Exam Room Efficiency-A Team Approach

Utilize staff more
Have Tech Specialties
Increase in techs, equals increased exams per hour
The Doctor needs to be a “Data interpreter, you become the data gatherer”
Why?

Doctor shortage looms as a crisis
By LISA GIRION
Los Angeles Times
A looming doctor shortage threatens to create a national healthcare crisis by further limiting access to physicians, jeopardizing quality and accelerating cost increases.
Twelve states -- including Texas, California and Florida -- report some physician shortages now or expect them within a few years. Across the country patients are experiencing or soon will face shortages in at least a dozen physician specialties, including cardiology and radiology and several pediatric and surgical subspecialties.

Healthcare reform predicted to worsen family-doctor shortage, trigger longer ER waits.
Bloomberg News (11/13, Wechsler) reported the “health overhaul, aiming to add 36 million Americans to the insurance rolls, will worsen a family-doctor shortage, triggering longer waits for office visits and crowded emergency rooms.” Currently, “underserved areas...need 16,679 more primary-care physicians.” Indeed, the pending legislation “would raise pay for family doctors, increase residency training and forgive school debt to help meet that deficit.” But it’s predicted that “those measures...will take years to make a difference.” In the meantime, Boston has already seen longer wait times that were “driven in part by” its “healthcare reform initiative.”

Tech Specialties
- Optical Techs
- Front Desk Techs
- Billing & Coding Techs
- Testing Ophthalmic Techs
- Exam Room Techs (Drs./Ophthalmic Techs)
- Etc., Etc.

Drs. Techs/Ophthalmic Technicians
Duties:
- Greet the patient (identify yourself)
- Establish reason for visit
- Discuss insurance
- Create a folder
- Begin exam

Drs. Ophthalmic Tech procedures
Fills out necessary paperwork, then front desk gives chart to tech
Tech calls pt back to pre-testing room:
- Performs AR, VF Screening (HDT),
- Reads glasses, color vision, stereo test, (always described purpose of testing).
- Ask your doctor what he wants for pretesting/pre-exam room (don’t assume).
**Tech then takes pt to exam room:**
Records HPI, ROS, Meds, Fam Hx, Ocular Hx (include any eye inj, sx and or disease including dates) on the exam sheet.
Checks Visual Acuity, preliminary refraction, pupils, motility then puts chart on outside wall and instructs Dr that pt is ready.

**Dr and Tech go into exam room:**
Dr goes over Hx with pt then performs final refraction followed by external/internal exam with slit lamp. Goldman, staining, dry evaluation, etc.
While the Dr is examining the pt he is dictating to the Tech who is recording the results in the patient’s chart.
Dr will then decide if further testing is needed. If so tech will take pt to the testing room perform all tests that the Dr has ordered.

**“Assessment” = “Finding”**
Finding = proceed with appropriate Testing

Dr. wrights orders under “plan” on exam sheet for documentation purposes and passes off to Testing Tech......

Follow the S.O.A.P. rules.
He will have already dictated/ written his “assessment”.
Therefore, the plantesting, will follow the diagnoses in the “assessment”.
Do all testing associated with “assessment”.

Exam - Assessment -Plan - Testing – Testing Interpretation
-Billing and Coding - Next Steps
**Assessment**  
(example of narrow angle glaucoma)

A routine exam turned medical from patient complaint and findings…... (You found something)

From Testing, doctor discovers narrow angles, high pressures then quizzes patient on family history and symptoms (previously not mentioned to tech!)

Under Assessment, “narrow angles”, “high pressures”, “headaches in the middle of the night, that wake the patient up”.

(Refer to Tom’s rules)

**Plan**

Run: GDX, Visante, Gonio Lens, Fields, Photos, BAT, IOP’s, Pachy, DFE, Prescribe glasses (original C.C.)? etc.  
(Explain what you are doing as you work and why all tests cannot be run on the same day)

***Ophthalmic Tech may pass off the testing Tech at this point. Then Dr. goes on to next exam room with Ophthalmic Tech, etc. (good flow with sufficient tech support)

After all testing has been done tech will then walk pt back to exam room for the Dr to go over test results and make a plan for the next visit. Tech will fill out interpretation reports, record any final notes and fill out the flow sheet while the Dr is talking to the pt.

---

**Testing**

**GDX**

The Machine

RNFL Evaluation with Scanning Laser Polarimetry

GDx VCC

What It Does

What It Does

How to interpret the results
Is this a good "Interpretation and Report"? 

No

Based on S.O.A.P. what should it say in the center box?

Go back to “Assessment”
(Write on print out)

1. Headaches in the middle of the night
2. Narrow angles
3. High pressures
4. Family history of glaucoma
5. Early cataracts
6. Dry eyes, with keratitis

Go to “Plan”
(Write on print out)

1. Begin drops to lower pressure
2. Depending on angles, refer for P.I.
3. Discuss frequency of visits with patient

Visante

The Machine

What It Does

How to interpret the results:

Go back to “Assessment”
(Write on print out)

1. Narrow angles
2. Headaches in the middle of the night
3. High pressures
4. Family history of glaucoma
5. Early cataracts
6. Dry eyes, with keratitis

Go to “Plan”
(Write on print out)

1. Begin drops to lower pressure
2. Depending on angles, refer for P.I.
3. Discuss frequency of visits with patient
Gonioscopy/Gonio Lens

How to interpret the results

This is a proper “Interpretation and Report”

Follow “Assessment and Plan” again.
Use same criteria for the interpretation and report as with the other machines.

Or, use the “circle and X’s” on the exam form.

Note: A Visante and a Gonioscopy, theoretically do the same thing.
That is, measure the angles of drainage for glaucoma interpretation.

Fields
The Machine

What It Does

How to interpret the results?
Go back to “Assessment and plan”
(Use interpretation from slide 18)
Follow the same routine/thought throughout all testing
(It’s the same information over and over again)

What it does
Phakic Retinal Report
RETINAL PHOTOGRAPH
GLAUCOMA
Indications for Testing: Symptoms---Suspected Disease---Chronic Disease
Photographs – Digital Image
u Code: 92250        Right Eye / Left Eye / Both Eyes                                   Test Reliability: Good / Bad

How to interpret the results?
Go back to “Assessment and plan”
Follow the same routine/thought through all testing

Pachymetry
(Pachy)
The Machine’s
Sonogage Pachymeter
Visante Pachymetry

What they do

Visante Pachymetry

How to interpret the results?

Go back to "Assessment and plan"

Follow the same routine/thought through all testing

Pachy Conversion Table:

<table>
<thead>
<tr>
<th>Corneal Thickness</th>
<th>Conversion Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>445</td>
<td>7</td>
</tr>
<tr>
<td>455</td>
<td>6</td>
</tr>
<tr>
<td>465</td>
<td>6</td>
</tr>
<tr>
<td>475</td>
<td>5</td>
</tr>
<tr>
<td>485</td>
<td>4</td>
</tr>
<tr>
<td>495</td>
<td>4</td>
</tr>
<tr>
<td>505</td>
<td>3</td>
</tr>
<tr>
<td>515</td>
<td>2</td>
</tr>
<tr>
<td>525</td>
<td>2</td>
</tr>
<tr>
<td>535</td>
<td>1</td>
</tr>
<tr>
<td>545</td>
<td>1</td>
</tr>
<tr>
<td>555</td>
<td>0</td>
</tr>
<tr>
<td>565</td>
<td>0</td>
</tr>
<tr>
<td>575</td>
<td>-1</td>
</tr>
<tr>
<td>585</td>
<td>-3</td>
</tr>
<tr>
<td>595</td>
<td>-4</td>
</tr>
<tr>
<td>605</td>
<td>-4</td>
</tr>
<tr>
<td>615</td>
<td>-5</td>
</tr>
<tr>
<td>625</td>
<td>-6</td>
</tr>
<tr>
<td>635</td>
<td>-6</td>
</tr>
<tr>
<td>645</td>
<td>-7</td>
</tr>
</tbody>
</table>

OK, the doctor has completed his exam, the ophthalmic Tech has filled her/his testing orders. After all testing has been done tech will then walk pt back to exam room for the Dr to go over test results and make a plan for the next visit. Tech will fill out interpretation reports (after Dr review). Record any final notes and fill out the flow sheet while the Dr is talking to the pt.

The doctor will then explain each test to the patient and its relevance to the diagnosis (assessment) and what is his/her plan for the patient. The tech is taking verbal cues from the conversation.
Example: “since you're pressures are so high, we are going to start you on an eye drop, medication, called Travatan Z. You will take this drop every night before you go to bed. We will start you off with a sample, then write you a prescription if the drop gives us our desired results”. This comment to the patient, is another embedded instruction for the tech to place a sample bottle of the patients medication on the desk for the doctor to hand to the patient.

Tech will then walk pt up to the front desk to be checked out and schedule next appointment….OD or OMD.

(This has also been discussed in the exam room and checked at the bottom of the form).
Or, use the form below and send a copy of the exam form. Consult request sticker saves time and is sufficient.

Consultations vs. Referrals — What’s the Difference?

Coding for a Consultation vs. a Referral continues to baffle many physicians. Since consultation codes pay substantially more than a referral (new patient) visit, practices often play it safe by coding all such visits as a new patient visit, thereby earning all the legitimate revenue they have earned for a consultation. On the other hand, depending on your specialty, billing too frequently for consultations is likely to flag you for an audit by Medicare and other payers.

So what’s the difference?

A Consultation is a request by a physician for the advice or opinion of another physician regarding the evaluation and/or management of a specific problem.

A Referral is the transfer of care from one physician to a second physician when the second physician assumes responsibility for treatment of the patient.

Remember the three Rs of consultations, all of which must be documented in the patient’s medical record:

• You must have received a written Request for consultation from the other physician.
• You must Render an opinion.
• You must send a written Report to the requesting physician.

Review Tech Procedures (from a tech/Kelly’s point of view)

Pt checks in at front desk:
Fills out necessary paperwork, then front desk gives chart to tech
Tech calls pt back to pre-testing room:
Performs AR, VF Screening (HDT), Reads glasses
Tech then takes pt to exam room:
Records HPI, ROS, Meds, Fam Hx, Ocular Hx (include any eye inj, sx and or disease including dates) on the exam sheet.
Checks Visual Acuity, preliminary refraction, pupils, motility then puts chart in wall and instructs Dr that pt is ready.

Dr and Tech go into exam room:
Dr goes over Hx with pt then performs refraction followed by internal exam with slit lamp.
While the Dr is examining the pt he is dictating to the Tech which is recording the results in the patient’s chart.
Dr will then decide if further testing is needed. If so tech will take pt to the testing room perform all tests that the Dr has ordered.
After all testing has been done tech will then walk pt back to exam room for the Dr to go over test results and make a plan for the next visit. Tech will fill out interpretation reports, record any final notes and fill out the flow sheet while the Dr is talking to the pt.
Tech will then walk pt up to the front desk to be checked out and schedule next appointment (with who)?

• Hand off flow sheet to billing and coding person at front desk for check out………..On to the next patient.
• Total Dr. time with patient,10-20 minutes at most.
• Total Tech time with patient, possibly an hour or more!
• Less Dr. time, more patients per hour.
• Requires more tech’s to work this well, 2-3/Dr.

Case Studies
Case Study #1

Routine Exam

- Pt comes in with a routine refractive complaint and tech takes pt back to start pretesting.
- Tech will perform a workup including AR/VF screening, Read Glasses and/or get previous CTL info, Chief Complaint, ROS, Medications, Allergies, Motility, Pupils, History (social, family, prev sx or inj), Visual Acuity, Preliminary refraction.
- Record prelim refraction on a sticky note and put on the chart.
- Inform Dr that pt is ready.
- Dr/Tech go into room.
- Dr performs refraction and does internal exam. Tech is filling out exam sheet as Dr is dictating. Tech is also filling out glasses Rx and super bill while the Dr is examining the pt.
- Dr gives pt findings and Tech is still dictating in the chart what the Dr is recommending to the pt as well as a plan including when to return back to the office.
- Tech walks pt over to the optician (or done in exam room) and explains what Dr is recommending for pt.

Case Study #2

Routine exam turns into medical exam

Pt makes appt for a routine exam but when tech takes pt back to start testing and gets CC the pt tells the tech she is seeing flashes and floaters. Tech then performs workup like a routine exam then instructs the Dr the pt is ready.

Dr/Tech go into exam room and Dr reviews CC.

The exam then turns into medical exam based on the complaint and the testing necessary that day.

This means we will no longer be using the patients vision insurance for the exam and will switch over to their medical insurance (they can still use their vision ins for glasses that day)

Dr will perform refraction and external/internal exam. Dr will then dilate patient and order testing which may include VF and photos.

Tech will take pt and perform testing then bring pt back to exam room for DFE.

Dr will go over results with pt and make a plan.

Tech will be scribing in the chart and filling out interpretation reports while the Dr is spending face to face time with the pt.

Case Study #3

Routine Exam / Harvesting Medical

Tech performs workup like a routine exam then instructs the Dr the pt is ready.

Dr/Tech go into exam room.

Dr performs refraction and does IOP & Slit Lamp.

During external/internal exam Dr finds that pt has narrow angles, moderately high IOP’s, large C/D ratio and Family Hx of glaucoma.

Dr then explains to the pt that he/she has findings and will have them back another day under their medical insurance to perform a medical exam and testing.

Dr will make a plan while the tech is recording.

The assessment should indicate refractive disorder as primary and Narrow angles as a second finding. The plan should indicate glasses RX given and will have pt back for further testing including Visante, Pachy, GDX, IOP and Gonio.

Always document plan for the next visit including which testing is indicated.

On the next visit tech can perform the testing before the pt sees the Dr.
Case Study #4

Medical Exam following Routine
Pt comes in and checks in at front desk.
Tech gets chart and brings pt back to and performs Visante, Pachy, GDX, and takes pt to exam room to do same workup as routine minus the refraction.
Remember we are billing the pt's medical insurance so for a comprehensive exam you will need to go over all elements again with the pt (CC, HPI, ROS, meds, family hx, social hx, allergies). Visual Acuity, pupils, motility.
Remember to always clean the equipment (chin rest, phoropter, goldman) between patients.
Dr/Tech will go into exam room and Dr will do internal exam including gonio and go over test results with pt.
The tech is dictating in the chart as the Dr is performing the internal exam. The tech is also filling out the interpretation reports from the tests performed.
While the Dr is talking to the pt the tech should be documenting the assessment and plan in the chart including future tests needed, target IOP and when to have the pt back.
If the Dr decides to send the pt for a consult then the tech will put a consult sticker at the bottom of the exam sheet and fill in the question "Will LPI prevent angle closure?"
Tech will then walk the pt up to the front desk to make the appt.

Case Study #5

Dry Eye Evaluation
Pt comes in for exam and complains of dry, irritated eyes.
Tech gets out AT sample and plug brochure for Dr to give to pt. This is an example of "prompting".
Dr will give AT/brochure to pt and have them try that first. Dr will have pt back in 2 wks and if NI w/AT Dr will do Temp Plugs.
At the 2wk appt pt will get CCHPI and if Ni w/AT tech will set up plug tray, instill antibiotic and get out plug int report.

Resources
Commonly Prescribed Oral Medications
Dosages, Uses and Contraindications

Oral Antibiotics:

**Augmentin**
500mg BID or 875mg BID
(Sinus infections)
(No in PCN allergy)
(available generic)

**New 1000mg XR extended release-bid dosing**

**Z – Pack**
take as directed
(Acute Hordeola)
(Good in pregnancy)

**Zithromax**
(250mg or 500mg X 5 D)
(Penicillin derivative)
(Sinus infections)
(No in E-mycin allergy)
(Expensive, followup med)

**New Z Tri-Pack-3 day dosing pack**
(Lid laceration infections)
(No with Theophylline)

**Biaxin**
250 - 500mg BID
(E-mycin derivative)
(X 10 days)
(Upper respiratory infection)

**Erythromycin**
333mg TID
(Acute Hordeola)
(GI upset)
(Inexpensive)
(X 10 days)
(Prophylaxis)
(Best in pregnancy)
(No in E-mycin allergy)
(No with Antihistamine RX)
(No with Theophylline)
(No in Hepatic disease)
(OK in PCN allergy)

**Amoxicillin**
500mg TID
(Acute Hordeola)
(Inexpensive)
(X 10 days)
(Prophylaxis)
(Caution if allergies)
(875mg BID X 10 days Upper respiratory)
(Take with food)

**Cephalexin**
500mg BID
(Acute Hordeola)
(Inexpensive)
(X 10 days)
(Prophylaxis)
(Good 1st choice)

**Keflex**
250mg QID
(Bronchitis)
(Good for anaerobic infections)
(No in PCN allergy unless)

**Tetracycline**
250 – 500mg QID
(Lid disease)
(NO in pregnancy or kids)
(X 1 month)
(Acne Rosacea)
(Causes photosensitivity)

**Doxycycline**
100mg BID
(OMIT in pregnancy or kids)
(Better compliance BID x 1 month)
(Acne Rosacea)
(Causes photosensitivity)
(Inexpensive)
(then QD 4 months)

**Tequin**
400mg qd
(High-risk patients for MRSA (health care workers))
(Start pre-op in these patients at risk)
(Also start if intraocular foreign body or endophthalmitis suspected)

In general, antibiotics interfere with effectiveness of birth control pills – counsel & document!

Always ask about allergies, pregnancy, nursing, other meds, and systemic health problems before prescribing, and check with pharmacist for help.

www.PCON.COM
**MEDICAL INSURANCE VERIFICATION**

- **Patient's Name:**
- **Appt. Date:**
- **Patient's DOB:**
- **Home Phone:**
- **Work Phone:**
- **Insured's Name:**
- **Relationship:**
- **Insured's SS#**
- **Group #**
- **Employer**
- **Member # (if different than SS#)**
- **Insurance Company**
- **Phone Number**
- **Claims Mailing Address**
- **Insurance Type:** Medical - HMO, PPO, Other
- **Is our doctor participating on this plan?**
  - (if no, get out of network benefits)
- **In Network Benefits**
- **Out of Network Benefits**
- **Does this plan require a referral from the PCP?**
- **Effective Date**
- **Copay Amount**
- **Deductible Amount**
- **Has deductible been met?**
- **Amount paid to date**
- **Benefits other than for office visit:**
  - % up to
  - out of pocket
- **Does diagnostic testing or procedures for eye disease/disorders require precertification?**
  - (Example CPT Codes: 92135, 68761,)
  - **Precertification Phone Number**
- **Insurance Rep Verifying**
- **1st Eye Care Employee Verifying**
- **Date Verified**
- **Patient contacted regarding benefits?**
  - **Date Contacted**

**Profit Analysis**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Total Revenue</th>
<th>Total Cost</th>
<th>Profit</th>
<th>Hourly Revenue</th>
<th>Hourly Profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy</td>
<td>$843</td>
<td>$802</td>
<td>$41</td>
<td>$642</td>
<td>$360</td>
</tr>
<tr>
<td>Notes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| School Nurse Emergency Bag Inventory**

- **Small black nylon carrying case (could be imprinted with AOA logo)**
- **Laminated 2-sided Ocular Emergencies Flow Chart: What To Do (from our School Nurses’ Guide)**
  (2) Coverlet® eye occlusor
  (2) Johnson & Johnson small eye pad—oval
  (1) tube GenTeal™ lubricant eye gel
  (1) eye patch
  (2) Alcon® contact lens case
  (1) small pair scissors
  (1) box Allergan Refresh® Celluvisc® lubricant eye drops
  (1) box Alcon® Systane™ lubricant eye drops
  (1) box Opti-Free® Express® No Rub™ Multi-Purpose disinfecting solution
  (1) box Alcon® eye stream® eye wash solution sterile
  (1) box Advanced Vision Research® Liquid Gel Lubricant Eye Gel
  (1) roll tape
  list of contents and reorder form

**Suggested items to add:**
- (1) Eye wash cup
- (1) Foldable Snellen chart
- Local O.D. referral list
- Student Vision Checklist/Report Form

---

**Proper Shade**

<table>
<thead>
<tr>
<th>Shade</th>
<th>Lenses</th>
<th>Frame</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2.0</td>
<td>Brown</td>
<td>$500</td>
</tr>
<tr>
<td>2</td>
<td>2.5</td>
<td>Gold</td>
<td>$550</td>
</tr>
<tr>
<td>3</td>
<td>3.0</td>
<td>Blue</td>
<td>$600</td>
</tr>
<tr>
<td>4</td>
<td>3.5</td>
<td>Green</td>
<td>$650</td>
</tr>
<tr>
<td>5</td>
<td>4.0</td>
<td>Red</td>
<td>$700</td>
</tr>
</tbody>
</table>

**Allergies:**

- ____________________________________________________________________________

**Notes:**

- ____________________________________________________________________________
- ____________________________________________________________________________

**PLEASE SCHEDULE**

**ALL MEDICAL FOLLOWUP**

APPOINTMENTS WITHIN THE SLOWEST MONTHS:

- November
- December
- February
- April
- May
- September
- October
- March
- January
- July
- June

**BUSIEST MONTHS:**

- August

**PLEASE SCHEDULE**

**ALL MEDICAL FOLLOWUP**

APPOINTMENTS WITHIN THE SLOWEST MONTHS:

- November
- December
- February
- April
- May
- September
- October
- March
- January
- July
- June

**BUSIEST MONTHS:**

- August
Office of the Future – Tom’s Pearls

1. Call Optician into exam room. This where glasses are sold!
2. Hire high-quality Ophthalmic Technicians to assist in billing, coding, prompting, collaborating with, scribing, follow-ups, appointments, etc.
3. Go medical without giving up optical. Buy as much diagnostic equipment as possible.
4. Consult Vs referral…. Consult stickers.
5. Wear scrubs or white lab coat.
6. Five-day workweek.
7. Never handle a piece of paper twice. This includes your Interpretation and Reports.
8. “No”, is not a bad word. Learn to use it.
10. Take time off in the slowest months.
11. Never refer out what you can take care of yourself within the scope of your practice!

Contacts:

1. We will only be fitting 2 to 3 brands of contacts. It cost $10 to order a trial lens. Therefore, only fit CL’s that we have in inventory. Preferably a 1 months lens, so they get their whole year supply at one visit. Remember CL’s are the lowest profit of all the things you do, therefore don’t lower it more by adding visits and orders.
2. We do not allow Extended wear. Too much risk and it increases office visits with complaints.
3. We do not fit Bifocal contacts. It represents the lowest profit of all.
4. We do not fit toric Gas Perms
5. Avoid fitting anyone 38 years and older.
6. Try to fit 1 month lenses when possible. 2-week lenses only get an average of 3 boxes/year.
7. Most important: While you are spending multiple visits with contacts, you are wasting visits that could be used for medical.

Harvesting: You may be able to harvest one (or more) medical for every ten routine eye exams. Dry eyes, Diabetic, cataracts, glaucoma, etc.

Glaucoma:
Glaucoma will be a large part of our practice over the years to come. Always make sure that you initiate testing before you send them off to an OMD for cataracts or anything else. Some will treat them and keep them if you haven’t initiated testing. Run all tests before you refer them out. Fields, photos, GDx, Pachometry, Gonioscopy, plugs, etc.

Routinely require DFE, IOP’s. If there are finding, and only if there are findings, run Pachometry, Gonioscopy, plugs, etc.

Remember the most important thing of all:

Have fun!