Some components of the ophthalmic exam are performed by technicians, requiring adequate knowledge of eye to diagnose appropriately.
Dry eye is one of the most frequent causes of patient visits to eye care practitioners, affecting an estimated 30 million people in the U.S.1 Dry eye symptoms may adversely affect visual function, potentially resulting in reduced quality of life and productivity.2-4

Determining the major etiology behind the dry eye is essential to optimal management. In aqueous deficient dry eye, hyperosmolarity results when lacrimal secretion is reduced. In evaporative dry eye, tear hyperosmolarity is caused by excessive evaporation from the exposed tear film due to insufficient production of protective lipids.5

Diagnosing the underlying cause of dry eye symptoms can be complex. The 2017 Tear Film and Ocular Surface Society Dry Eye Workshop recommends a systematic approach that starts with symptom screening, using validated questionnaires, followed by diagnostic tests intended to accurately classify the condition as aqueous deficient, evaporative, or mixed.6 It is estimated that 30-70% of patients experience mixed dry eye.7 If only aqueous deficient or evaporative dry eye is addressed in these patients, they may be unable to derive adequate relief. A simple way to help relieve patient symptoms is to recommend a dry eye solution designed for all major types of dry eye, such as SYSTANE® Complete. SYSTANE® Complete is designed to supplement all layers and stabilize the tear film, providing relief for all major types of dry eye.8,9,10

SYSTANE® Complete contains HP-guar, a non-ionic polymer that becomes a gel upon instillation and is known to enhance the effect of the active ingredient. SYSTANE® Complete uses Alcon’s advanced lipid nanotechnology which allows for an increased concentration of HP-guar resulting in better coverage8,10,11 and long-lasting relief.10-12

In addition, SYSTANE® Complete is designed to minimize blur on instillation due to its nano-droplet formulation.10 Patients using SYSTANE® Complete in my practice report experiencing long-lasting relief.

Patients approach their eye care providers seeking our recommendation for what we feel is going to be best for them. SYSTANE® Complete helps simplify this choice because it is suited for all major types of dry eye, providing patients with better coverage of the ocular surface, fast-acting hydration, and long-lasting relief—it’s one simple choice for optimal relief of dry eye symptoms.12-14

"It is essential that ECPs make a recommendation to ensure patients use the best product for their dry eye symptoms"8

SYSTANE® Complete in my practice report enhanced symptom relief compared to SYSTANE® Balance Lubricant Eye Drops.12-14

Tech role
Continued from page 1

A word of caution should be made though, because some patients relate an unreliable history or one filled with extraneous facts, which can lead to the inability to arrive at a proper diagnosis.

When dealing with challenging patients, experience and expertise are required to “weed through” histories to identify relevant facts.

This article will discuss important components of the ophthalmic examination that are usually performed by technicians.

Adequate knowledge of the eye, ocular adnexa, sensory inputs, and visual pathways are critical to arriving at some of the important diagnoses discussed as follows.

Cases were extracted from the author’s practice to illustrate principles and to emphasize the importance of thoughtful, complete adherence to the correct examination sequence.

Anatomy
The eye is situated within the bony orbit and is covered and protected by the eyelids. Fibers that transmit visual signals leave the eyes within the optic nerves (cranial nerve II), pass through the optic foramen in the posterior orbital wall and the cavernous sinuses, before converging at the optic chiasm.

Nasal fibers of the optic nerves—those that perceive the temporal visual fields—cross through the chiasm to the contralateral side where they converge with temporal fibers from the other nerve to form the optic tracts.

These terminate in cell bodies within the lateral geniculate bodies of the thalamus. Optic radiations connect these cells to the visual cortex in the occipital lobe—the area of the brain that perceives vision.

Other cranial nerves integral to the visual system include III (oculomotor), IV (trochlear), V (trigeminal), VI (abducens), and VII (facial). These nerves provide motor input to the muscles in the orbit, face, ciliary body, iris, and eyelids, as well as sensation to the eyelids, eyes, and orbital tissue.

Examination
The complete ophthalmic examination consists of assessments and measurements of the following:

1. Visual acuity
2. Motility
3. Visual fields
4. Pupils
5. Eyelids and adnexa
6. Anterior segment
7. Intraocular pressure
8. Fundus

The technician should approach each patient systematically with careful attention to data gathering according to the aforementioned list. This approach is particularly significant when faced with complex patients for which a diagnosis is not readily apparent; in these patients, careful performance of each step is vital.

The balance of this article will use case presentations to illustrate the importance of several components of the ophthalmic exam.

Visual acuity measurements
Visual acuity is usually measured by having patients read Snellen eye charts. Some acuity numbers have particular significance.

1. A visual acuity of 20/40 is generally needed to read standard newspaper. Having 20/40 in one eye usually qualifies one to obtain a driver’s license in any state.

2. A visual acuity of 20/200 defines blindness in most cases. Legal blindness is defined as a patient who has one of the following deficits:
   a. Best corrected visual acuity of 20/200 or worse in the better eye, or
   b. A visual field of 10 degrees or less regardless of the visual acuity.

Note that patients frequently express the following misconceptions:
   - “I’m legally blind in my right eye.” Remember that legal blindness is a patient definition, not an eye definition.
   - “I’m legally blind without my glasses.” Remember that legal blindness is based on the best corrected visual acuity.

Never assume that patients are capable of reading the letters on the eye chart. Illiterate patients may identify the big “E” but may not recognize any other letters, and such a patient is unlikely to admit to not being able to read.

If one suspects that a patient with 20/400 visual acuity should be able to see better, the examiner should test visual acuity with the “tumbling E” chart or children’s charts that contain drawings.

Tech role continued on page 4
Tech role
Continued from page 3

CASE 1
A 75-year-old woman who had previously undergone successful bilateral cataract surgery awoke with painless, significant vision loss in her left eye. She saw her cataract surgeon who could not make a diagnosis; he sent her to a retina specialist who also was unable to determine the cause.

A neuro-ophthalmology consult was requested, but the patient ended up on my schedule instead.

My technician began to methodically collect data and emerged from her room in 5 minutes with the correct diagnosis.

Here is what she had found:
Visual acuity:
OD: 20/20 OS: counting fingers at 4 feet
Automated refraction:
OD: -0.25 + 0.50 x 90
OS: +12.50 D
Visual acuity OS with AR and pinhole: 20/40

Pupils: No afferent pupillary defect
Certain data in this case contribute to making the correct diagnosis:
- The AR (+12.50 D) is more suggestive of aphakia than pseudophakia.
- The visual acuity when measured with the AR and pinhole establishes the fact that this eye still can see well.
- The absence of an afferent pupillary defect rules out optic nerve and widespread retinal disease.

With these data my technician diagnosed a dislocated intraocular lens (IOL). The slit lamp photographs taken after pupillary dilation are shown in Figures 1A and 1B.

Fibrotic capsular remnants can obscure the edges of implants and confuse examiners regarding the presence or absence of a lens. The silicone plate/haptic IOL in this eye had dislocated through a previously opened (by YAG laser capsulotomy) posterior capsule and settled against the inferior ciliary body in a difficult-to-visualize position.

Following vitrectomy surgery with IOL exchange and the implantation of an anterior chamber IOL, the patient achieved a visual acuity of 20/20.

CASE 2
A 75-year-old man complained of a spot in the left side of his vision for four days. This was unaccompanied by other symptoms, was unchanged, and was present in both eyes.

On examination his best corrected visual acuity measured 20/20 OU, but on confrontation visual field testing he had a left-sided defect approximately 45 degrees from fixation in both eyes. A Humphrey 24-2 visual field was normal in each eye.

Because of the concern that his history and confrontation field defects suggested the presence of a lesion that may not have been detected on Humphrey field testing, magnetic resonance imaging (MRI) of the brain was obtained.

It showed damage in the visual cortex of the right occipital lobe due to a cerebrovascular accident (stroke) (Figure 2).

The patient was referred to his primary care physician for further evaluation and initiation of antiplatelet or anticoagulant therapy.

CASE 3
A 44-year-old man complained of the worst headaches of his life and double vision for one day. His visual acuities were 20/20 OU, but he had a left exotropia and left ptosis. The left eye could not adduct, and there were severe deficiencies in supraduction and infraduction.

The pupillary diameters measured 3 mm OD and 5 mm OS, the left pupil reacted sluggishly to light, but there was no afferent pupillary defect.

This constellation of symptoms (exotropia with gaze restrictions, ptosis, and mydriasis) is characteristic of a pupil-involving third nerve palsy.

Though pupil-sparing third nerve palsies are usually vascular (due to diabetes or systemic arterial hypertension), a pupil-involving third nerve palsy is due to compression of the third nerve by a posterior communicating artery within the brain (Figure 3).

This constitutes a neurosurgical emergency that requires immediate referral of the patient to the emergency room (ER).

The patient needs emergent neurologic imaging with magnetic resonance angiography or cerebral angiography, followed by clipping or coiling of the aneurysm, because rupture of the aneurysm produces a 50 percent mortality rate.

Critical to making this diagnosis is the identification of the mydriasis. If the pupil is normal, the patient is diagnosed with a vascular third nerve palsy, does not require referral to the ER, and can be followed as an outpatient. Pupillary involvement (mydriasis), however, necessitates an emergent referral to the ER.

Conclusion
These three cases illustrate the relevance of key steps in the patient workup that are usually conducted by the technician. Performing these accurately means making the correct diagnosis, even when other technicians and physicians failed to do so. In some cases this may even mean saving the patient’s life.

Remember that examinations need to be performed methodically and completely to not overlook important findings. Therefore, the technician must learn proper technique for each step of the examination to recognize significant abnormalities, because some of these will not be recognizable later in the examination.
Tapping technician’s expertise in averting claim denials

Knowledge is power: know the top reasons why claims get denied and be proactive in prevention

By Matt Baugh

Exceptional patient care and valuable protected revenue can be achieved when we, as ophthalmic technicians, assist ophthalmologists by performing at our best. Taking patient histories, performing delegated ancillary testing, and scribing with the physician all proved opportunities to ensure that patients have a rewarding experience while we are with them in the office.

In addition to quality medical care, how can you help avoid claim denials, which are costly to the practice and confusing for the patient?

Claim denials are costly for any ophthalmology practice. It takes a team of committed individuals to help prevent these mistakes through a process of education, application, and communication. Technicians are critical members of the team who help bridge the gaps between the front and back office and between physicians and patients. This article addresses three pertinent questions about claim denials and the technicians’ role in how to avoid them.

1. **WHY DO CLAIM DENIALS MATTER?**

Ophthalmic practices are always seeking ways to increase efficiency. Every practice has processes in place to deal with claim denials, but how about a process that helps avoid the majority of these denials? Claim denials create inefficiencies by causing unnecessary work or rework.

By avoiding and preventing claim denials, technicians can dramatically increase the overall efficiency of the practice by decreasing the amount of work done on the back end with correcting and resubmitting claims.

Why should the technician want to be involved? Learning how to avoid claim denials supports ophthalmic technicians’ ultimate goal of caring for patients.

When a claim is denied, patients are often notified by their insurance, which creates unnecessary stress and worry for the patient, in addition to more work for them. Techs can help by recognizing common claim denial reasons and working to prevent them.

2. **WHAT ARE SOME TYPICAL DENIALS?**

There are many reasons why claims are denied. Some of the top reasons include insufficient documentation, inappropriate CPT or ICD-10 codes, missing or wrong modifiers, correct coding initiative (CCI) edits, prior authorization not obtained, and medical vs. vision. Following is an overview of common claim denials and how technicians can help patients steer clear of them.

**Insufficient documentation**

Sufficient and appropriate documentation is needed to help establish medical necessity for all billable services: exams, testing, minor and major surgeries, etc. As technicians, we can help ensure that all documentation is complete and appropriate by knowing the requirements.

How many elements of the exam are needed for a new patient level 4 E/M code? How many elements of the history of present illness are present? What are the different requirements for intermediate and comprehensive eye visit codes? Does this test require an interpretation or report?

Knowing the answers to these questions allows the tech to appropriately assist in fulfilling the necessary document requirements and prevent these types of claim denials.

**CLAIM DENIALS CONTINUED ON PAGE 6**
Claim denials
Continued from page 5

Inappropriate codes
“As gas is to a car and electricity is to a light bulb, so are diagnosis codes (ICD-10) to procedure (CPT) codes.” You need to have the correct CPT code for the procedure, test, or surgery associated with the correct diagnosis for the claim to be accepted by insurance.

Once we know the medical necessity requirements for specific services, we can actively look over the chart documentation to make sure the test and diagnosis are correctly linked. A necessary step is appropriately identifying laterality, coding to the highest level of specificity (avoid using unspecified codes), using the correct CPT code and modifier. “Scrubbing” documentation in this way by reviewing the documentation before the claims are sent to insurance can significantly decrease the amount of denials.

Missing or wrong modifiers
Did you know that certain tests and or surgeries are always bundled together? Sometimes a modifier allows these tests to be billed out, and sometimes they don’t. Modifiers tell the whole story to the payer and indicate that the test, surgery, or exam has been changed in some way.

The incorrect use or absence of a required modifier is one of the top five reasons claims are denied. Knowing how to use modifiers appropriately will help technicians understand some billing nuances and limitations.

Modifiers can be appended to office visits (-24, -25, -57), diagnostic testing services (-RT, -LT, -TC, -26, -50, -59), and surgeries (-50, -54, -55, -58, -59, -78, -79, -RT, -LT).

Following is a helpful summary of how and when to use the most common office and surgery modifiers.

CCI edits
CCI edits are a list of services that are “bundled” or not individually payable when performed the same day. CCI edits affect the following in various combinations:
- Exams can be bundled with other exams.
- Exams can be bundled with tests.
- Tests are often bundled with other tests.
- Tests can be included with surgery bundles.
- Surgery can be combined with other same day/same session surgery.

The next chart is a grid of which
testing services are bundled together. The description “mutually exclusive” is used to describe a combination of tests that should never be unbundled (by using a modifier) unless a payer has a written policy that states it is OK to do so. Billing for a combination of tests that are bundled can be unbundled in specific situations (using a modifier).

Billable same-day combinations do not require the use of a modifier to be billed out. For example, when fluorescein angiography and indocyanine green chorioangiography are performed by two separate machines on the same patient, is only one of the tests billable? Which test? The answer: The one that gives the physician the information needed for diagnosis and or treatment.

**Prior authorization not obtained**

Prior authorizations are becoming a more common requirement for commercial insurance and Medicare Advantage plans. Although a prior authorization does not guarantee payment, no prior authorization guarantees no payment.

Technicians play a critical role in making sure prior authorizations are in place for tests and minor procedures that are performed in the clinic and minor rooms. Make a list of these common tests and procedures that require a prior authorization.

**Medical vs. vision**

Patients can have vision insurance coverage, which covers routine eye exams usually once per year and requires a “vision” diagnosis as the primary diagnosis, or medical insurance coverage, which covers medical eye problems and requires a medical diagnosis as a primary diagnosis.

What are vision diagnoses? Refractive diagnoses such as myopia, hyperopia, and presbyopia are typically billed for vision exams.

Some vision insurance plans also require the use of a Z code:

- Z01.00 — encounter for examination of eyes and vision without abnormal findings
- or
- Z01.0 — encounter for examination of eyes and vision without abnormal findings

Medical diagnoses are anything pathologically occurring with the eyes: glaucoma, cataracts, macular degeneration, to name a select few. How many times do you hear this from a patient in response to your question of, “How can we help you,” or “What brings you in today?” “I am here for my yearly checkup” or “my annual eye exam” (or maybe even “I don’t know!”)?

These are not appropriate chief complaints and phrases that indicate that the patient would like to use his vision insurance. Technicians can communicate with physicians when patients want their vision insurance billed for this particular visit and if a medical concern is revealed during the exam, explain to the patient what the next step may be (consider billing medical insurance, returning for another visit to address the medical concern, potential out-of-pocket expenses if the patient has only vision coverage).

If the claim is sent to the wrong insurance or the correct primary diagnosis is not listed, this can be difficult and time-consuming to fix on the back end.

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**Claim denials continued on page 10**
Neurostimulation in the treatment of dry eye disease

Inducing a basal tear response has potential to counteract the progressive nature of dry eye

By Marc Bloomenstein, OD, FAAO

In addition to symptoms that may compromise vision, dry eye disease (DED) discomfort can be potentially detrimental to patients’ quality of life. Interventions designed to treat signs and symptoms of DED can be burdensome, especially if a multitiered approach is used.

Regimens involving any combinations of pharmacotherapy, warm compresses, supplemental tears, and omega-3 supplementation require diligence for what may seem like modest improvement. Yet, current treatment approaches can be highly effective when employed correctly. At the same time, patients and providers welcome approaches to simplify treatment.

A recent innovation in DED is said to be an effective treatment with potential to reduce reliance on pharmacotherapy. The TrueTear device (Allergan) uses neurostimulation to induce the production of basal tears, or more simply, a “real tear.”

The patient-administered device is inserted into the nose so that two prongs at the distal end approach the ophthalmic branch of the trigeminal nerve. A short electrical pulse—its strength can be attenuated by the

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He is a consultant for Allergan.

power settings—stimulates activity within the trigeminal nerve (5V1), with additional activity to cranial nerve VII, thus innervating the lacrimal glands.

How it works
Although it might seem that using TrueTear would induce reflex tears, the resulting response is the induction of a basal tear response. The mechanism by which patients begin to produce natural tears is not yet understood. Two theories regarding the mechanism of action have surfaced:

- Stimulation of the trigeminal afferent nerve fibers in the nasal cavity via the anterior ethmoidal nerve may initiate the nasolacrimal reflex, thereby leading to “an increase in activity in the superior salivatory nucleus region of the brain, which is responsible for control of natural lacrimation.”

- The electrical stimulus to the trigeminal afferent nerve fibers may cross over to the pterygopalatine ganglion, in turn shifting to the parasympathetic pathway to stimulate facial nerve VII that connects to goblet cells and meibomian glands.

These two theories are not mutually exclusive, and it may be that each mechanism is partly accurate.

In the prospective, single-arm, multicenter, open-label OCUN-010 study, patients exhibited improvement on Schirmer’s testing on days 0, 7, 30, 90, and 180 compared with baseline.

Anecdotally, I can confirm these results in patients in my clinic, with some saying they experience longer-lasting relief from symptoms related to the use of artificial tears.

Neurostimulation history
Many may recognize the concept of neurostimulation in medicine. For example, studies have described the use of neurostimulation in the management of chronic migraine pain, in rehabilitative settings, and for the treatment of post-traumatic stress disorder and cognitive neurologic conditions, such as Alzheimer’s disease. Neurostimulation has been used successfully for over 30 years.

The U.S. Food & Drug Administration has approved neurostimulation devices, including pacemakers, defibrillators, cochlear implants, and implantable devices intended to treat pain, essential tremors, refractory epilepsy, Parkinson’s disease, obsessive-compulsive disorder, obesity, and even retinitis pigmentosa.

Why this approach?
The science behind TrueTear provides strong rationale for its use and supports its clinical applicability. However, there may be more reasons to consider adding this device to one’s dry eye practice—especially for patients using supplemental tears.

The plethora of supplemental tear
options means that each patient can likely be matched with a formulation that will provide some benefit. At the same time, artificial tears are inherently palliative. In this regard, using the TrueTear device has potential to replace artificial tears with real ones.

TrueTear can potentially be complementary to other treatments. The device is disruptive in the sense that it offers a fundamentally different mechanism of action (or perhaps multiple mechanisms), but it does not change the overall approach.

There will still be patients with underlying inflammation who will benefit from pharmacotherapy. Anything we can do to liberate patients from multiple forms of therapy is beneficial. We need only evaluate experience in treating glaucoma to note that as the regimen’s complexity increases, adherence tends to decline. Plus, patients may realize cost benefit from avoiding drops.

Many patients may be candidates for this device. The potential to reduce

NEUROSTIMULATION CONTINUED ON PAGE 10

INTRODUCING TRUETEAR TO THE PRACTICE

By Patti Barkey, COE

Introducing any new product or service to one’s practice should be thoughtful and purposeful. The TrueTear device is no exception.

Given that this device is relatively new to market and based on its distinctive mechanism for relieving dry eye, it is understandable that there is no rulebook, per se, on how to roll it out. Each provider and clinic operation will need to determine on their own whether TrueTear is something to which they want to dedicate time and resources and then how to introduce it to patients.

For our practice, TrueTear has been very successful. Patients have been receptive, and our clinicians have reported encouraging early results using the device. At the same time, we think that our careful process of rollout and introduction contributed to our success.

Following is a summary of our perspective on how we introduced TrueTear to the practice and lessons we learned along the way.

► INITIAL ROLLOUT: When we first decided to introduce TrueTear, we chose to offer it to any patient taking supplemental tears as part of her regular dry eye therapy regimen. (This is a huge group of people in our practice.) By specifically targeting this group, we allowed our staff to hone in on early education to these patients. New patients who might be considered for supplemental drops were added to the list—by doing so we think we are hitting the lion’s share of candidates.

► 30-DAY FOLLOW-UP VISIT: We require patients to schedule a follow-up appointment 30 days later. At first, this was in the interest of due diligence—the device was new and we wanted to see how patients were doing. As we learned, the re-check is a good opportunity to support the education provided during the initial visit. We found that while most patients used the device properly, some hadn’t mastered their technique. Some had dialed up the power and reached a level of success and confidence with use. The re-check appointment qualifies as a billable office appointment because it is a valuable touch point in ensuring the patient is using the device properly, deriving benefit, and is satisfied with the treatment plan.

► STAFF TRAINING: Before offering TrueTear, all clinicians who would be using the device received training. Most staff participated in training, including using the device themselves (if appropriate). We understood that everyone would be more effective at training patients if they had experience themselves. This relates to my belief that anyone who would encounter a patient who is a potential candidate or already using the device should be able to answer questions from the patient.

► CONSENT AND DOCUMENTATION: Another reason training staff about TrueTear is crucial is to ensure proper documentation protocols. In our case, we prepared a consent form with contraindications and instructions for use so that patients were fully aware. We also created a purchasing agreement that relayed conditions for returning the device if it was unsuccessful.

► PATIENT EDUCATION: Every practice will have its own style for educating patients. However, fundamental aspects to training might be helpful. For example, it helps to train patients in a quiet place away from distractions. While that is implicitly logical, there is a less appreciated reason for performing training in this manner: using the TrueTear device may cause the patient to sneeze. Keeping tissues on hand in the training area and training away from other patients might avoid concerns about spreading germs. We also position patients in front of a mirror while they are trialing the device so they can see for themselves what a properly inserted device will look like. In a similar vein, we instruct our counselors to be careful with their word choice. Action words like “buzz,” “shock,” “zoom,” “vibrate,” “flutter,” “zap,” or “stimulate” might imply movement and induce undue anxiety. Instead, we prefer to describe the sensation as a “gentle pulse.” This may seem like a minor point, but anything we can do to make patients comfortable with using TrueTear will help them have a good experience with the device.

Patti Barkey is practice administrator, chief executive officer, and certified ophthalmic executive in Jacksonville, FL. She is also creator and executive director of Dry Eye University and executive director for Dry Eye Access. She speaks on behalf of Allergan, Johnson & Johnson Vision, and ScienceBased Health.
TOOLS TO HELP

Claim denials
Continued from page 7

The ideal process to handle the question of, “Is this exam medical or vision?” begins when the patient first makes the appointment, reinforced at registration and during the exam, communicated to the physicians, and then verified by scrubbing the documentation.

How does this knowledge boost my career?
The more you know, the more you can help. Just like learning about the anatomy of the eye, various diagnoses or procedures can help you help the patient and physician; learning about reasons claims are denied and how to prevent them can give you more tools to help patients, physicians, and your practice.

What type of technician do you want to be?
Tech 1 has limited skills and tools to help the practice, like a pocketknife. Tech 2 has many skills and tools to help the practice, such as a Swiss army knife. Secondly, which technician is more valuable to the patient, physician, and practice: Tech 1 or Tech 2?

By increasing your skills and learning how to avoid claim denials you increase your value to your practice and enhance your ability to be of service to patients. With increased ability comes greater job satisfaction, stability, responsibilities, and possible growth opportunities.

Neurostimulation
Continued from page 9

dependence on other forms of therapy suggests that TrueTear may be useful for a range of patients across nearly the spectrum of DED severity. I am educating my patients with signs of DED that TrueTear may reduce or eliminate the need for supplemental tears by inducing a physiologic, natural tear.

Introducing to patients
It is worth the time to educate patients about and demonstrate its proper use. DED patients are motivated to learn about modalities that might offer symptomatic relief.

It’s important to have a device in the office to show patients its basic principles and to assuage anxieties or apprehension. Using TrueTear is similar to using a nasal spray.

Convey to patients before they start using TrueTear:
- TrueTear has been proven safe and effective in clinical trials.
- The intensity of the electrical stimulation can be modulated.
- Stimulation can be sustained for as long as the patient feels comfortable. – TrueTear is Bluetooth-enabled; the accompanying smartphone app provides information about how often the device is used—but more importantly, it tracks the battery life (Note: the app is currently supported only on Apple devices; Allergan plans to release an Android version soon.)

It may be that using neurostimulation with patients experiencing mild DED can provide long-term benefit in slowing or stopping progression. Equally as promising, stimulating the basal tear response might affect long-term remodeling, delivering on the promise of restoring homeostasis to the ocular surface.

References
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