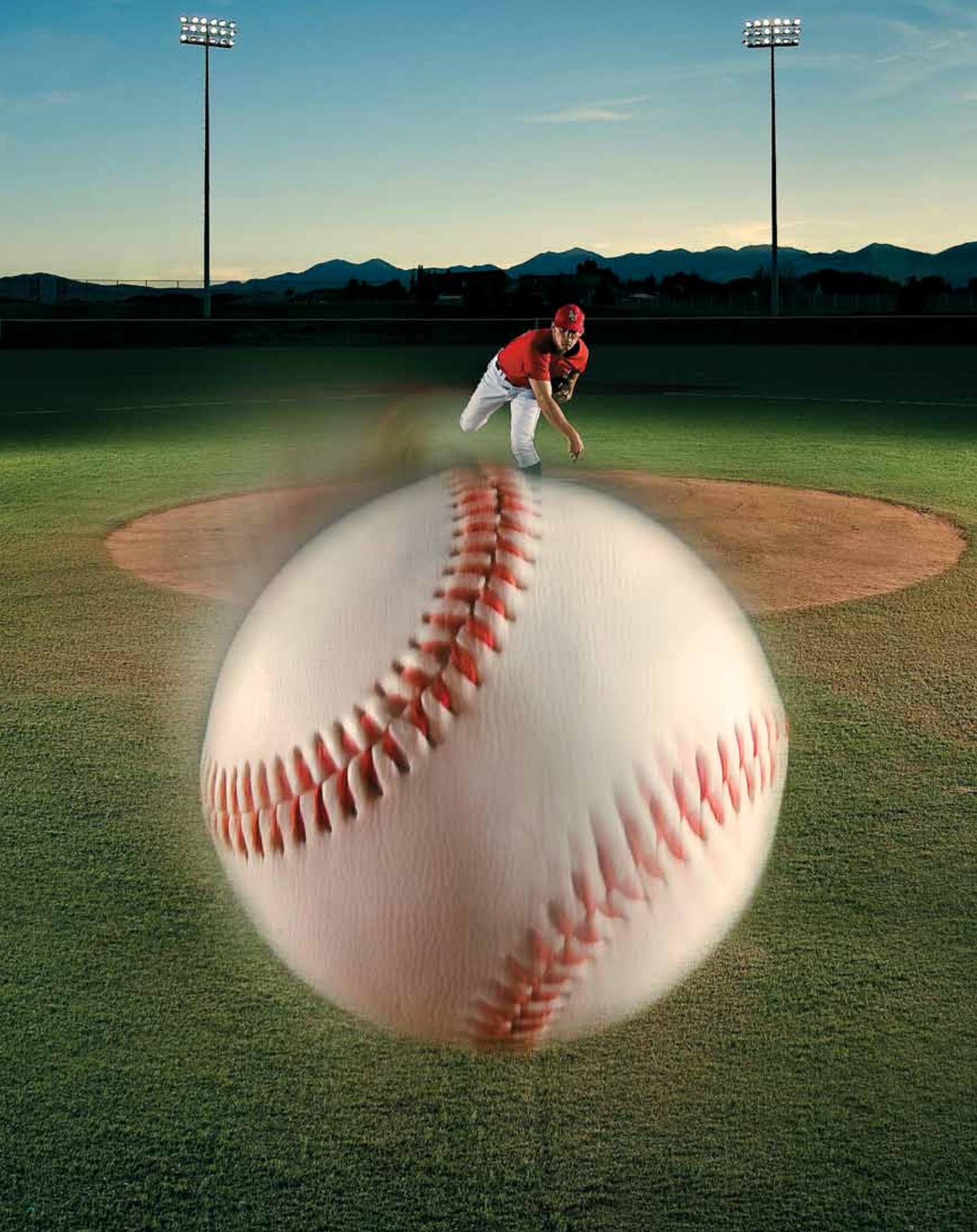
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or putting, vision  
leads competitors to  
victory. Today, thanks  
to advancements in  
the science of vision,  
it's a whole new ball  
game for athletes.

# A WHOLE NEW BALL GAME

BY BOB WOODS

Optometrists have been working with athletes for decades, helping them hit baseballs, tennis balls, golf balls and hockey pucks; shoot baskets; and throw touchdowns. While applied to athletics, the basic principles of vision remain the same as in most any physical endeavor: Vision is the signal that directs the muscles of the body to respond.

"The major concept is that the eyes lead the body," says Arnold Sherman, O.D., an associate clinical professor at the State University of New York (SUNY) College of Optometry's University Eye

Center in New York City and director of its Sports Vision Center. He has been assisting local professional athletes and teams since the 1970s, and is a founder and past chair of the AOA's Sports Vision Section.

"There have always been a certain number of athletes interested in sports vision, but in the last four or five years there's been a tremendous increase in the science behind it," Dr. Sherman says. "Research has been coming out that shows definite improvements can be made in performance."

A study at the University of California, Riverside (UCR) reported that players on the school's baseball team improved their batting averages by training with a computer application designed to improve vision through perceptual learning. Pro hockey players who trained with special eyewear that only allowed them to see action intermittently showed significant improvement in practice drills, according to findings by Duke University researchers. And a technique called "the quiet eye," developed by a University of Calgary kinesiologist, has helped golfers see the ball better and basketball players improve their free-throw shooting.

As a result of such positive outcomes, there has been a tremendous growth in sports vision training, not only among highly paid professionals seeking one more competitive edge but also among amateurs, young and old, who want to hone their skills. Optometrists play an essential role, yet the complementary sciences being introduced to the training methods have brought psychologists, nutritionists, kinesiologists and even video game designers into the picture.

#### Brain power

Advancements in the science of vision are impacting the nature of competition across the world of athletics. Athletes, coaches and researchers are teaming up to try outside-the-box approaches to



**"THE MAJOR CONCEPT IS  
THAT THE EYES  
LEAD THE BODY."**

—ARNOLD SHERMAN, O.D.

## SUPERSTAR ATHLETES OVERCOME VISION IMPAIRMENTS

Suffering from various visual impairments, these athletes have overcome visual struggles to achieve tremendous athletic feats.

**Steve Holcomb** led the U.S. bobsledding team to a gold medal at the 2010 Winter Olympics in Vancouver and a pair of bronze medals at the 2014 Olympics—even though in 2007 he was nearly blind. Holcomb suffered from keratoconus, an eye condition that causes structural changes in the cornea, greatly distorting and reducing vision. In 2008, he eschewed career-ending corneal transplant surgery, opting instead to undergo a noninvasive procedure developed by Brian Boxer Wachler, an ophthalmologist in Beverly Hills, Calif., in which a solution containing riboflavin is used to strengthen the cornea and reduce the cone-like shape caused by keratoconus. Patients sit under an ultraviolet light for 30 minutes to activate the solution. Dr. Wachler typically combines that with Intacs, which involves implanting tiny plastic segments into the eye to flatten out the cornea. Today, the procedure is known as the Holcomb C3-R Cross Linking System.



Soon after **Casey Kotchman** finished the 2010 season with the Seattle Mariners, hitting an unsatisfying .217, he made an appointment to see the doctor who had performed Lasik surgery on him in 2004. The first baseman admittedly wasn't seeing the baseball well and was diagnosed with a bacterial infection in both eyes. After undergoing a procedure in which the doctor removed pus from his tear ducts, Kotchman followed up with sports vision therapy with Gary Lovcik, O.D., including dozens of sessions using the RevitalVision computerized program. In 2011, Kotchman signed with the Tampa Bay Rays, for whom he hit a career-best .306 that season.

**Larry Fitzgerald**, wide receiver for the Arizona Cardinals, suffered a depth perception problem as a child. His optometrist grandfather, Robert Johnson, began vision therapy with him at age 8, as a means to address learning troubles in school. Eventually Dr. Johnson tailored many of these exercises to athletics. To improve Fitzgerald's precision, control, spatial judgment and rhythm, for instance, Dr. Johnson would hang a painted ball from the ceiling and have him try to hit the colored dots on the ball with the matching colored stripes on a rolling pin. Fitzgerald attributes his successful football career, which includes seven Pro Bowl trips, to the vision therapy he underwent as a child.



ALEX LIVESLEY/GETTY IMAGES; RON VESELY/GETTY IMAGES; NORM HALL/GETTY IMAGES

enhancing performance.

One of the scientific principles that guides the work of Fraser Horn, O.D., associate dean for academic programs at Pacific University College of Optometry, is perceptual learning, which generally entails repeated exposure to specific stimuli in order to

achieve changes to the perceptual system that improve one's ability to respond to the environment. In sports vision, that translates to manipulating the pathways between the eyes and the brain.

Dr. Horn, the chair-elect of AOA's Sports Vision Section, has been involved in both

research and training with the university's baseball, soccer, football and tennis teams, as well as local athletes. "The better an athlete can see, the better he can react," Horn says. "Baseball is the best example. If batters can see the release point of the ball out of the pitcher's hand better,



**"WITHIN THE LAST DECADE OR SO, WE'VE STARTED TO LEARN THAT BRAIN FITNESS IS A BIT AKIN TO PHYSICAL FITNESS."**

—AARON SEITZ, PH.D.

they get better information, so their reaction is maybe a fraction of a second faster. Fractions of a second can make all the difference.”

From the standpoint of visual acuity, hitting a 95-mph fastball is arguably the hardest task in sports. It’s no wonder, then, that the average vision of Major League Baseball players is 20/12, says Horn. Yet even though they’re genetically blessed with above-average vision, good eyesight alone does not make for a Hall of Fame-worthy hitter, and that’s when sports vision training comes into play.

“We work on making things more automatic,” Horn says of his inter-

action with batters, in conjunction with the team’s coaches and trainers. “Based on visual information, their reaction becomes more automatic and more reflexive, and we give them feedback so they can make more accurate decisions.”

The Pacific University baseball team’s batters use iPad apps designed to improve eye-hand coordination and reaction time and participate in drills based on the cognitive load theory. “We’ll have a batter do an indoor hitting exercise, and when he gets good at it, we add a cognitive demand, such as a metronome, to make it more difficult for them—something beyond

what they’d experience on the field. Therefore, when he gets on the field, things are easier, more automatic, and he can handle the increased stress of a critical, ninth-inning situation. That’s the perceptual learning part.”

Perceptual learning is the specialty of Aaron Seitz, Ph.D., an associate professor of psychology at UCR. His background is in basic vision sciences as a means to understanding neuroplasticity, a concept by which the adult brain can be fundamentally rewired. “Within the last decade or so, we’ve started to learn that brain fitness is a bit akin to physical fitness,” Seitz says. “If we exercise our brain in the proper ways, pretty much everything that the brain does should be able to be improved.”

According to Seitz’s research in this field, a central issue in neuroscience is how the brain selectively adapts to important environmental changes. He says while the

brain needs to adapt to new environments, its architecture has to be protected from modification due to continual bombardment of undesirable information. Clarifying how the brain solves this so-called stability-plasticity dilemma in its sensory areas is the primary goal of his research.

To test the hypothesis that the temporal coincidence of a stimulus and a reward will result in learning of that stimulus, Seitz and his research team designed a study in which a perceptually “invisible” motion stimulus (i.e., not attended by subject) was paired with the letter-target of a rapid serial visual presentation task. “We found that learning effects pre-

viously thought to be either due to attention, or resulting from mere stimulus exposure, actually result from a reinforcement process, similar to that found in conditioning,” Seitz states.

### Playing to win

About four years ago, Seitz’s research caught the attention of Gary Lovcik, O.D., co-owner of Anaheim Hills Optometric Center in California and a sports vision practitioner. Lovcik has worked with Nike, which includes sports vision as part of its comprehensive SPARQ (Speed, Power, Agility, Reaction and Quickness) Sensory Performance training system for athletes, used by professional scouts and teams

to analyze prospects. He’s also used RevitalVision, interactive Web-based software that provides a series of individualized visual stimuli designed to enhance the neural interactions in the visual cortex, with his sports vision patients. Both of those techniques improved athletes’ vision, Lovcik says, but he contacted Seitz about developing a less expensive, more accessible product.

Last year, they introduced a computer and tablet application that combines Lovcik’s and Seitz’s research and expertise, called UltimEyes. The two teamed up with accomplished video game designers to create the app. The game requires

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the player to identify a series of faint and fuzzy patterns, which are shown against a hazy, gray background. The patterns become increasingly faint to exercise the player's vision. Sounds help players locate the target.

Seitz approached UCR baseball coach Doug Smith

prior to the 2013 season about using the app with his team. A total of 37 UCR baseball players followed a preseason regimen using it and reported stronger vision. Junior infielder Nick Vilter's vision tested at 20/15 when he began drills with the app before the 2014 season and says at the end of

the sessions, his vision improved to 20/12.5. Last year, Vilter registered a .215 batting average over 53 games and 158 at-bats. In

the first 27 games this year, he hit .363 in 91 at-bats.

Smith was surprised by the results. "Our guys stopped swinging at some pitches and started hitting others," he says. "Their strikeouts went down and batting averages went up."

Although the statistical and anecdotal results of the study are impressive, Seitz readily admits that there's more research to be done. "There were probably a lot of other things that made some impact, and we don't have a good estimate of what these things are for that particular team that particular season," he says. "The other thing, even if it's all attributable to our intervention, is to what extent is it that the players are more confident because they got something special versus actual changes in their vision? If I had to guess, I'd say half the effect would be vision itself and half attributable to things not directly vision."

### 'Eye' is for improvement

As Dr. Sherman says, the eyes lead the body. Starting with the eyes continues to prove successful for a number of athletes in various sports.

Last year, researchers at Duke University's Center for Cognitive Neuroscience published their findings from a study conducted on 11 players from the National Hockey League's Carolina Hurricanes. In the preseason, they trained using special eyewear, designed by Nike, featuring lenses that switch between transparent and opaque, producing stroboscopic visual conditions—much like a strobe light. The players who trained with the strobe eyewear experienced an 18 percent performance improvement in a series of on-ice skill tests. A control group, however, showed no change.

Joan Vickers, a professor of kinesiology at the University of Calgary, trains athletes with a helmet outfitted with cameras and mirrors that helps them track where they look as they play their sport. A golfer, for instance, looks steadily at the intended target for a second or two, looks back at the ball and lets his gaze rest there before and even after the stroke. It's what Vickers calls a "quiet eye." The quiet eye has four characteristics: It is directed to a critical location or object in the performance space; its onset occurs before the final movement common to all performers of the skill; its duration tends to be longer for elite performers; and it is stable, confirming the need for an optimal focus prior to the

**"SOME ARE WEEKEND WARRIOR WHO JUST WANT TO SEE BETTER AND ENJOY THEIR LIFESTYLE. FOR ME, THAT'S THE FUN PART OF SPORTS VISION."**

-FRASER HORN, O.D.



JAY C WENER/THINKSTOCK

final execution of the skill.

In 2009, the Public Broadcasting Service series "Scientific American Frontiers" documented Vickers' vision training with Calgary's women's basketball team. For three seasons, they used the quiet eye technique to improve their free-throw shooting. When they started the training, the team was shooting 54 percent from the foul line. After three years, that number jumped to 76 percent.

### Changing the game

There's so much that can account for any athlete's performance, good or bad, which is where other nontraditional training routines become a factor. There's weight training for specific muscle groups, sports psychology for visualization and relaxation, and nutrition counseling for improved physiology—including vision.

"Two nutritional substances, lutein and zeaxanthin, are very important," Dr. Sherman says, referring to a pair of nutrients found in kale, spinach and other greens. "They're known to hold off macular degeneration and cataracts."

As far as what's still to come regarding the science behind sports, vision is sure to be part of it. Some studies are exploring the relationship between vision and concussions, a major concern at all levels of sports. In April, a team at the University of North Dakota's department of psychology reported the findings of their study to determine the utility of oculomotor-based evaluation

protocols in screening for lifetime concussion incidence in elite hockey players. The study, published in the journal *Brain Injury*, provides a relatively sensitive screening tool to assess the probability of one or more previous concussions in an athlete. This model may allow athletic personnel to address in a timely manner the risks associated with repeat concussions, and to develop individualized concussion management protocols.

The AOA's Vision Rehabilitation Section has developed the new Brain Injury Electronic Resource Manual. Developed over six years, the manual is a comprehensive resource to aid optometrists in evaluating patients with brain injury. Maria Santullo Richman, O.D., member of the committee that

developed the manual and chair of the AOA's Vision Rehabilitation Section, says for the best patient outcomes, optometrists need to be involved with the rehabilitation team.

"In the past, few optometrists were on staff at hospitals or in rehabilitation centers. We wouldn't see these patients until much

later in their care continuum. That's changing, and this manual reflects the optometrist's role in the rehabilitation model."

The manual—and follow-up volumes in development—is available to members who join the Vision Rehabilitation Section.

In the meantime, athletes will continue to keep their eyes on the ball. "I have patients who are motivated athletes who want to do well," Dr. Horn says. "Some are weekend warriors who just want to see better and enjoy their lifestyle. For me, that's the fun part of sports vision."

*Bob Woods is a freelance writer based in Madison, Conn., who covers sports, among other topics.*

For more information on AOA sections, visit [aoa.org/vrs](http://aoa.org/vrs) and [aoa.org/svs](http://aoa.org/svs).



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## STUDENT SPOTLIGHT

### OPTOMETRY'S MEETING® 101

With Optometry's Meeting® nearing, first-time student attendees might be wondering what to expect. *AOA Focus* asked veteran student attendees to share their advice on how to make the most of the event. Welcome to Optometry's Meeting 101.

#### Susan Ly, University of the Incarnate Word, Rosenberg School of Optometry

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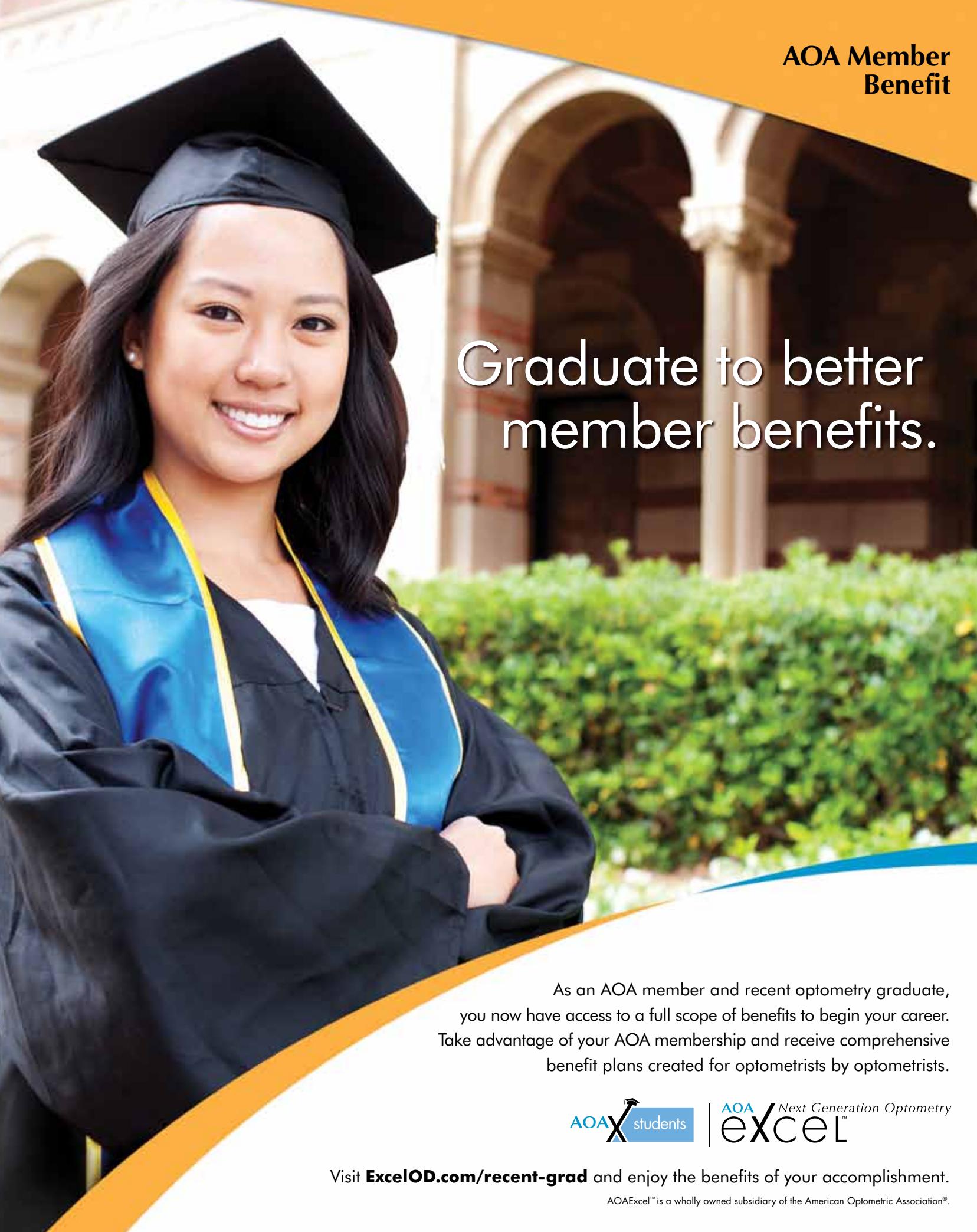
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business  
cards and  
distribute  
them wisely.

#### Andrew Steele, The Ohio State University College of Optometry

"You very well may meet the doctors you will practice with some day. This is your chance to make a positive first impression. Bring along tasteful business cards and distribute them wisely. Introduce yourself to leaders, company representatives and practitioners. Ask pertinent questions. Listen more and talk less."

Always dress in appropriate clinic attire while at the meeting venue (with the exception of the Student Bowl). And bring along some gel inserts for your feet and your preferred pain reliever."

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A large photograph of a young woman in a graduation cap and gown, smiling and standing outdoors with her arms crossed. She is wearing a blue and gold stole.

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## ASK THE CODING EXPERTS

# LOCATION, LOCATION, LOCATION

For reimbursement, consider each procedure on its own merits

Confusion arises when a procedure's classification as surgical or nonsurgical is defined by its placement in the code set.

In the June 1996 *Current Procedural Terminology* (CPT®) Assistant Coding Commentary titled "The Great Debate: When Is 'Surgery' Not Surgery?" the CPT Editorial Panel addressed the potential problems that occur when reporting certain procedures. Confusion arises when a procedure's classification as surgical or nonsurgical is defined by its placement in the code set.

For example, problems occur for beneficiaries who lack coverage for "surgery" but would be covered if the service did not fall within the surgery section. Likewise, confusion surrounds the reporting of nonsurgical procedure codes located in the surgery section for services performed by qualified health care professionals that may inadvertently suggest they actually perform surgery.

Even today, CPT users—both providers and payers—express these concerns. With technological advances, many incisional surgeries have become nonincisional (e.g., laser) or minimally invasive (e.g., epilation). Many of these procedures are located in the surgery section.

However, language has been added to the introductory section of the CPT 2014 code set to help clarify differences in surgical and nonsurgical procedures. This language also addresses generalizations on code descriptors based solely upon current code set subsection titles. Below is the new text excerpted from the "Instructions for Use" section of the CPT 2014 codebook:

It is equally important to recognize that, as techniques in medicine and surgery have evolved, new types of services including minimally invasive surgery as well as endovascular, percutaneous and endoscopic interventions have challenged the traditional distinction of surgery versus medicine. Thus, the listing of a service or procedure in a specific section of this book should not be interpreted as strictly classifying the service or procedure as "surgery" or "not surgery" for insurance or other purposes. The placement of a given service in a specific section of the book may reflect historical or other considerations.

With that clarifying addition, an article in the June 1996 *CPT Assistant* recaps the history and intent behind a CPT code's location and reiterates the structure of the CPT data set:

Because CPT is a "nomenclature" rather than a strict classification system, there may be some procedures that appear in sections other than those where they ordinarily would be "classified." From a historical perspective, CPT has always placed proce-

dures in general sections according to where physicians will most conveniently find them.

From a coding perspective, the CPT coding book is divided into six major sections:

- Evaluation and Management;
- Anesthesia;
- Surgery;
- Radiology (Diagnostic Imaging);
- Pathology and Laboratory; and
- Medicine.

The semantic differences have led to difficulties for physicians and patients in receiving reimbursement for procedures that have been performed. Some health insurance contracts strictly limit the definition of a surgical procedure and do not cover other "surgical" procedures. For example, when a procedure such as punctal occlusion (68761) is placed under the "surgery" heading in CPT, a payer may not cover the service and deny it as a "nonsurgical" procedure. Other health insurance contracts may not cover "surgery" of any type, and the inclusion of a procedure in CPT under the surgery chapter may lead payers to deny benefits. The issue is sometimes further complicated when third-party payers use "type of service" indicators. Although these indicators are often similar to, or the same as, the section names of CPT, they may be defined differently by payers and the definitions may vary between payers.

Therefore, when evaluating procedures for reimbursement or other purposes, it is essential that you consider each procedure on its own merits, and not simply on the location of the code in CPT. —*Doug Morrow, O.D., Harvey Richman, O.D., Rebecca Wartman, O.D.*

# 3 WAYS TO FOCUS ON YOUR STRENGTHS

Boost your practice and fulfill your satisfaction as a doctor

Sometimes ODs overcommit to cases that would best be handled by another OD. You might find yourself attacking every contact lens fitting and managing all types of posterior and anterior eye disease. True, in rural America it is much more difficult to not be the all-in-one eye doctor. The current state of optometry requires ODs to be knowledgeable in a much broader scope than 25 years ago. However, the most powerful and successful practices are those laser focused on their strengths.

Finding and focusing on your strengths will not only propel your practice forward but also will fulfill your satisfaction as a doctor. Here are three ways to get started.

## 1. Communicate.

Become the expert in your area of interest. My dry eye practice has grown exponentially over the past seven to eight years as I have focused on communicating dry eyes to many of my patients—even the



healthy ones. I evaluate the health of a patient's eyes by looking for such conditions as undiagnosed dry eye. I tell patients, "You do not appear to have dry eye today, but I do encourage you to wear sunglasses regularly and watch for these symptoms." Communication is the first step to tweets, posts and comments from patients about the services you offer.

## 2. Refer to other ODs.

Twenty-five years ago the competition was tight for refracting and diagnostic testing. Things have changed, and there are optometrists in your area who are more comfortable than you are at various areas of pathology. A good friend of mine who recently took his board certification test commented on how much more comfortable he was with the anterior segment section than the posterior segment. Are you going to lose patients by referring to your colleagues? Most likely not.

*"Are you going to lose patients by referring to your colleagues? Most likely not."*

frequently refer for vision therapy, and amazingly those patients return to my care for glasses, eye disease management and contact lens checks. If you find you are losing patients by referring to other optometrists, consider finding someone else to refer to. There are many great ODs looking to partner with other ODs.

## 3. Know your limits.

Recently, I had a patient who had undergone multiple refractive surgeries and was unsuccessfully fit in RGP contact lenses at another office. He came to me for a second opinion regarding his options. After much time and effort communicating with the patient, I decided that he would be best treated with a scleral contact lens. I was tempted to jump into scleral lens fits, but decided someone who has not only fit them but also worked with them routinely would be the best option for the patient. Together we decided his case was difficult enough that he wanted to see an expert in this area. I started researching for someone who could "fit" them and who also had a growing referral base of patients they were fitting. Patients respect you for knowing your limits. I told the patient that if he had been a dry eye patient, I would be the one for him to see; similar to me referring him out, doctors refer dry eye patients in. Don't forget to always plant seeds.

Treating everything does not mean you are successful in treating everything. If referring to other ODs is something you are unwilling to do, consider hiring an associate that complements your clinical practice.  
—Chad Fleming, O.D., AOAExcel™  
Business & Career Coach

# CLINICAL ABSTRACTION

EYE CARE ADVANCES

## ALTERNATIVES FOR AMD



**F**or age-related macular degeneration (AMD), the most common treatment is an injection of the AMD drug Avastin. But injections can be painful and daunting to patients. They also limit the role ODs can play in treating AMD, the most common cause of vision loss in people age 50 and older.

However, new research is pointing the way to novel treatments and more OD participation. For example, research from University College of London's Institute of Ophthalmology, published in the April 24 issue of *Small*, showed eye drops may be a viable treatment. Working with animal models, researchers delivered significant concentrations of nanoparticles loaded with Avastin.

Patients likely would welcome the alternative to injections. So would ODs. "Having these medications available in an eye drop form has the potential to be much friendlier for patients—and something that is easily within the scope of optometrists to perform," notes Geoffrey Goodfellow, O.D., chair of the AOA Publications and Education Committee.

Ben Davis, Ph.D., lead author of the research, wrote: "All the components we used are safe and

well established in the field, meaning we could potentially move quite quickly to get the technology into trials in patients—but the time-scales are dependent on funding."

Eye drops aren't the only alternatives in development. Scientists at Trinity College Dublin are examining IL-18, a component of the immune system that slows the production of damaging blood cells behind the retina. They tested whether IL-18 can be administered intravenously in research published in the April 2014 edition of *Science Translational Research*.

"This is the first way to look at intravenous management of AMD," says Jay Haynie, O.D., AOA member and executive clinical director for Retina and Macula Specialists in Washington.

More research is needed to verify the safety of IL-18. However, the IV approach comes with potential benefits, including being effective at various stages of the disease.

"In the future, I believe AMD will be treated with four different modalities: intravenous, injectable treatment by retina surgeons, eye drops and oral medication," Dr. Haynie says. —Brooke Auxier

**Get AMD patient education materials at [aoa.org/marketplace](http://aoa.org/marketplace).**

## RESEARCH IN BRIEF

### Effects of Anti-VEGF

➤ To test whether anti-VEGF injections—used to treat both neovascular age-related macular degeneration (AMD) and retinal vein occlusion (RVO)—affect intraocular pressure (IOP) over time, researchers analyzed data on 629 eyes with AMD and 95 with RVO. Three percent of eyes with AMD experienced IOP elevation, compared with 7.4 percent of eyes with RVO. The researchers concluded: "A history of multiple intravitreal anti-VEGF injections was not a significant risk factor for IOP elevation in our study."

Paper: "Long-term Effects of Multiple Intravitreal Anti-Vascular Endothelial Growth Factor Injections on Intraocular Pressure"

Authors: Yoon Jeon Kim, Kyung Rim Sung, Kyoung Sub Lee, Soo Geun Joe, Joo Yong Lee, June-Gon Kim, Young Hee Yoon

Source: *American Journal of Ophthalmology*, February 2014 (e-publication ahead of print)

### App Concerns

➤ Apps for eye care are flourishing, but should professional practitioners be wary? Researchers surveyed eye care-related apps for the iPhone. After identifying 182 apps, they found that the majority lacked user ratings and had 3,000 or fewer downloads. Only 37 percent included professional input in their development. "Despite the rapid emergence of eye care apps, a low level of qualified professional involvement in app development and a lack of peer review after publishing remain," the authors note.

Paper: "iPhone Applications for Eye Care Professionals: A Review of Current Capabilities and Concerns"

Authors: Nicholas M. Cheng, Rahul Chakrabarti, Jonathan K. Kam

Source: *Telemedicine and e-Health*, April 2014 (e-publication ahead of print), Vol. 20, No. 4, P. 385

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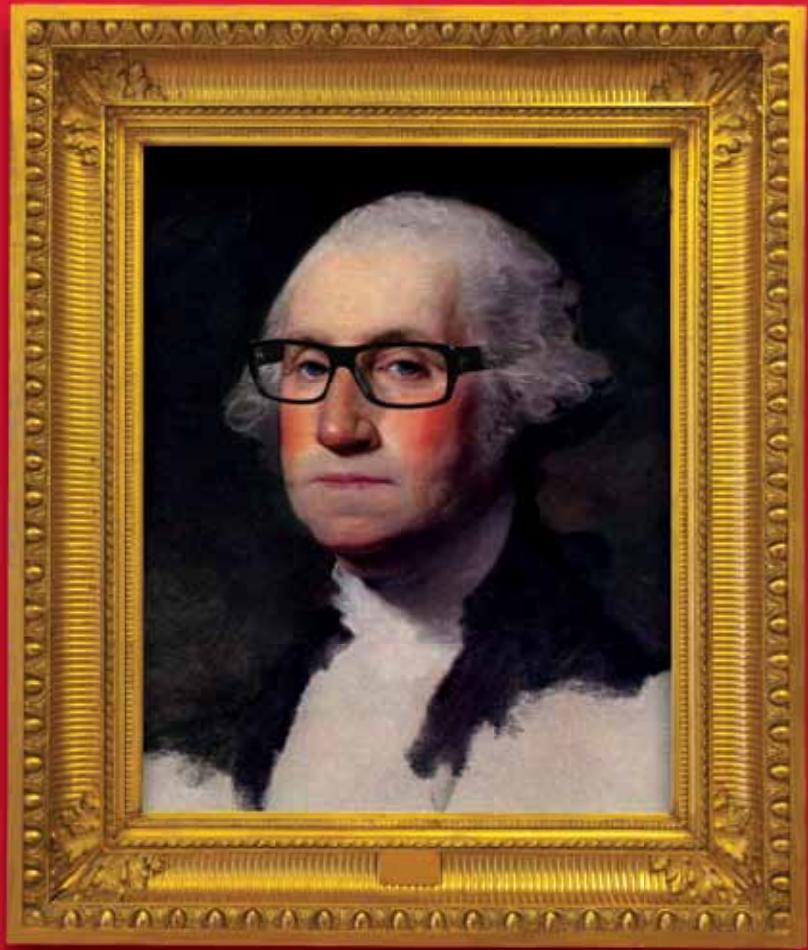
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There's truly something for everyone in 2014, including more than 224 hours of continuing education featuring new speakers and interactive sessions showcasing the latest innovations in eye and vision care. Plus, an inclusive "town hall" session will offer a unique forum to discuss the hot topics facing our ever-changing industry. And of course, an unprecedented number of new networking opportunities will bring colleagues and friends closer together in America's City of Brotherly Love.

**Great registration discounts are available through June 24<sup>th</sup>!**



**JUNE 25-29, 2014 • PHILADELPHIA**

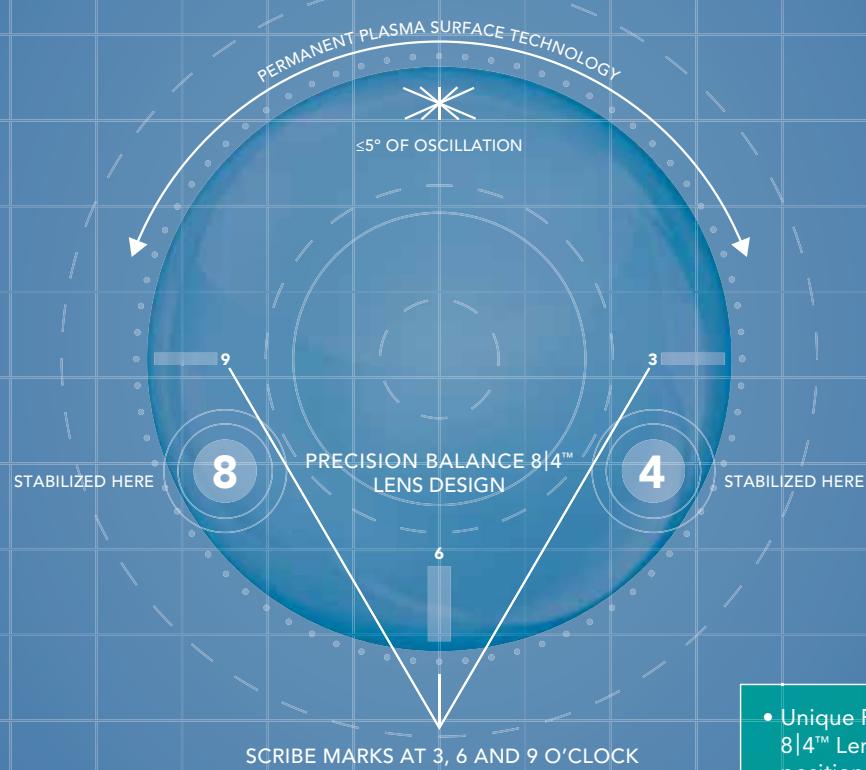


**Optometry's meeting®**



ENGINEERED FOR SUSTAINED PERFORMANCE

# THIS IS WHY our unique design and plasma surface gives your patients clear, stable vision\*\* and comfort<sup>1,2</sup>



Visit [MYALCON.COM](http://MYALCON.COM) to learn why AIR OPTIX® for Astigmatism contact lenses are the lenses of choice for many eye care practitioners.

- Unique PRECISION BALANCE 8|4™ Lens Design keeps lenses positioned at 8 and 4 o'clock for consistent stability and reliable visual acuity
- Permanent plasma surface technology provides superior wettability<sup>3†</sup> and deposit resistance<sup>4††</sup> for consistent comfort from Day 1 to Day 30<sup>2</sup>



PERFORMANCE DRIVEN BY SCIENCE™

\*Dk/t = 108 @ -3.00D -1.25 x 180. Other factors may impact eye health. \*\*Based on subjective vision ratings and investigator-graded surface deposits. †Compared to ACUVUE® OASYS®, ACUVUE® ADVANCE®, PureVision®, Biofinity® and Avaira® contact lenses. ††Lipid deposit resistance compared to ACUVUE® OASYS®, ACUVUE® ADVANCE®, PureVision®, Biofinity® and Avaira® contact lenses. \*Trademarks are the property of their respective owners.

**Important information for AIR OPTIX® for Astigmatism (lotrafilcon B) contact lenses:** For daily wear or extended wear up to 6 nights for near/far-sightedness and astigmatism. Risk of serious eye problems (i.e., corneal ulcer) is greater for extended wear. In rare cases, loss of vision may result. Side effects like discomfort, mild burning or stinging may occur.

**References:** 1. Alcon data on file, 2008. 2. Eiden SB, Davis R, Bergenske P. Prospective study of lotrafilcon B lenses comparing 2 weeks versus 4 weeks of wear for objective and subjective measures of health, comfort and vision. *Eye & Contact Lens*. 2013;39(4):290-294. 3. In vitro measurement of contact angles on unworn spherical lenses; significance demonstrated at the 0.05 level; Alcon data on file, 2009. 4. Nash W, Gabriel M, Mowrey-McKee M. A comparison of various silicone hydrogel lenses; lipid and protein deposition as a result of daily wear. *Optom Vis Sci*. 2010;87:E-Abstract 105110.

See product instructions for complete wear, care and safety information.

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Rx only