BILLING AND CODING

CRACKING THE CONTACT LENS CODES

A look at the basics of specialty contact lens billing and coding.

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You've fit a patient with some great new specialty lenses, but now how do you get paid? This is a common, frustrating topic for many practitioners. In this article, we will break down the basics of billing and coding for specialty lens patients through a series of cases. Keep in mind, different insurance companies have different rules and recommendations for which codes to use, but here we will outline some of the basics to get you started.

However, before we delve into the cases, it is important to know the available Current Procedural Terminology (CPT) codes. These contact lens codes are divided into two categories—contact lens fitting and contact lens materials—but often both are necessary. In addition, all practitioners will need to be familiar with International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), provided by the Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), for medical coding and reporting in the United States. Of most relevance will be the codes between H00 and H59, which cover diseases of the eye and adnexa. However, depending on the health of the patients, other codes will be relevant as well.

CONTACT LENS FITTING CODES

Here is a list of the applicable CPT codes and definitions for contact lens fitting. The codes are published annually by the American Medical Association.

*92310 **Contact lens fitting for corneal lenses, both eyes, except for aphakia.*** Use this code when you are fitting soft contact lenses or corneal GP lenses, unless the patient has aphakia. This is a bilateral code, so you would only bill this code once, even if you fit both eyes.

*92311 **Contact lens fitting of a corneal lens for aphakia, one eye.*** Use this code when you are fitting a soft contact lens or corneal GP lens for aphakia.

*92312 **Contact lens fitting of a corneal lens for aphakia, both eyes.*** Use this code if you are fitting a soft contact lens or corneal GP lens for a patient who has aphakia if you are fitting both eyes.

*92313 **Contact lens fitting of a corneoscleral lens, both eyes.*** Use this code if you are fitting a patient with a corneoscleral lens, mini-scleral lens, or full scleral lens.

*92071 **Fitting of a contact lens for treatment of ocular surface disease.*** Common uses of this code would be for a patient who has punctate keratitis due to dry eye, in which the practitioner utilizes a bandage contact lens. This code is only for the contact lens fitting portion, so be sure to bill for the supply of the lens separately.

*92072 **Fitting of a contact lens for management of keratoconus, initial fitting.*** Use this code when you are fitting a patient who has keratoconus, no matter what type of lens you select (soft lens, corneal GP, hybrid, scleral). This code can be a bit ambiguous: Do you only use this code when you first fit your patients? What happens when they come back next year and are re-fit; then what code do you use? What does initial fitting mean? What if they were fit by another practitioner? Was that their "initial fitting"? If patients have worn contact lenses before, but they are a new patient in an office, would it be considered an initial fitting? The answer is unclear, as insurance companies have differing definitions and rules; however, there are many billing and coding articles, webinars, FAQs, patient letter samples, etc. available online.

*92499 **Other ophthalmological services or procedures.*** Use this code when fitting a custom impression-based scleral lens.

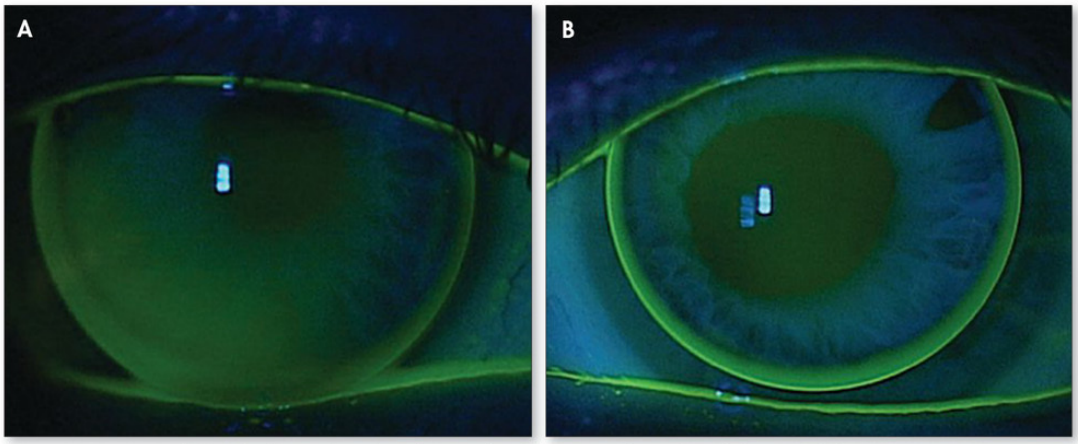

Figure 1. A successful fit of a lenticulated GP lens on both the (A) right and (B) left eyes of the patient in Case 5.

CONTACT LENS MATERIALS CODES

Practitioners should also be familiar with these Healthcare Common Procedure Coding System (HCPCS) codes and descriptors from CMS for the various contact lens materials as well as examples of lenses to which these codes apply.

V2510 Contact Lens, GP, Spherical, Per Lens

V2511 Contact Lens, GP, Toric, Per Lens

V2512 Contact Lens, GP, Bifocal, Per Lens An example would be a translating multifocal GP lens or an aspheric multifocal GP lens.

V2513 Contact Lens, GP, Extended Wear, Per Lens Use this code for patients in a hyper-Dk lens material or for patients who are sleeping in their lenses.

V2520 Contact Lens, Hydrophilic, Spherical, Per Lens Any spherical soft contact lens would fall into this category.

V2521 Contact Lens, Hydrophilic, Toric, Per Lens An example would be any standard soft toric lens.

V2522 Contact Lens, Hydrophilic, Bifocal, Per Lens An example would be a standard soft multifocal lens.

V2523 Contact Lens, Hydrophilic, Extended Wear, Per Lens Use this code when the contact lens is made of a high-Dk material or when your patients are sleeping in their contact lenses.

V2531 Contact Lens, GP, Scleral, Per Lens Use this code when fitting scleral lenses (including corneo-scleral, mini-scleral, or full scleral). Do not use V2530, which is a scleral lens that is *gas-impermeable*. All scleral lenses are made of GP materials to keep the eye healthy, except for extremely rare cases of PMMA scleral lenses for patients who have phthisical eyes.

V2599 Other Type of Contact Lens Use this code for other types of contact lenses, such as hybrid lenses. It can also be used for an impression-based scleral lens.

V2627 Scleral Cover Shell

While similar, each insurance company has its own specifications when it comes to submitting claims. The following case studies will look at patients who have various conditions and who have different vision insurance, and it will examine how to code and bill these eyecare situations.

CASE 1: HERPES SIMPLEX KERATITIS

A 58-year-old white female was referred to the clinic for evaluation of a corneal scar in the right eye. She suffered from herpes simplex keratitis more than 20 years ago, which left her with a corneal scar. With glasses, her best-corrected vision was 20/80 in the right eye. With the scleral lens that was chosen, she could achieve 20/25 vision OD. She had vision insurance through Vision Service Plan (VSP). The ICD-10-CM code we used for her diagnosis was:

H17.11 central corneal opacity, right eye

For VSP, it is important to provide the lens type, the manufacturer, and the name of the design in box 19. In this case, we put:

Scleral, Art Optical, Ampleye

For VSP, you will also need to pull an authorization for medically necessary contact lenses and use that authorization to bill the fitting and the lenses. In this case, we used 92313 for the fit (corneo-scleral lens fitting) and V2531 for the scleral lenses. Be sure to use the correct diagnosis code to avoid payment rejections.

VSP will tell you to bill the full eye examination (92004 or 92014) along with the medically necessary contact lens fit and lenses; in our experience, however,

there is less confusion and complications when billing for the full examination first and then obtaining a new authorization for the medically necessary contact lenses. VSP payment bundles the contact lens fitting, dispense, and follow-up care for these lenses, so do not bill the patient's vision or medical insurance for any other services or products related to the contact lenses during this time.

CASE 2: PELLUCID MARGINAL DEGENERATION

A 28-year-old male who had pellucid marginal degeneration (PMD) was referred to us for a possible EyePrint custom impression-based scleral lens (EyePrint Prosthetics LLC). He had attempted corneal GP lenses over the past few years, but complained of constant foreign body sensation and frequent lens dislodgment.

After presentation of all options, he desired to proceed with the EyePrint. An impression of the ocular surface was obtained on both eyes, followed by a diagnostic lens fitting. Through diagnostic scleral lenses, he was able to achieve 20/20 vision in both his right and left eyes. The impressions of both eyes were sent to the laboratory along with the diagnostic lens information, and a pair of prosthetic devices were created. This patient has successfully worn the custom impression-based scleral lens for three years. The CPT codes that we used included:

92499 Eyeprint PRO prescribing $ _____

V2599-RT Eyeprint PRO impression and lens for right eye $_____

V2599-LT Eyeprint PRO impression and lens for left eye $_____

H18.463 peripheral corneal degeneration OU

As most insurance companies will not cover the EyePrint Prosthetic, an Advanced Beneficiary Notice (ABN) is signed by all patients who elect to receive this procedure. A written contract outlining the fees along with global period, etc. should be signed by each patient as well.

CASE 3: IRREGULAR CORNEA AND SCLERAL LENSES

A 42-year-old Caucasian male presented to our office for a comprehensive eye examination and contact lens fitting. He reported a long history of keratoconus and had intrastromal corneal ring segments implanted in the left eye in 2014. His chief complaint included pain from his current scleral contact lenses.

His complete examination results yielded findings of best-corrected visual acuity in both eyes of 20/20 with scleral lenses. His presenting lenses were fitting tight around the limbus, likely the cause of an area of corneal neovascularization in the left eye. The visit yielded diagnoses of:

H52.13 myopia

H52.213 irregular astigmatism

H18.613 stable keratoconus

H16.402 corneal neovascularization

To document his corneal neovascularization and monitor its change over time, an anterior segment photograph was taken.

He desired a new set of scleral contact lenses, but was unsure of his out-of-pocket costs. Our office called his insurance to obtain information about his coverage. During such a call, our office utilizes a "Pre-Determination of Coverage" (PDC) form. The form serves as a tool for our staff members to obtain information from insurance company representatives and as a reference for patients when we explain their out-of-pocket expenses and obligations during the fitting process. Staff members document with whom they spoke, verify coverage (or lack thereof) by reporting the procedure codes, and inquire about contact lens material coverage with materials codes.

In general, answers from insurance companies about contact lens material coverages tend to be "no," but a knowledgeable staff member can often further describe the medical necessity of these medical devices and that coverage explanations are sometimes found in the plan benefits near the durable medical equipment or other device sections.

The PDC form includes a list of potential tests and follow-up visits that may result in additional expenses to the patient. These tests could include topography, anterior segment photography, anterior segment optical coherence tomography, and pachymetry. The goal of the form is to be completely transparent with the patient so that both parties are in agreement of services to be rendered.

In this particular case, it was noted that he had a remaining deductible of about $350 and was covered for fitting and materials after deductible payment. This patient's initial visit to our office was coded as noted below and submitted to his health insurance:

92004 (comprehensive eye exam, new), H18.613 (keratoconus)

92015-22 (refraction, complex), H52.13 (Myopia)

98225 (anterior segment imaging), H16.402 (corneal neovascularization)

He later returned for a lens fitting after communicating with our insurance team. A topography image was taken, and sclerals were fit and designed with the appropriate lens

powers and fit adjustments. At the conclusion of this visit, he paid the remainder of his deductible. The following codes were submitted to his medical insurance:

92072 (bilateral code) (Initial fitting of contact lenses for keratoconus), H18.613

V2531 (2 units) (scleral gas permeable contact lenses), H18.613

92025 (Corneal topography), H18.613

Each of the three follow-up visits were billed as office visits with appropriate evaluation and management (E&M) and diagnosis codes and were submitted to his health insurance.

This case is a fairly straightforward example of how to use a patient's insurance coverage. Utilizing a form to predetermine coverage is valuable in maintaining open and transparent communication with patients so that no financial surprises leave either party with unmet expectations.

Another note of interest is the use of the -22 modifier on complex refractions or any other procedure requiring extra time and interpretation. This can be submitted to insurances with a letter explaining the increased difficulty and time needed when refracting patients who have irregular corneas for a potential reimbursement of 150% of the contracted rate; however, it does not guarantee an increased payment.

CASE 4: POST-PENETRATING KERATOPLASTY SCLERAL LENS REFIT

A 71-year-old Caucasian female presented to our office for a contact lens fitting. She has a history of keratoconus in both eyes, for which she had corneal transplants more than 20 years ago. Her current scleral lenses are causing fogging of her vision in the left eye after a few hours of wear.

On evaluation, microcystic edema and corneal bullae were noted on the left cornea, despite a well-fitting scleral lens. We explained that it was likely due to the fact that her left transplant had reached an age at which there were not enough endothelial cells to maintain clarity of her cornea. Rather than performing a new contact lens fitting, she was referred back to her corneal specialist for an evaluation for an endothelial transplant. The visit was billed as follows:

Office visit, level 3

99213, Z94.7 (corneal transplant status), H18.22 (corneal edema, due to contact lens, OS)

92132 (anterior segment OCT imaging), H18.212 (corneal edema, due to contact lens, OS

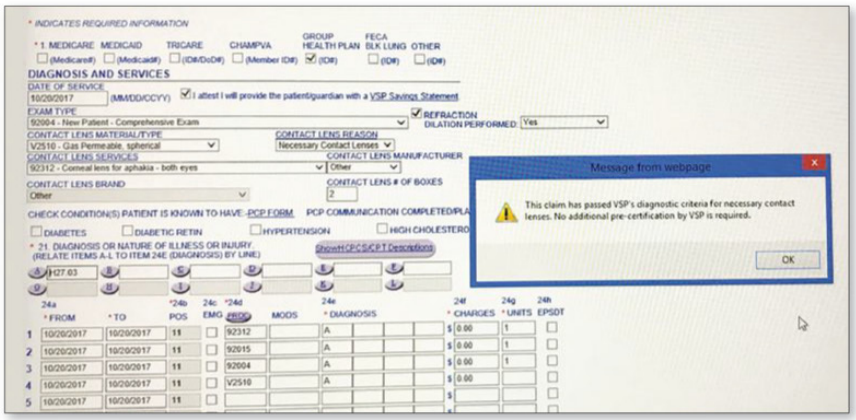

Figure 2. Coding for the patient in Case 5.

She returned for a scleral contact lens fitting about four months later after a successful endothelial transplant surgery. The scleral lens fitting was performed in office, along with topography. Her corneal surgeon had recently performed an endothelial cell count; had that not been recently performed, this would have been an ideal time to obtain baseline readings.

The fitting was billed as follows:

92313 (bilateral code) (fitting of contact lens, with medical supervision), Z94.7

92025 (corneal topography), Z94.7

V2531 (2 units) (scleral contact lenses), Z94.7

Similar to the patient in Case 3, office visits were billed to her medical insurance until the fitting was complete. A key point about this case is to first manage any conditions that may prevent a successful lens fitting with office visits. Proceed with a fitting once the ocular health is able to support a contact lens.

CASE 5: BILATERAL APHAKIA

A 33-year-old female presented to our clinic because her GP contact lenses were three years old. She complained of blurry vision and of seeing haloes around lights while driving at night. She could only wear the lenses for 12 hours because they felt itchy. She had a history of congenital cataracts and had undergone cataract surgery at age 2 for her right eye and at age 4 for her left eye.

Her manifest refraction was OD +11.75 –0.50 x 177, Distance visual acuity (DVA) 20/25, Near (N) VA 20/25 and OS +11.75, Add +2.75, DVA 20/25, NVA 20/25. Her keratometry readings were OD 45.83/46.58 @ 65 and OS 45.67/46.04 @ 125.

Her overall eye health was good. Each iris had a patent peripheral iridotomy (PI) with the right eye positioning at 12 o'clock and the left eye positioning at 2 o'clock.

She was successfully fit with a lenticulated GP lens in each eye with the following parameters (Figure 1): OD +14.00D / 7.46mm / 9.5mm, Optimum comfort (Contamac), DVA 20/30 and OS +12.00D / 7.34mm / 9.4mm, Optimum comfort, DVA 20/30.

Billing for Aphakia with VSP In this case, the diagnostic, CPT, and materials codes (respectively) were:

H27.03 (aphakia, both eyes)

92312 (corneal lens for aphakia – both eyes)

V2510 (contact lens, gas permeable, spherical, per lens of which 2 lenses are needed)

As stated earlier in Case 1, the name of the laboratory and the type of contact lens also needs to be entered into box 19. In this case, that was:

Essilor contact lenses, spherical GP contact lenses

Figure 2 shows the coding for this case.

Note: Failure to record your contact lens evaluations, fittings, and follow ups may result in the denial of payment for services. Ensure that your medical records accurately support the diagnosis submitted on the claim when billing for Visually Necessary Contact Lenses. By doing so, payment will not be denied if the diagnosis billed is substantiated by the clinical findings documented in the patient's record.

CASE 6: KERATOCONUS FIT WITH SCLERAL LENSES

A 39-year-old female was referred to our clinic by a laser-assisted in situ keratomileusis (LASIK) surgeon for a contact lens evaluation. She was a poor candidate

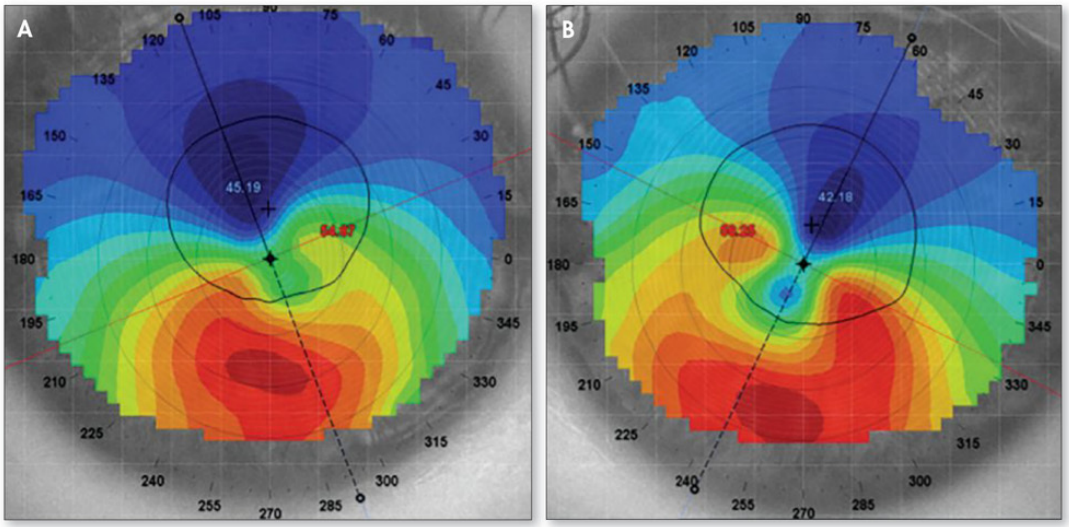

Figure 3. Topography of the right (A) and left (B) eyes of the patient in Case 6.

for refractive surgery because she was diagnosed with keratoconus and was currently wearing glasses. She had tried GP and hybrid contact lenses without success in the past.

Her unaided visual acuity was OD Count Fingers (CF) at two feet, Pinhole 20/50 and OS CF at one foot, Pinhole 20/50. Her manifest refraction was OD –6.50 –5.25 x 110, VA 20/50 and OS –7.50 –4.50 x 080, VA 20/40. Her keratometry readings were OD 45.19 / 54.87 @ 22, with an apical reading of 62.47D and OS 42.18 / 56.25 @ 154, with an apical reading of 58.22D. Figure 3 shows her topography.

With slit lamp examination, the corneas showed mild inferior scarring just inferior to the pupil in both eyes, the bulbar and palpebral conjunctiva were healthy and white, and the anterior chambers were deep and free of cells and flare.

The iris appeared healthy, with normal anatomy and convexity, and the lenses' capsules, cortex, and nuclei were all clear. Pachymetry was OD 425 microns and OS 418 microns.

She was successfully fit with a scleral lens with parameters of OD –19.75D / 6.19mm / 15.2mm, Insight scleral (Metro Optics), DVA 20/25 and OS –20.62D / 6.0mm / 15.2mm, Insight scleral (Metro Optics) DVA 20/25. Figure 4 shows the fitting relationship.

Visually Necessary Contact Lenses with VSP Contact lenses are covered in full for patients diagnosed with keratoconus. These patients must be eligible for materials on the date of service.

Coverage is limited and may require special handling to ensure proper reimbursement. Examination and material (prescription lenses and frame) copays for contact lenses apply unless otherwise specified. Bill scleral lenses using HCPCS V2530 or V2531. Note that hybrid contact lenses are not scleral lenses and will not be reimbursed as sclerals. Bill hybrid lenses using V2599.

When submitting a claim using V2530 or V2531, provide the following information in box 19:

Type of lens – Scleral

The scleral lens manufacturer/brand

If this information is missing or incomplete, it will result in claim reimbursement at the V2599 rate, whichever is lower.

In this case, this patient was billed using the following diagnosis, ICD-10-CM, and materials codes (Figure 5):

92072 (fitting of contact lens for management of keratoconus, initial fitting)

H18.603 (bilateral stable keratoconus)

V2531 (scleral GP contact lens, of which two are needed)

The following information was entered into box 19 on the claim:

Insight scleral lens, gas permeable scleral lens, and Metro Optics (laboratory)

Eyemed Many of the Eyemed plans (as stated by the Eyemed provider manual) include benefits for contact lenses when the member's vision and spectacle prescrip-

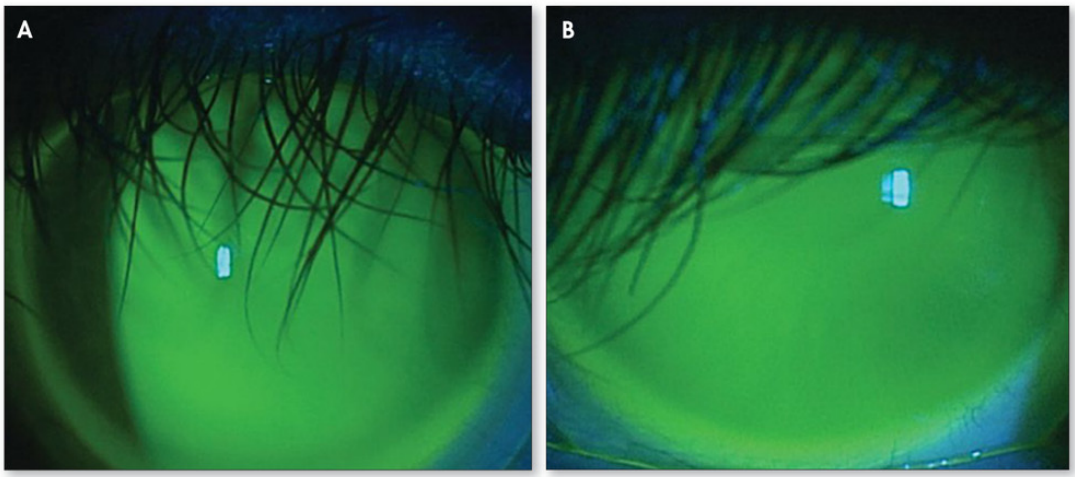

Figure 4. The scleral lens fitting relationship for the right (A) and left (B) eyes of the patient in Case 6.

tion meet certain criteria.

For example, contact lenses are covered if the patients/members have keratoconus and their vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses. For the purposes of Eyemed's benefit, there are two types of keratoconus as defined in our ectasia scale:

1. *Emerging/Mild* Contact lenses in this tier are anticipated to include, but not be limited to, scleral, semi-scleral, and hybrid designs/materials. Patients in this category will fit the following criteria:
   * Multiple spectacle remakes
   * Unstable topography
   * Light sensitivity/glare issues
   * Signs including Fleischer's ring, Vogt's striae, and scissors reflex with retinoscopy
   * No scarring
   * Topography (steep K < 53D)
   * Corneal thickness > 475 microns
2. *Moderate/Severe* Patients who begin in the emerging or mild categories and who are not successful with contact lens materials and keratoconus designs may be elevated into this moderate/severe tier. Contact lenses in this tier are anticipated to include, but are not be limited to, scleral, semi-scleral, and hybrid designs and materials. Patients who qualify as moderate/severe will have all of the emerging/mild symptoms, plus:
   * Mild to no scarring or some scarring
   * Topography (steep K of 53D or higher)
   * Corneal thickness up to 475 microns
   * Refraction not measurable

In this case, the claim was filed in hard copy with the medically necessary form as discussed in Case 5. The procedure code billed was 92072AD because the patient met the requirements of the advanced stage—mild scarring, topographies steeper than 53D, and thin corneas. The diagnosis code billed was H18.621, and the materials code was V2531(scleral GP contact lens of which two contact lenses are needed).

CASE 7: DRY EYE CONTACT LENS WEAR

Successful lens wearers are among the happiest patients in the practice and are more loyal, likely to refer others, and often become part of the practice family. These are usually the patients with whom you have the greatest rapport and who are the least likely to bother you with complaints. Patients may say that they are "doing fine" even if their wearing time has dropped by several hours. The insidious progressive nature of dry eye disease is another reason for problem denial. That's one of the reasons to always probe for possible problems to proactively identify and treat them before they become catastrophic.

A 27-year-old very successful and longtime soft contact lens wearer presented for a routine yearly examination under her vision care coverage. With little probing, she opened up that intensive computer use was making her eyes dry, especially by the end of the day. She also shared that she was removing her lenses earlier than she had in the past and wearing her eyeglasses more frequently.

After a slit lamp examination, it was apparent that she had meibomian gland dysfunction (MGD) with significant gland obstruction. She was then refitted from monthly replacement lenses into Bausch + Lomb Biotrue Oneday lenses, and we suggested to also set up a separate visit to fully evaluate her dry eye symptoms and MGD.

I explained that her medical insurance would cover the examination, but that there would be a separate fee for some of the advanced testing that would be performed during that visit. Her vision care insurance was billed for the comprehensive examination using 92014, and an annual supply of new lenses was ordered after proper fit and vision was confirmed.

Two weeks later, the patient was seen for a dry eye evaluation. This included meibography, non-invasive tear breakup time measurement, tear meniscus height, redness index when appropriate, lipid layer thickness measurement, and blink assessment. After a comprehensive external and slit lamp examination including staining, the findings were reviewed with the patient, and she was educated about the chronic and progressive nature of MGD and dry eye. It was explained that this was contributing to her contact lens issues, and a conservative approach for treatment was outlined.

The patient's medical insurance was billed for a level 3 exam using CPT code 99213. In addition, she was billed out-of-pocket for the additional advanced testing that is not covered by her insurance. She was advised of the additional cost upfront, and we routinely have patients sign an ABN.

Although treatment varies from triglyceride-based omega-3 supplements to prescription products, treatment options are recommended in office. This is a convenience to patients, improves compliance, and is also a profit center for the practice.

CASE 8: CONTACT LENS MANAGEMENT OF A DRY EYE SUFFERER

As dry eye and MGD become increasingly common, we will encounter more patients presenting with ocular surface complaints. Managing moderate-to-severe dry eye patients can be challenging.

For example, a 68-year-old female who had been a patient for approximately two years was a longtime dry eye sufferer. She was doing well using a variety of therapies including a thermal pulsation treatment for obstructive MGD, triglyceride-based omega-3 supplementation, hypochlorous acid applied to the lids twice daily, and lubricating wetting drops as needed. Her lipid layer thickness measured using ocular surface interferometry was typically marginal, but she produced significant meibum on diagnostic expression. Tear instability and rapid breakup time with transient diffuse corneal fluorescein staining was also noted. She had no contributory health history.

The ICD-10-CM codes used to bill her insurance for related visits was:

H04.123 (dry eye syndrome-bilateral)

H02.89 (other unspecified disorders of the eyelid including MGD)

Alternatively, coding MGD as a subset of blepharitis H01.00x is possible, but can be more convoluted as specific eye and lid notation may be necessary. Typically, level 2 and 3 99000 codes are used for billing services to insurance.

In dry eye patients, necessary additional testing and procedures may not be covered by insurance. Lid debridement and thermal pulsation are examples. Patients are advised of any additional costs; informed consent for procedures is given and, when necessary, patients are required to sign ABNs.

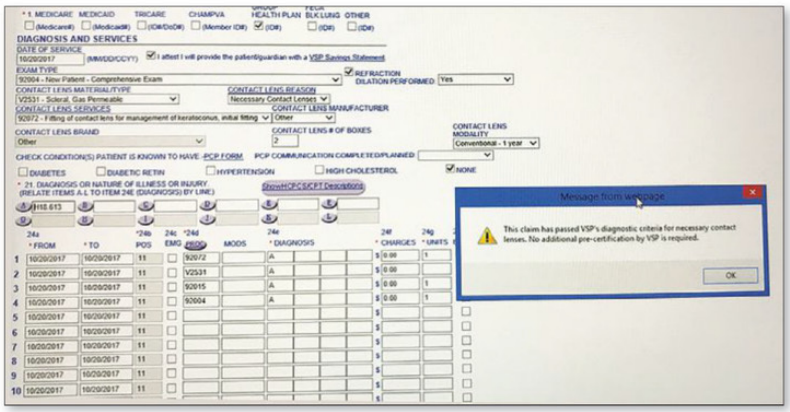

Figure 5. Coding for the patient in Case 6.

At a recent visit, this patient reported substantial worsening of symptoms with significant discomfort and light sensitivity. Slit lamp examination revealed bilateral wide vertical linear bands of dense corneal staining. The punctate lesions were slightly elevated, reminiscent of Thygeson's superficial punctate keratitis (TSPK); however, Thygeson lesions are typically widely scattered and diffuse. Because of the linear vertical appearance, both upper lids were carefully examined, but were unremarkable. A cryopreserved amniotic membrane graft was attempted in the more severely affected eye, but was discontinued due to comfort issues.

To manage the severe discomfort, bandage lenses were fitted using Alcon Dailies Total1 daily disposable lenses for continuous use for three days at a time. They provided almost immediate relief. The off-label use was discussed with the patient as were the general risks of bandage lenses with ocular surface disease. This was noted in the record. The patient did well for several days, but upon returning for a follow-up visit, both lenses were absent and the lesions were present, but slightly less symptomatic. Corneal topography performed at this visit revealed unusually flat curvatures, so the lenses were changed to flatter-fitting Acuvue Oasys (Johnson & Johnson Vision). This was a good reminder to not overlook basic fitting fundamentals, even with bandage lenses. The bandage lenses have been effective so far, with the patient asymptomatic and stable while the corneal lesions have slowly resolved. Bandage lenses are billed using:

92071 fitting of contact lens for treating ocular surface disease

When fitting soft lenses for bandage lens use, there can always be concern pertaining to the risk of infection and other complications. Off-label use for longer wearing periods including daily disposable lenses also increases potential risk. However, in some cases, the benefits clearly outweigh the risks. Additionally, informed consent and access to emergency care, if necessary, adequately address the medicolegal concerns.

SUMMARY

Successful specialty contact lens practice depends upon not only fitting expertise, but also the ability to properly code and bill for services. This article provides several relevant cases and how they were managed. **CLS**

Dr. Woo owns Havasu Eye Center, Parker Vision Care, and Blythe Vision Care. She is the vice president of the Scleral Lens Education Society and a GPLI Advisory Board member. She is a consultant or advisor to Alcon, Blanchard, Bio-Tissue, B+L, Essilor, and X-Cel.

Dr. Messer practices in Minneapolis in a private optometry office focused on specialty contact lenses. She is a consultant to Precilens and CooperVision.

Dr. Achong-Coan completed her residency in cornea and contact lenses at the Pacific University College of Optometry in Oregon where she is a clinical adjunct assistant professor. She is a fellow of the American Academy of Optometry and a fellow of the International Academy of Orthokeratology. She has provided consulting and research services to CooperVision and has received honoraria from X-Cel.

Dr. Epstein is internationally recognized for expertise in complex contact lens management and medical complications of contact lenses, dry eye, and anterior segment disease. He co-founded Phoenix Eye Care and The Dry Eye Center of Arizona and serves as the Director of Cornea - External Disease. Dr. Epstein also heads Ophthalmic Research Consultants of Arizona. He is a stock shareholder of NovaBay Pharmaceuticals and has received honoraria for consulting, performing research, speaking, and/or writing from Alcon, B+L, Bio-Tissue, Essilor, EyeEco, Oculus, PRN, NovaBay, Novartis, Sight Sciences, Shire, TearLab, and TearScience.