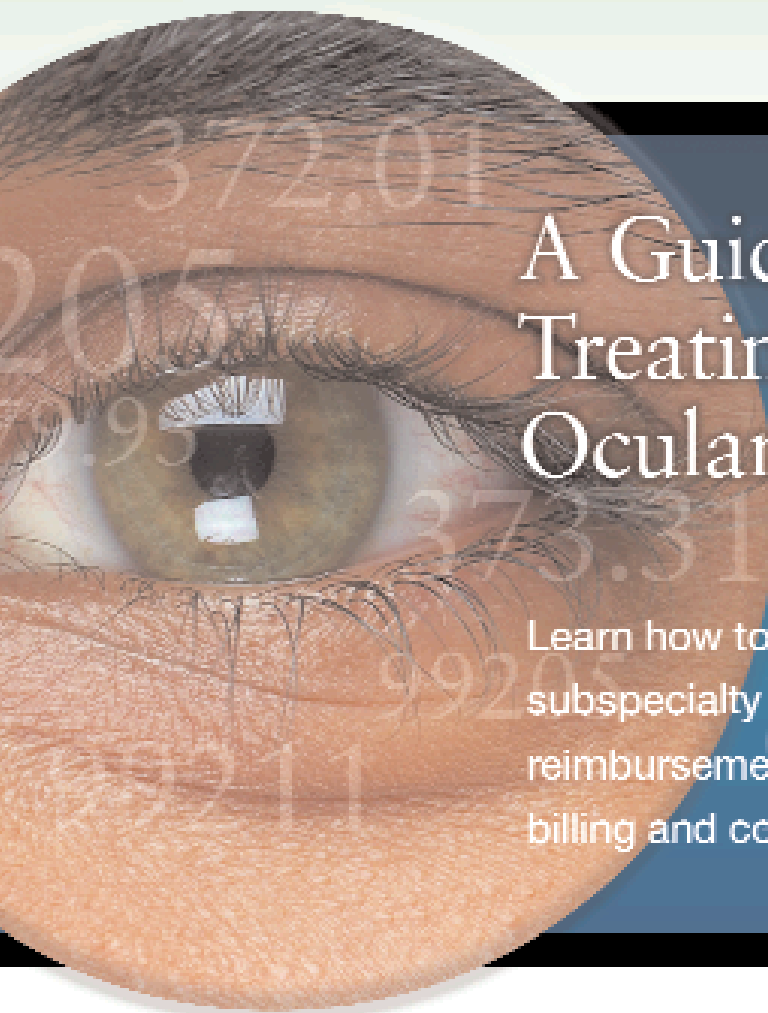


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A SUPPLEMENT TO

OPTOMETRIC
Management

MAY 2007



A Guide to Diagnosing, Treating and Coding for Ocular Allergy

Learn how to develop an allergy subspecialty as you maximize reimbursement through accurate billing and coding.

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By Scot Morris, O.D., F.A.A.O.

Grow Your Practice With a Focus on Ocular Allergy

Build your allergy patient base by making accurate diagnoses, offering the best treatments and increasing revenues with proper billing and coding.

We all see many patients with ocular allergy. Some walk into our offices during an acute episode, making the problem simple to diagnose. Others present with minor signs and symptoms or have contact lens intolerance that's not obviously linked to allergy. But whether allergy episodes are acute or not easily recognizable, we know they impact patients' overall eye health and comfort. Our challenge as clinicians is to detect ocular allergy in all its presentations and treat it effectively — all within an accurate and efficient coding and billing framework that will help grow our practices.

In this article, I'll discuss the most common types of allergy, how to diagnose them quickly and accurately and the best treatments. I'll also discuss how to bill and code appropriately to ensure proper and timely reimbursement.

Ample opportunity

About 1 in 5 Americans suffers from allergies.¹ Among them, approximately 4% present primarily with ocular symptoms and 75% with allergic rhinitis, often associated with ocular allergy symptoms.² What's more, 54% of contact lens wearers with ocular allergies say their lenses are uncomfortable during flare-ups.³ About 73% of contact lens wearers with allergies change their wearing schedule or rewetting habits, and 42% switch to eyeglasses when contact lens wear becomes uncomfortable during allergy season. So there is ample opportunity for us to learn how to treat our patients more effectively and improve their quality of life.

Early, accurate diagnoses

As your patients' primary eyecare provider, you're on the front line of ocular allergy detection. Make sure you're tuned in to the signs and symptoms.

Itching is usually a patient's number one complaint. In fact, it's considered a red flag indicating ocular allergy. Other signs and symptoms include watery eyes, red eyes and ocular dryness, which often accompany other complaints, such as a runny nose and sneezing. During the examination, you may find conjunctival follicles or papillae, or, in some cases, giant papillary conjunctivitis. Another clue: Ocular allergy symptoms occur bilaterally.

Consider all of these factors along with the patient's family or personal history. If one of the patient's parents has an allergy, then the patient has a 1 in 3 chance of developing one.⁴ If both parents have allergies, the patient has a 7 in 10 chance. A previous history of allergy symptoms, such as sneezing, runny nose and watery eyes, may indicate undiagnosed allergy.

Allergic Conjunctivitis

- Epidemiology—5% to 25% of population
 - Symptom severity: allergic conjunctivitis rhinitis Ig E-mediated*
- Causes
 - Environmental Factors
- Indigenous: Pollens, climatic influences, aromatic hydrocarbons
 - Genetic Factors
- Allergic parent increases risk 4x; 10x if both parents are allergic
 - Medications
- Drying agents decrease clearing secretions of the mucosal membranes
 - Devices
- Contacts

Hinkley, JAMA 2000;118:1019
Wolfeck-Wolfeck et al., Schwaub-Med Wochenschr 1997;118:1019

Of the 1 in 5 Americans who suffers from allergies,¹ about 4% present primarily with ocular symptoms and 75% with allergic rhinitis.²

The Symptoms

- Sandy/Gritty Sensation
- FB Sensation
- Vision Fluctuation
- Dryness upon waking
- Chronic eye/chalazion
- Chronic Tearing/Discharge
- Epiphora
- Blurred Vision
- Tired/Sore Eyes
- CL Intolerance
- Itching***
- Ocular Redness
- Chemosis
- Watery discharge
- Eye lid Edema
- Facial Issues
 - Dermatitis
 - Haze
- Respiratory Problems
 - Hay Fever
 - Asthma
 - Snoring
 - Nasal Congestion

Adult patients with allergy also have dry eye symptoms. Once you've confirmed a dry eye diagnosis, you can proceed with appropriate treatment.

If this appears to be the patient's first bout with allergy symptoms, ask about lifestyle changes. Perhaps the patient has a new pet, a new house or even a new sweater. Or maybe it's peak allergy season and your patient's mild allergies are now exacerbated by new contact lenses. If you're unable to determine what's triggering the symptoms, you may need to refer the patient to an allergist for radioallergosorbent testing to determine the allergens to which she's allergic. Once the patient knows the triggers, she can avoid them and begin to feel more comfortable. The final diagnosis will indicate one of these four types of ocular allergy:

- **Seasonal allergic conjunctivitis (SAC):** This is the most common ocular allergy that occurs mainly in adults. Patients are allergic to environmental allergens, from pollens to dust. Their eyes become itchy and watery, and you may notice injection and a minor reaction in the conjunctival papillae upon examination.

- **Vernal keratoconjunctivitis (VKC):** Boys and young men usually develop this type of ocular allergy. Symptoms may include ptosis, ropy discharge, cobblestone papillae, Trantas dots and shield ulcers.

- **Atopic keratoconjunctivitis (AKC):** This type of allergy is seen mostly in adult patients, but it can occur in individuals in their early teens. Symptoms of AKC are similar to those of VKC, although the papillae are typically smaller and the eyelids are thicker and more edematous. These patients usually have coexisting systemic allergies, such as chronic rhinitis, focal dermatitis and asthma.

- **Giant papillary conjunctivitis (GPC):** Typically seen in contact lens patients, GPC causes a thick mucous discharge, inflamed superior papillae and blurry vision.

Dry eye conundrum

Adult patients with allergy often have dry eye symptoms as well. You'll need to measure tear break-up time and test for dry eye disease if allergy treatment alone doesn't clear up an acute allergy episode. For allergy and dry eye, explain to patients how you'll proceed with treatment. You can't cure dry eye or allergy, but you can help patients feel comfortable and keep them in their contact lenses by meeting with them regularly and adjusting treatments as needed.

Choosing the right therapies

Once you've addressed the dry eye and have identified the type of allergy the patient has, you can provide ocular symptom relief. Explain to patients who are tempted to buy eye drops at the drug store that OTC medications, such as antihistamine/vasoconstrictor combinations, aren't the best treatments.

You have several drugs from which to choose. Antihistamines like emadastine difumarate 0.05% (Emadine) work quickly, but not long term. Combination antihistamine/mast-cell stabilizers, such as epinastine HCl ophthalmic solution 0.05% (Elestat), olopatadine HCl ophthalmic solution 0.1% (Patanol) and azelastine HCl ophthalmic solution 0.05% (Optivar) have the histamine-lowering power of an antihistamine plus the inflammation-reducing effect of a mast-cell stabilizer. They're the first choice for many eyecare professionals.

If these combination drugs don't effectively reduce inflammation, corticosteroids, such as loteprednol etabonate 0.2% (Alrex), loteprednol etabonate 0.5% (Lotemax) and fluorometholone alcohol (FML), can help. Monitor their use and have patients stop taking them when inflammation decreases. Another option is to use nonsteroidal anti-inflammatory drugs (NSAIDs), such as ketorolac tromethamine 0.5% (Acular) and diclofenac (Voltaren Ophthalmic), to relieve pain and inflammation.

These basic drug guidelines hold true for all types of ocular allergy. However, it's always essential to treat any infection first with antibiotics and, finally, to make the eyes clearer and more comfortable.

Schedule patients to return to you in 2 weeks, and ask them to call you in the interim if any problems arise. If patients have concomitant conditions, such as dry eye, they may need to use prescription eye drops regularly. Patients with allergy alone can use a combination antihistamine/mast-cell stabilizer as needed for relief of ocular allergy symptoms. Let patients know they should return to you any time if

OCULAR ALLERGY CASE STUDIES

Vernal Keratoconjunctivitis (VKC)

The Patient: 25-year-old man

Signs and Symptoms

- Thinking of discontinuing soft contact lens wear
- Chronic swollen eyelids
- Morning discharge
- Known chronic allergies
- Intermittent eczema

The Exam

- Minor lid edema
- Pale palpebral conjunctiva
- Moderate superior papillary reaction
- No significant inferior palpebral conjunctival involvement
- Mucous strands in the tear film seen in lissamine green staining
- Limbal Trantas dots
- Mild bulbar conjunctival injection
- Mild inferior papillary reaction
- Some diffuse limbal infiltrates were noted
- No perilimbal changes

Treatment

- Epinastine HCl 0.05% (Elestat) in both eyes every 12 hours
- Prednisolone acetate (Pred Forte) in both eyes every 4 hours
- Artificial tears every 2 hours
- Referred to an allergist for atopy and a dermatologist for eczema

Coding

- Vernal conjunctivitis (372.13)
- New patient, moderate severity, 30 minutes (99203)

Giant Papillary Conjunctivitis (GPC)

The Patient: 45-year-old man

Signs and Symptoms

- Irritation
- Occasional blurred vision
- Contact lens discomfort
- Itchy eyes in the morning
- No chronic allergies
- Noncompliant with cleaning hydrogel contact lenses

The Exam

- Multiple protein deposits on center of toric contact lenses
- Clear lid margins
- Cobblestones
- Severe nonstaining papillary hypertrophy
- Moderate hyperemia of the superior palpebral conjunctiva
- Moderate mucous strands in the tear film and upper fornices
- Mildly hyperemic bulbar conjunctiva
- Clear corneas

Treatment

- Discontinuing contact lens wear for 3 to 4 weeks
- Epinastine HCl ophthalmic solution 0.05% (Elestat) every 8 hours
- Loteprednol etabonate 0.5% (Lotemax) every 8 hours
- Switching to daily toric lenses
- More frequent office visits to monitor stabilization

Coding

- New patient, moderate to high severity, 45 minutes (99204)
- Chronic allergic conjunctivitis (372.14)

Seasonal Allergic Conjunctivitis (SAC)

The Patient: 18-year-old woman

Signs and Symptoms

- Red, watery, itchy eyes

The Exam

- Mild lid edema
- Moderate bulbar conjunctival edema and injection
- Mild inferior papillary reaction
- Mild punctate keratitis of the inferior cornea

Treatment

- Epinastine HCl 0.05% (Elestat) every 12 hours
- Cold compresses
- Artificial tears every 2 hours
- Avoiding allergens
- Using epinastine 0.05% as needed after acute episode resolves

Coding

- Established patient, low to moderate severity, 10 minutes (99212)
- Simple chronic conjunctivitis (372.11)

Allergy-related Diagnostic Codes

These International Classification of Diseases (ICD-9) codes cover most diagnoses related to ocular allergy:

- 372.01 Serous conjunctivitis, nonviral
- 372.02 Acute follicular conjunctivitis
- 372.03 Mucopurulent conjunctivitis
- 372.05 Acute atopic conjunctivitis
- 372.11 Simple chronic conjunctivitis
- 372.12 Chronic follicular conjunctivitis
- 372.13 Vernal conjunctivitis
- 372.22 Contact blepharoconjunctivitis
- 373.31 Eczematous dermatitis, eyelid
- 373.32 Allergic dermatitis of the eyelid
- 379.93 Eye redness
- 379.99 Itchy eye
- 372.71 Hyperemic conjunctiva
- 372.73 Conjunctival edema
- 375.15 Tear film insufficiency
- 375.22 Epiphora, insufficient drainage

the eye drops aren't working, and that you'll diagnose and treat the problem promptly. Together, you'll be managing the allergy symptoms for many years. In fact, you'll need to see patients with chronic allergy as frequently as you see your dry eye patients.

Accurate coding and billing

Since ocular allergy is a chronic, lifetime condition, you'll be able to build the allergy segment of your practice. From a business perspective, this makes perfect sense — as long as you position your practice to receive accurate and timely reimbursement. To that end, focus on your documentation.

The first step in documenting any patient visit is to establish medical necessity. To do this, document a medical chief complaint. Second, write down the specifics about the medical exam and history, diagnosis, treatment and patient education you've provided. A patient with allergic conjunctivitis needs at least two, possibly three, visits, and you must document the details of each one.

Next, choose the proper codes based on the documentation. Each medical diagnosis has its own International Classification of Diseases (ICD-9) code. (See "Allergy-related Diagnostic Codes.") Before you submit any paperwork for reimbursement, you must become familiar with the criteria for each ICD-9 and medical services code. Current Procedural Terminology (CPT) codes divide patients into "new" and "existing"

Codes for Ocular Allergy-related Medical Services

These Current Procedural Terminology (CPT) codes address the severity and time spent on new and existing patients:

New Patient

- 99201 Self limiting, minor severity, 5 min.
- 99202 Low to moderate severity, 10 min.
- 99203 Moderate severity, 30 min.
- 99204 Moderate to high severity, 45 min.
- 99205 Moderate to high severity, 60 min.

Established Patient

- 99211 Self limiting, minor severity, 5 min.
- 99212 Low to moderate severity, 10 min.
- 99213 Moderate severity, 15 min.
- 99214 Moderate to high severity, 25 min.
- 99215 Moderate to high severity, 40 min.

categories and assign codes based on the medical severity and time spent with each patient. (See "Codes for Ocular Allergy-related Medical Services.")

Tying it all together

Your clinical duties can seem separate from the paperwork you need to complete to keep your practice running smoothly. The truth is they're not. They go hand in hand. As you build your allergy patient base and continue to develop the medical services you offer, you'll find that documentation will help you clarify and organize patient care. Coding not only forces you to define what you do, it also enables you to pull together data about a specific diagnosis or activity. Your attention to diagnosing and treating allergy effectively will have enormous benefits for your patients. And your attention to billing and coding will deliver those same great benefits to your bottom line. **OM**

Dr. Morris is a featured international speaker and educator. He practices at Eye Consultants of Colorado in Conifer, Colo. He's the founder of Morris Education & Consulting Associates, a professional continuing education and consulting firm.

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By Scot Morris, O.D., F.A.A.O.

Carve Out an Allergy Niche

Create the right environment for allergy diagnoses, patient education and profitability in your practice.

The prevalence of ocular allergy makes it easy to develop an allergy subspecialty in your practice. The most effective way to accomplish this is to look at allergy as part of the inflammatory ocular surface disease category, which includes dry eye syndrome. Many allergy sufferers present with symptoms similar to those of dry eye patients and, in some cases, they may receive some of the same treatments. As clinicians, we must educate patients with inflammatory ocular surface disease by informing them that they have a chronic problem requiring a long-term treatment regimen and ongoing care.

Here's how to increase the awareness of allergy in your practice, involve your staff and educate patients to develop a viable allergy niche.

Raising awareness

As an optometrist, you're the patient's first chance to receive an accurate ocular allergy or dry eye diagnosis. So it's best not to wait for patients to come into your office with a major complaint. Instead, you should prepare yourself to detect signs and symptoms before they become severe and to handle acute flare-ups. Specifically, let's look at the process for ocular allergy detection.

Some patients know they have allergies, and others don't. If they have moderate to severe allergic conjunctivitis combined with other symptoms, such as a runny nose and sneezing, they're probably right. Of course, you and your staff can spot these patients the moment they walk in the door. The questionnaire you give patients to complete to determine whether or not they have allergies should include inquiries about itching, redness, history and recent activities that may have brought on an attack.

However, it's better to determine if patients have allergies before signs and symptoms arise. To do this, you'll need to raise awareness among associates and

staff about the patient's allergy history and symptoms, which, as you know, is part of their overall ocular health. Just as a history of rosacea may be the reason for a patient's dry eye and contact lens problems, a history of allergy should be top of mind when patients complain of contact lens intolerance or other ocular surface discomfort.

Because patients may not know they have allergies, it helps to ask not only about their history but also about symptoms. Questions, such as "Do your eyes ever feel itchy?" "Do certain activities, such as dusting or raking leaves, cause you to sneeze or develop a runny nose?" can provide important clues. Even patients who answer no to these questions may have some hidden allergies or sensitivities.

So make sure you evaluate all of the answers and clearly mark "allergy" or "possible allergy" on the patient's chart. This information can help you choose the best contact lens or diagnose the origin of conjunctivitis down the road. By raising your awareness of the potential for allergy, you'll improve the quality of patient care and build a lucrative subspecialty in your practice.

Staff involvement

You also can increase allergy awareness among your staff. Talk to them about your goals to expand the scope of your practice. Take the time to train, motivate and empower them by conducting a series of combined training sessions on allergy and dry eye. This information will help them discuss patients' complaints on the phone, at the front desk and in the exam rooms. Tell employees their tone should be positive as they inform patients that the doctor will determine their problem and help them feel better.

Next, give each staff member a responsibility that will help the practice reach its goals, and offer the support and resources everyone needs to complete

the tasks. Some members of your staff talk to patients on the phone or in the waiting room. Others discuss the history form or perform routine testing. Still others handle the reimbursement for allergy-related services, which requires knowledge of allergy coding.

Explain that you'll be conducting future meetings to assess progress and set additional benchmarks. And give employees an incentive to motivate them and help them succeed. For instance, if your practice experiences an 8% increase in medical exams, you can give each employee a percentage of the profits based on his or her salary or a flat fee.

Patient education

Another aspect of building a successful allergy subspecialty is patient education. Do your patients know that allergies may be affecting their ocular comfort or ability to wear contact lenses? Certainly, the ones who come into your office with an acute allergic episode don't need convincing. However, as with dry eye patients, you must educate allergy sufferers about the signs, symptoms and effects of ocular allergy. And you must tell them that you can help.

The first step is to inform them about ocular surface diseases, such as allergy and dry eye. I place pamphlets in the waiting room that explain the definition, causes and treatment options for ocular surface disease. The handout has a checkbox-style questionnaire on the back and a clear message that my practice treats these conditions.

The pamphlet makes it clear that ocular surface disease may require multiple medical visits over a lifetime. It states there is no one-time cure and that allergy is a chronic medical issue that may cause symptoms periodically for years. It also states that the doctor and patient can find the right treatment to manage the condition. For instance, if patients have allergies, the doctor can recommend certain medications or suggest switching to different contact lenses.

Not only does this handout get the message out, it also helps patients realize they may have a problem and need your services.

Once patients know something about ocular surface disease, you and your staff need to be ready to explain it in greater detail if they ask questions. This is the second step. You know the answers already. Just make sure your employees are well informed. Work with your staff to develop a script to address

Separating Routine Eye Care From Medical Visits

Whether a patient presents with an acute allergy episode or with some allergy-related contact lens issues, it pays to approach visits for vision testing and medical issues separately. For instance, if a patient has a chief complaint related medically to ocular surface disease, such as allergy or dry eye, you have the option to proceed with the medical exam and postpone the vision testing for another time. In milder cases, the reverse order may make more sense.

Either way, you will create a second billable visit (and more chair time) where you can perform more extensive ocular surface disease testing, including vital dye staining and the Schirmer test. By breaking down your approach into two visits, you will have more time to educate patients about etiology and treatment strategies as well as another opportunity to demonstrate that you offer high-quality eye-care services. You want these patients to become loyal and generate referrals to your practice.

your patients' concerns. At a minimum, the script should explain each test, the type of allergy they have, treatment options, common drug side effects and the time it usually takes for symptoms to resolve.

The third step in this educational process involves giving patients a follow-up letter. The letter should explain the circumstances under which patients should call your office to schedule an initial or follow-up appointment. Allergy patients may pass the letter along to someone else with the same problem who may decide to contact your practice.

As a good follow-up procedure, note the dates on your calendar when patients' come in to visit you for seasonal allergy treatment, and send them a reminder to schedule an appointment the same time next year. The whole experience of raising your awareness and that of your patients — and relieving their symptoms — makes for an excellent start in carving your allergy niche. **OM**

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- 1. What percentage of Americans present primarily with ocular allergy symptoms?**
 - a. 2%
 - b. 3%
 - c. 4%
 - d. 6%
- 2. What percentage of contact lens wearers with allergies change their wearing schedule and rewetting habits during allergy season?**
 - a. 60%
 - b. 73%
 - c. 80%
 - d. 90%
- 3. What is the number one complaint that's considered a red flag, indicating a patient has an ocular allergy?**
 - a. Itching
 - b. Watery eyes
 - c. Dryness
 - d. Red eyes
- 4. If one of the patient's parents has an allergy, what are the chances that the patient will develop an allergy?**
 - a. 7 in 10
 - b. 4 in 8
 - c. 2 in 5
 - d. 1 in 3
- 5. What is the most common ocular allergy that occurs mainly in adults?**
 - a. Vernal keratoconjunctivitis (VKC)
 - b. Seasonal allergic conjunctivitis (SAC)
 - c. Atopic keratoconjunctivitis (AKC)
 - d. Giant papillary conjunctivitis (GPC)
- 6. Which type of ocular allergy is typically seen in contact lens patients and causes a thick mucous discharge, inflamed superior papillae and blurry vision?**
 - a. Vernal keratoconjunctivitis (VKC)
 - b. Seasonal allergic conjunctivitis (SAC)
 - c. Giant papillary conjunctivitis (GPC)
 - d. Atopic keratoconjunctivitis (AKC)
- 7. Which drug doesn't have the histamine-lowering power of an antihistamine plus the inflammation-reducing effect of a mast-cell stabilizer?**
 - a. Epinastine HCl ophthalmic solution 0.05% (Elestat)
 - b. Olopatadine HCl ophthalmic solution 0.1% (Patanol)
 - c. Emadastine difumarate 0.05% (Emadine)
 - d. Azelastine HCl ophthalmic solution 0.05% (Optivar)
- 8. The Current Procedural Terminology (CPT) code for a new patient with an ailment categorized as "self-limiting, minor severity, 5 minutes," is which of the following?**
 - a. 99201
 - b. 99211
 - c. 99212
 - d. 99205
- 9. Allergy sufferers present with similar symptoms and receive some of the same treatments as which type of patient?**
 - a. Posterior blepharitis patients
 - b. Anterior blepharitis patients
 - c. Microbial keratitis patients
 - d. Dry eye patients
- 10. Patient education pamphlets should make it clear that ocular surface disease may require which of the following?**
 - a. Multiple medical visits over a lifetime
 - b. One visit per month for 6 months following an initial diagnosis
 - c. Two to three visits following the initial diagnosis
 - d. One visit following the initial diagnosis