7 Hours of CE for $85!

OCOS Annual Pathology Symposium
Sunday, August 10th

Savada Teymoorian, MD, MBA:
The Use of Cataract Surgery in Angle Closure Glaucoma

Brian Kim, MD: Doctor, I See Spots in My Vision

Timothy You, MD:
Updates in Retina Care—What the Practicing OD Needs To Know

Tom Tooma, MD: Refractive Surgery Pearls

John Au, MD: The Benefits of VerifEye to Cataract Surgery

Negar Niazi, OD: Ocular Manifestations of Multiple Sclerosis

Lisa Garbutt, MD: The Red Eye

George Salib, MD: Glaucoma Updates

Rachelle Lin, OD: Double Vision

8 am - 4 pm (Sign-in begins 7:15 am)
Continental Breakfast & Lunch Included

$85 OCOS Members
$95 COA Members
$120 Non-COA & At the Door

RSVP at www.ocos.org
Dear Colleagues,

Summer is officially here and that means we at OCOS have been hard at work putting together your Pathology Symposium for 7 hours of GREAT continuing education ranging from double vision to multiple sclerosis. I’m looking forward to a fun event with fun topics and good food! I hope you will be there.

DIRECT FROM COA: We need your help to expand your patient treatment protocols! We need help lobbying lawmakers to vote "yes" on SB 492 (advanced procedures bill), COA’s sponsored legislation to redefine the profession of optometry. COA has scheduled appointments with state lawmakers in their district offices on Friday, July 18 and Friday, July 25. It will take less than 30 minutes out of your day to explain to your elected representative why he or she should support SB 492.

Where are we in SB 492? The bill is now waiting to be heard in its final committee, Assembly Appropriations, before moving on to the Assembly and Senate Floors for a vote. There could not be a more urgent time for you to take action on the bill. We are facing strong opposition and need every single doctor of optometry and optometry student to meet with their lawmakers.

If you can’t take time out of your day, please write your local legislators and let them know that you support SB 492 and why. Also, stay tuned to the action alerts from COA and take the couple minutes it takes to send an email. Your voices are crucial!

Thank you for your membership and continued support of organized optometry. The OCOS board and I are truly here for you...the members so please feel free to contact us with your questions or concerns. I would also like to congratulate the new OD class of 2014! We are looking forward to call you our colleagues and working with you. Enjoy your summer everyone!

Sincerely,
Isabell Choi, OD

Upcoming OCOS Meetings:

October 14 - Membership Drive
December 9 - Holiday Mixer

Welcome New Member!
Carmen Barnhardt, OD, MS, FAAO

Perceptions
Orange County Optometric Society

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NVISION Laser Eye Centers Announces New Surgeon

Dr. John Au will perform surgery at the Fullerton and Newport Beach locations.

NVISION Laser Eye Centers’ CEO Todd Cooper announced that Dr. John Au has joined the company. Dr. Au will be performing cataract and LASIK surgeries at the Fullerton and Newport Beach locations.

“As we continue to grow and expand our business throughout California and beyond, we seek surgeons with impeccable credentials and experience to underscore NVISION’s status as a premier provider of eye surgery services,” says Cooper. “Dr. Au has trained with top innovators in the field of cataract and cornea-refractive surgery, and shares their passion for continuously improving patient outcomes.”

Dr. Au completed his Bachelor of Science degree in pharmacology at the University of California, Santa Barbara. As a post-baccalaureate, he spent two years at the University of California, San Francisco engaged in basic science research. He then graduated from Virginia Commonwealth University School of Medicine, where he was inducted into both Alpha Omega Alpha and Phi Kappa Phi Honor Societies.

Dr. Au completed his ophthalmology residency at the Cole Eye Institute, Cleveland Clinic Foundation, where he served as chief resident for his graduating class. He also completed his fellowship training, specializing in cornea-refractive surgery, at the Cole Eye Institute.

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Glucoma patients count on their eye care providers to be their guardian angels, at least when it comes to their sight. When treating glaucoma, regardless of the method used, the singular goal is to reduce intraocular pressure (IOP) and prevent damage to the optic nerve.

For years, ophthalmologists have been limited to three standard treatment options for glaucoma: medicine, laser trabeculoplasty, and incisional surgery. When time allows and vision is not (yet) affected, glaucoma specialists will first try to ameliorate intraocular pressure with a regimen of medicinal eye drops containing anti-hypertensive agents. When medical treatment is insufficient or not appropriate, selective laser trabeculoplasty (SLT) is often used to treat the drainage angle of the eye. If medicine and SLT fail, glaucoma surgery may be required to prevent loss of vision.

This trifecta of treatments does have its shortcomings. Medicine fails to work when patients forget to take it, and typical medicinal noncompliance is believed to be about 50%. Laser therapy can quickly reduce intraocular pressure, but may not be enough. Glaucoma surgery, though often successful, entails a taxing postoperative course for patients. Furthermore, what happens when patients exhaust their treatment options without success? Minimally invasive glaucoma surgeries (MIGS) such as the iStent are filling the gaps between treatment options, doing so with little risk during cataract surgery.

**iStent**

The iStent is the smallest FDA-approved stent available (at 1 mm long and .33 mm high) to be used in the body. It falls under the MIGS category, as it provides additional IOP reduction with little risk while already performing cataract surgery. Currently, it is the only FDA-approved MIGS procedure. Each iStent has a specific orientation for either a left or right eye with the goal to direct it toward the inferonasal quadrant, where most of the collector channels are located. The dimensions of the iStent allow for natural placement within Schlemm’s canal, facilitating aqueous humor outflow and lowering intraocular pressure.

**Managing MIGS Post-op**

When co-managing patients who have had these procedures, always perform a gonioscopy with the first few weeks after surgery to view the iStent. Watch for abnormalities in the tissues such as fibrosis. Note that due to retained viscoelastic or red blood cells in the anterior chamber, which can and do obstruct the trabecular meshwork, you may notice an increase in IOP. However, most hyphemas resolve by the next day after surgery. IOP spikes after iStent can also be related to malpositioning or obstruction. It routinely can take up to 6 weeks to see the effects of the iStent. Patients should be instructed to continue with their current glaucoma drop regimen until that time, and then the decision can be made to alter treatment based on the results of the iStent procedure.

**Conclusion**

The goal for any glaucoma treatment is to ease the patient’s ocular hypertension and maintain the patient’s vision with minimal risks. When co-managing, do not hesitate to voice your concerns to the patient’s eye surgeon, and keep the line of communication open when you see patterns in data, e.g. consistently rising intraocular pressure.
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To Co-Manage or Not To Co-Manage?  
That Is The Question!

The co-management of cataract surgical patients is, as you know, a tremendous responsibility and a gratifying experience at the same time. For most of us, we have been following our patients for many years, providing them with excellent eye care, and then one day we (and the patient) see that they need cataract surgery. We care about our patients and want the best for them—the best surgeon, the best experience for the patient, and an excellent result.

We know that cataract surgery always has risks and the possibility of complications, so we do not take this decision lightly, despite the 98% success rate.

We also know that surgical abilities, advancements in technology used, and overall patient experience vary widely among surgeons, adding to the importance of the decision of to whom you refer the patient. Do you want to refer to a big box type of practice where the care might not be as personal (and who has an optical shop to tempt your patients), or do you want a practice/surgeon who will spend time with the patient to ensure maximum understanding and satisfaction and who will return your patients to you? We all want a happy patient who returns to thank you and bless you for an outstanding referral and experience!

So now that the patient has come back to your office singing your praises for your wise choice of referral and for their surgical experience, do you want to do their post-operative care and examinations? The answer to this question varies widely among optometrists, which is to be expected. Some offices do not allow or encourage co-management, while others leave it up to the individual optometrist. At the Orange County Eye Institute, for example, we always pose this question to our referring doctors in order to make them as comfortable as possible referring their patients to us. Some optometrists want to be heavily involved in the postoperative care within the first 3 months after surgery, while others are happy to see them once they have healed and once they are ready for a refraction/glasses.

If you do NOT wish to co-manage, then the surgeon will send the patient back to you for ongoing eye care after the post-operative course of the patient has stabilized. You will not be involved in the post-operative management of the patient in the first 90 days after surgery in this case, and you will be happy to receive the patient back with their new and improved vision.

If you DO wish to co-manage in their postoperative care, the question then arises as to billing/compensation for your care. This can get a bit confusing, so let me break it down into easily understandable choices:

1. Co-manage and only bill insurance for the postoperative care, regardless of the type of IOL implanted (standard or premium)
2. Co-manage and get compensated extra for extra care involved with premium (Lifestyle) IOLs
3. Both 1 and 2
4. None of the above—see the patient postoperatively but do not bill or get compensation

If you are a participating provider for the patient’s medical insurance (Medicare, private medical insurance, etc), then you can bill the insurance company directly for the portion of the 90 day postoperative period in which you were responsible for the patient’s care. Ninety days of care equates to
20% of the cataract surgery fee, so you will bill a portion of that. For example, let’s say the surgeon releases the patient back to your care after 10 days of postoperative care, you would be able to bill for 80 out of 90 of the postoperative days. If the surgeon payment by insurance was $745, the maximum postoperative reimbursement would be 20% of $745, which would be $149. Since you were seeing the patient for 80/90 of the days, your portion of this would equate to 80/90 X 149 = $129. At the Orange County Eye Institute, we can show you how to do this if you need help.

Additionally, optometrists spend extra time and more of their expertise in the care of lifestyle (premium) IOL patients, and many would like to be compensated for this. This compensation would come directly from the patient (as opposed to coming from the ophthalmologist’s practice) to the co-managing optometrist so as to minimize the appearance of giving a “kickback” in the eyes of federal regulators. For instance, at the Orange County Eye Institute, we would have the patient either write a separate check to the co-managing OD during their pre-operative counseling here (which we would mail to the OD), or we would call the co-managing OD’s office with the patient’s credit card information. This payment is usually on the order of $250-$500 depending on the premium IOL used (in addition to what was billed from insurance). On the other hand, some optometrists feel uncomfortable with this arrangement as they feel their patients’ perceptions of them would be unfavorable, and so some prefer not to receive this compensation. Of course, we are all aware of the laws forbidding “kickbacks”, and we certainly do not engage in this practice—this compensation is for the extra work by the optometrist and the time involved in their extra care for these lifestyle IOL patients post-operatively.

This co-management fee for lifestyle IOLs is subtracted from the overall fee that we would charge the patients when we schedule the surgery (so there is no extra cost to the patient or to their insurance—this is clearly explained to the patient). You do not need to specify to the patient at the pre-operative appointment how much you will be compensated because the surgeon will not have decided on a final IOL recommendation yet. You can simply tell the patient that you will work closely with the surgeon in their post-operative care, and that the surgeon’s office will give them the details as to the IOL and the payment arrangements if the patient is a candidate for and elects to have a lifestyle IOL implanted. Even if they do not choose a premium IOL, you can still bill insurance as mentioned above if you are involved in their postoperative care.

So that’s it in a nutshell! The co-management of cataract surgery by optometrists is a very personal and important decision but one that can significantly impact the post-operative care of the patient, not to mention the bottom line for your practice. If you decide not to co-manage, the surgeon will be happy to take care of the patient post-operatively for you. If you wish to co-manage, the surgeon will work closely with you in the post-operative period to deliver the best care to the patient.

If you have questions regarding this process, please do not hesitate to contact me at gsalibmd@oceyeinstitute.com or at my office at the Orange County Eye Institute.
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To Enhance or not to Enhance, That is the Question!

Author: Kristen Brown, O.D., F.A.A.O

I have been a TLC Optometrist for 18 years and can say from the bottom of my heart that TLC is a company that is committed to optometry and stands behind its mission to change patient’s lives. This assurance and loyalty is continually reinforced by our “Lifetime Commitment” program. Whether in Canada or The United States, the Lifetime Commitment is one of the most favorable and more common reasons why patients choose to have laser vision correction at TLC. With the Lifetime Commitment, eligible patients receive enhancements at no cost as long as they continue to see their TLC Affiliate Optometrist each year for comprehensive eye examinations.

Fortunately, the likelihood of needing an enhancement at TLC after LASIK or PRK is just 2.1%, historically well below industry average.1,2 This encompasses the entire TLC population including myopes, hyperopes and patients with severe astigmatism. Patients with a higher preoperative Rx (e.g., > -6.00, > +3.00, and > -2.00 cyl) are more likely to need an enhancement and may take longer to stabilize (6-12 months).

The likelihood of enhancement depends on several factors including, but not limited to:

- Severity and type of the preoperative refractive error
- Patient healing and response to the initial laser treatment
- Post-operative dry eye and management
- Patient compliance with post op medications
- Diagnostic testing and laser technology utilized

Retreatments after LASIK and PRK have been shown to be safe and effective.2,3 In the past, many surgeons would feel comfortable lifting very old flaps or even re-cutting a pre-existing flap. In 2014, it is a much more common practice to perform surface ablation (PRK) as the primary enhancement option especially if the flap is older. The goal is to reduce the risk of epithelial ingrowth. This decision (PRK versus flap lift) is dependent on many factors.4

Most surgeons will enhance if UCVA is 20/40 or worse and will wait 3-6 months after the original procedure before considering an enhancement.2,5 This is to insure stability of the Rx and to lower the risk of needing yet, a third procedure. Not all patients with a post-op refractive error need an enhancement. If they do, that is what our Lifetime Commitment is for. A patient with -0.75 residual Rx after the original LVC may be thrilled with their outcome. Refractive happiness is subjective.

If you plant the seeds of a patient needing an enhancement, the patient will want an enhancement. Let the patient tell you how they feel about their refractive outcome.

Not all patients need to be referred back to the center for enhancement evaluation if they are happy and healthy. Clearly, if there is a medical issue that is a different situation.

Patients in their 50’s to 60’s considering an enhancement need to be carefully assessed for lenticular changes, not just cataracts. The number one reason I determine a patient to be a non-candidate for enhancement at this age is early lenticular changes. “But my doctor said I don’t have cataracts.” While this is true, many do have early lenticular changes and additional laser will not solve the problem. Brightness Acuity Testing (BAT) or other qualitative assessment of vision may be helpful in determining if lenticular changes are visually significant. The best course of action is to wait until lenticular changes become a cataract. Patients may need spectacles in the interim.

Example: 57 y/o was -8.00 sphere before initial LVC. Patient was 20/20 PL SPH post-op but has shifted to +1.25 -0.50 x 90 20/20-2 at 15 years post op. This is typically NOT a LASIK regression issue. Look for lenticular changes.

20/Happy

Patients with a mild residual Rx that are 20/Happy do not need retreatment simply because there is a residual Rx. There are many reasons why a patient’s vision can change over their lifetime. Many times is it appropriate to enhance and sometimes not. A major component of the Lifetime Commitment is the need for the patient to have yearly comprehensive eye examinations. No one knows your patients’ eyes better than you. This knowledge is critical to the success of your patients’ outcome. If you are not sure whether an enhancement is appropriate or not, please contact your TLC Clinical Director.

1. TLC Data, Unpublished
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