

# Methods for making laser-assisted cataract surgery fit in your practice

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## Financing femto: Breaking even with direct acquisition

by Stephen Slade, MD



**Practice pearl:** Do your homework to ensure financial success with a femtosecond laser for cataract surgery. A simple pro forma including your number of cases, direct expenses, etc., will go a long way in guiding your decision. Also take a careful look at your available space options and needs for the laser.

—Stephen Slade, MD

### Surgeon details points to consider before purchasing femto laser

**A**s laser and lens technology advances, more cataract surgeons are considering the jump to femtosecond laser-assisted cataract surgery.

For a number of reasons, purchasing a femtosecond laser was the right choice for our practice, but each surgeon needs to take a look at his or her own practice to establish whether this is a viable option.

This article shares the process we used when analyzing this investment.

### Practical advantages

Rather than sharing laser access or using a mobile equipment service, we chose to purchase a

**“By developing the pro forma, we knew what to expect as we proceeded.”**

—Stephen Slade, MD

femtosecond laser for our ambulatory surgery center. With this option, the laser would be more available, making procedures more convenient and accessible for our patients. Because we own our laser, we can perform femtosecond procedures at any time, without relying on someone else's schedule. This offers us greater independence. I also think that owning our laser indicates our

permanence and commitment to patients.

Although we initially began using the femtosecond laser during our investigational work, we did not know how often we would use it in our practice. Ultimately, our patient volume grew significantly. I consider femtosecond laser-assisted cataract surgery to be an excellent practice builder.

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### Educational Objectives

Ophthalmologists who participate in this activity will:

- Identify different pathways and models that permit the viable integration of LACS into a refractive cataract practice: accessibility pathways, reimbursement models for technology access, and practice flow models in a variety of settings; and
- Develop customized practice adoption plans for advanced technologies: protocols for staff training and proper patient conversation techniques for expectation management and acceptance of technology.

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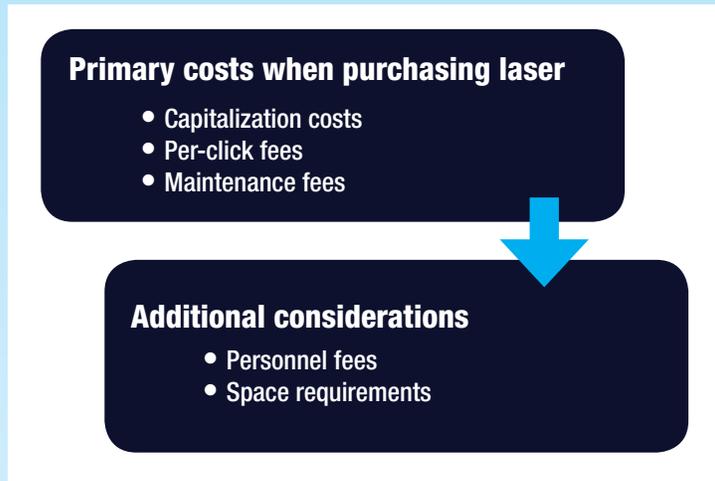


Figure 1. Primary costs when purchasing a femtosecond laser

Our patients are impressed with the technology and our experience with it. They appreciate the precision and potential of the laser. We were impressed with our results with the technology.

### Costs of ownership

Of course there are a number of considerations when weighing this investment.<sup>1-3</sup> To determine whether we should purchase the technology, we asked our accountant to develop a pro forma for acquiring the laser, which included the capitalization costs, per-click fees, and maintenance fees (Figure 1). Of course, we also

added personnel costs for operating the laser and allotted a small amount of real estate in our practice for the device. We compared these totals with our practice revenue and growth potential.

Based on our volume of cataract cases, we thought the femtosecond laser would help us grow our practice.

I think surgeons who are exploring the option of purchasing a femtosecond laser should take these steps. Bartlett et al. also discussed how to perform a cost analysis when determining whether to purchase a femtosecond laser.<sup>4</sup>

By developing the pro forma, we knew what to expect as we proceeded. It is not a difficult exercise. There were no surprises, and the costs are relatively straightforward.

### Surgical fees

When charging patients for procedures, we simplify the process for them, offering three cataract packages, based on the surgeon's fees (Figure 2). These focus on patients' desired postoperative uncorrected vision. However, we do not overpromise that they will not need glasses.

The distance vision package includes a monofocal IOL and monovision if patients prefer. This is what insurance usually will cover. However, it does not correct astigmatism. Patients with astigmatism will need to wear glasses after surgery.

The middle package corrects astigmatism with either a toric IOL or arcuate keratotomy, providing good uncorrected distance vision. However, patients will need glasses for near and intermediate vision.

The goal of the third package is to treat presbyopia so patients can read without glasses at near, intermediate, and far.

We try to make the decision as easy as possible, without offering too many financial choices. For example, we charge the same

fee for astigmatic patients who receive a toric IOL as we do for those receiving arcuate keratotomies.

### Marketing the technology

After we implemented our laser, we began talking with patients about it and featuring it on our website. Surgeons also use other types of marketing, such as brochures and television, print, and radio advertisements. In our practice, our website and referrals from patients and doctors are our best marketing tools.

### Conclusion

Owning a femtosecond laser for cataract surgery has been very successful for us and has grown our practice. Although some surgeons worry that femtosecond procedures may take longer, the laser should not slow them down that much.

When considering this purchase, I recommend examining your baseline and the costs and developing a pro forma. If you think it will work, I encourage you to consider it strongly. I think it will work at your current level and help you grow your practice in the future.

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Package	Patient goals	What it includes	Anticipated result
Distance vision	Distance vision after surgery	Monofocal IOL, including monovision, if desired. No astigmatism correction	Glasses needed for near and intermediate. If astigmatic, will need glasses at all distances
Astigmatism correction	Astigmatism correction for distance vision	Astigmatism correction with toric IOL or arcuate keratotomy	Good uncorrected distance vision. Glasses needed for near and intermediate
Presbyopia correction	Ability to read at near, intermediate, and distance without glasses	Multifocal or accommodating IOL	Reduced dependency on glasses

Figure 2. Sample cataract packages based on the surgeon's fees

# Viable integration models with LACS: Choosing the accessibility model right for your practice

by David Dillman, MD



**Practice pearl:** Surgeons should not enter the LACS world until they firmly think that it is a better way to perform many of the various forms of cataract surgery.

—David Dillman, MD

## Various laser access options available for surgeons considering LACS

Increasing numbers of cataract surgeons are integrating laser-assisted cataract surgery (LACS) into their practices, while others may wonder

whether they can afford this investment.<sup>1</sup>

A number of tools can help them break down the costs involved and take the guesswork out of this decision.

### Exploring options

In 2012, when I began thinking seriously about adding LACS to my practice, I visited five surgeons who were performing the procedure. I watched them perform approximately 100 cases collectively and asked them about the pros and cons of the technology.<sup>2-4</sup>

I quickly decided that I wanted to offer this to my patients. However, based on these conversations, I decided that I would not purchase the laser. I had the necessary patient volume, but I did not have an ambulatory surgery center (ASC); these surgeons owned ASCs, where they could operate and maintain their lasers.

Alternatively, I talked with Sightpath Medical, a mobile access company I had used for cataract and refractive services. Around the time I was considering incorporating LACS technology into my practice, they developed a

- Surgeon purchases laser
- Surgeons in a community purchase laser together
- Surgeon chooses mobile access
- Surgeon chooses direct access (using femtosecond laser at colleague's ASC)

Figure 1. Femtosecond laser access models

- How many cases do you perform?
- How many cases are required to break even?
- How many cases are required to generate sufficient profit?
- Were there unexpected expenses? If so, what were they?
- If using a mobile service:
  - How many cases must be performed per OR day? Per quarter?
  - Are you required to pay a penalty if you do not meet the quota?
  - Other fees?

Figure 2. Starter questions when asking colleagues about their LACS practice

mobile femtosecond laser program for cataract surgery. This mobile access company provided all of the equipment and support needed to install, calibrate, and prepare my practice for laser-assisted cataract procedures. Other companies also provide this service, such as ForTec Medical and Precision Eye Services.

### Decision-making tools

I think surgeons who are not passionate about this technology should not commit to it.

Once you have made the decision to move forward, it is important to research each access option to establish the best one for your individual practice (Figure 1).

I recommend observing surgeons who perform many LACS cases and asking them how it impacted their practice. (For more information, see Bartlett et al.<sup>5</sup>) I was not hesitant to ask surgeons about their monthly costs, how many cases they had to perform

to break even, and how many cases they had to perform to generate sufficient profit (Figure 2).

An advantage of laser ownership is greater control over the equipment. However, surgeons need their own ASC and should have sufficient patient volume to support this purchase. Surgeons may want to use a mobile access service for the first 6 to 12 months to be sure they want to continue using the femtosecond laser.

Conversely, a surgeon may purchase the laser with other colleagues in the area, with each paying a portion of costs.

Mobile access poses few financial risks. Surgeons should consult with colleagues who have chosen mobile access and contact more than one company to investigate the terms and conditions of their agreements. Sightpath charges me a per-case fee and requires that I perform a

**“Surgeons should consult with colleagues who have chosen mobile access and contact more than one company to investigate the terms and conditions of their agreements.”**

—David Dillman, MD

## Plan for preparation: Practice flow efficiency with laser-assisted cataract surgery

by Gary Foster, MD



**Practice pearl:** The most important step in successful laser-assisted cataract surgery implementation is a definitive and consistent commitment from the surgeon. Careful staff education on the benefits of LACS allows the staff to arrive at a similar level of commitment and creates consistent education and communication to the patient about the procedure from the front desk all the way to billing. Optimized flow patterns through the OR and appropriate billing practices ensure the operational efficiency of the procedure.

—Gary Foster, MD

**For greater efficiency, surgeons and staff need to embrace technology, intensify patient education, and streamline protocols**

**T**ransitioning to laser-assisted cataract surgery (LACS) impacts cataract practices in numerous ways.<sup>1</sup> To achieve efficiency when providing this procedure, surgeons need to take a multi-pronged approach (Figure 1).<sup>2</sup>

The first step is for clinicians to commit to becoming excellent LACS surgeons. Secondly, the surgeon and staff need to be in

lock-step as they embrace this change. Next, the practice should establish a flow pattern that facilitates preoperative patient education and streamlines the process on the day of surgery.

### Commitment to LACS

Staff take their cue from clinicians, so surgeon commitment is essential. If surgeons are tepid one week about LACS but enthusiastic the next, staff will be confused and efficiency will decline.

Surgeons need to meet with all staff who interact with patients. Practices achieve the best possible outcomes when physicians take the time to explain the science of the technology, based on published papers that support their decision.<sup>3-6</sup> If staff understands the science, they will be more accurate and better equipped to answer questions.

During these meetings, surgeons need to clearly articulate the emphasis the practice will place on LACS and the consistent messaging that should be communicated to patients.

Without this level of training, surgeons will find pockets of resistance and mixed messaging among staff members, and patients will become confused. This confusion decreases patient confidence and can affect their final satisfaction and even outcome.

### Laying the groundwork

Surgeons can increase efficiency as we educate patients and guide them through the decision-making process.

Some parts of the preoperative process are best performed by the surgeon and others by trained staff. Since I began emailing educational materials to patients before appointments and asking technicians to review options with patients, administer lifestyle questionnaires, and present videos, patients have become well educated about their alternatives by the time they meet me.

**“Staff take their cue from clinicians, so surgeon commitment is essential.”**

—Gary Foster, MD

It is also helpful to recommend a specific course of action to patients. Ophthalmologists often offer patients a full range of choices but stop short of making a recommendation, which may disappoint those who are looking for guidance. If we understand patients' lifestyles and refractive goals, we know which option will be most likely to provide the vision they seek. Our advice will place the patient in the best position to make an informed decision.

### Surgical flow

Surgeon time for LACS is largely based on the operating room structure. If a surgeon uses one operating room and the laser is in the OR, the laser portion is performed and then it takes 3 to 4 minutes to place the patient under the microscope, prep/drape him or her, and begin cataract removal. This slows the surgeon's throughput.

However, if the laser is outside the operating room, surgeons often can proceed at their standard cataract surgery pace. The surgeon can perform the laser procedure on patient A, move to the operating room to finish a case, return to the laser to perform this part of the procedure on patient B, and then return to the operating room to complete cataract surgery on patient A. In this scenario, the laser portion of the case can be completed during the surgeon's standard turnover time.

If one surgeon operates from two operating rooms, the femtosecond laser decreases the overall throughput. However, the overall throughput increases if two surgeons work as a team—with one performing laser procedures and the other removing the cataract and implanting the intraocular lens.<sup>2</sup>

Surgeons also may increase efficiency by grouping LACS procedures at certain times of day or on specific days of the week.<sup>2</sup> This approach allows efficiencies in laser warm-up time and laser-specific staffing.

To determine which arrangement works best in an individual practice, Hansen et al. recommended conducting a time analysis.<sup>2</sup> Surgeons do not need to begrudge slower overall case times with LACS if they select appropriate fees that provide fair reimbursement for their time.

### Conclusion

Once you choose to commit to LACS, it is vital to map out a plan for efficiency by training your staff to be engaged in the process, providing uniform messaging, and carefully orchestrating your surgical flow. In addition, I recommend making the most of advanced technology and formulas, which will increase your chance of hitting the patient's refractive target the first time.

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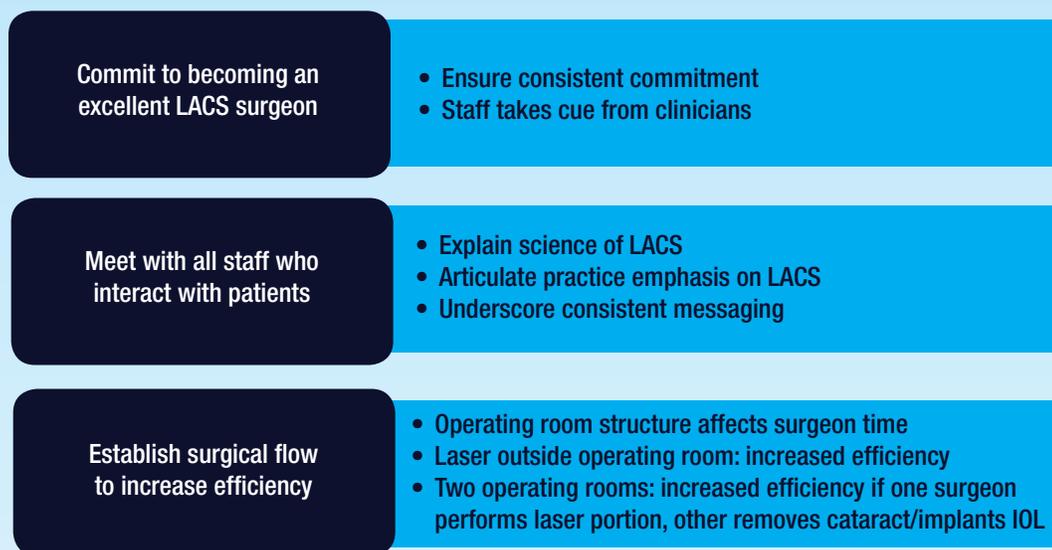


Figure 1. Multi-pronged approach to increase LACS efficiency

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## Adjusting fees

**M**any patients pay a bundled fee, including the company's procedure fee, my fee, the multifocal or toric IOL fee, and other necessary costs. Patients sign a financial informed consent, as well as the surgical informed consent, where we itemize the charges (including technology that we are using), charges to Medicare, and Medicare exclusions. We are very transparent when presenting our fees.

I feel very strongly about using the femtosecond laser for all of my multifocal and toric IOL cases, but I also think it makes some difficult cases easier, such as an extremely dense cataract. If a patient needs LACS in such a case but cannot afford the laser costs, I skip my fee if necessary. If they cannot afford my fee and the company's fee, I may drop my charge and split the company's cost with the patient or drop it entirely. When I tell patients that they need this technology, I need to find a way to make it affordable for them.

certain number of cases per year. However, surgeons with a low patient volume may have difficulty meeting this condition.

An advantage of mobile access is that their engineers calibrate the laser every time it is used.

In my opinion, surgeons using a mobile access service may be as profitable as a femtosecond laser owner. In my experience, I know exactly what I need to pay to use the laser and the fee I need to charge for the procedure to be profitable.

Surgeons also may pursue direct access, paying a per-use fee to a practice that allows colleagues to use their femtosecond laser in their facility.

## Conclusion

Surgeons who are contemplating LACS in their practices need to be passionate about this technology. Before choosing an accessibility option, they need to do their homework, weighing the pros and cons of each to determine which fits best in their practice.

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## Discussing LACS: Physician experience with proper patient conversation, expectation management, and acceptance

by Elizabeth Yeu, MD



**Practice pearls:** The enthusiasm for advanced technology IOLs and LACS is contagious. Patients and staff will be excited about this technology if surgeons are passionate about it. Having almost 4 years of experience with LACS and seeing the reliable, reproducible outcomes and high patient satisfaction continue to feed into the entire process. In addition, from the practice's perspective, being well informed, up-to-date, and educated on our own results helps maintain the integrity of what we offer patients.

—Elizabeth Yeu, MD

### *Consistent messaging and language are key in successful patient communication*

In our practice, we have found that patients welcome our commitment to femtosecond laser-assisted surgery (LACS) for cataracts. They like the idea of standardized procedures and surgery that provides the precision of the laser and is as “blade-free” as possible.

Patients with cataracts are interested in learning how we can improve their quality of vision by using LACS—and this is particularly true if they want to gain postoperative spectacle independence.

### **Cataract counseling**

Ultimately, every patient will not choose to have LACS, but during cataract counseling we discuss our three packages with all patients.

Because the cataract evaluation is keenly important, we follow a standardized protocol. This does not require a large ancillary staff, but all staff are trained and educated thoroughly and we ensure that everyone who interacts with patients uses similar language.

In our practice, we have “Cat Chats” with staff approximately three times per year in order to familiarize all the clinicians and the cataract team of counselors, surgical schedulers, and technicians with the evolving technology and techniques.

About 75% of our cataract surgery patients are directly referred from outside clinicians.

### Refractive cataract surgery evaluation checklist

- Diagnostic evaluation of astigmatism: minimum 2 devices
  - Topography, optical biometry, manual keratometry
- Patient characteristics
  - Height
  - Age
  - Hobbies
  - Profession
  - Time spent reading versus distance activities
  - How patient reads (e-reader, books, newspaper, computer, etc.)
- Existing co-morbidities (systemic, ocular)
- Patient refractive goals

Figure 1. Checklist for developing a refractive recommendation for patient having cataract surgery

Thus, they are new patients, and it is important to create a positive experience for them. The actual patient experience begins with a pre-appointment introduction phone call from our practice that introduces Virginia Eye Consultants to the patients and prepares them to expect a thorough appointment during their cataract evaluation, one that lasts approximately 3 hours to perform all diagnostics and provide the proper education surrounding cataract surgery. We make every effort to provide a personalized experience for them. We escort patients from one phase of the examination to the next. The technician who meets them for their workup takes them to cataract counseling and picks them up to take them to diagnostics. Then the technician dilates the patient's pupils and introduces the patient to the surgeon.

As we talk with patients, we stress visual outcome goals, such as achieving near and distance vision vs. distance vision only. To simplify the details, we do not discuss IOL brands or use terms such as “multifocal IOL.” We follow a uniform format, with uniform language, because cataract surgery can be a confusing process for patients.

Our cataract counselor jots down specific information about the patient, such as the patient's hobbies, visual goals, and profession. This sets up a more directed conversation with the ophthalmologist (Figure 1).

When I meet the patient, I provide a brief overview of cataract surgery, including the length of surgery, what to expect, and risks and benefits. I also explain that there is no safety difference between manual cataract surgery and LACS, but it provides a

greater level of safety for conditions such as Fuchs' dystrophy or zonular weakness.<sup>1,2</sup>

The most important part of the discussion is identifying patients' refractive goals in relation to their desired level of spectacle independence, profession, hobbies, and needs; this guides me in making a recommendation. I encourage them to ask questions to help them make a decision. In my practice, 55% of patients desire greater spectacle independence for distance, near, or both.

I explain that refractive options with LACS help provide a level of spectacle independence that they would not have if they had blade-assisted surgery. To minimize the need for glasses at a specific focal point, in my experience LACS has produced more reliable results. We review our cases routinely, and with LACS vs. manual cataract surgery with a monofocal IOL, my spherical equivalent outcomes are within 92% of the predicted target vs. 76% to 78% with manual cataract surgery, respectively.

In addition, I can use LACS to reproducibly treat 1.0 D of astigmatism or less; if astigmatism exceeds 1.0 D, however, I recommend a toric monofocal or toric presbyopia-correcting IOL option. I routinely add LACS for advanced technology IOLs because my personal results demonstrate that LACS adds greater refractive predictability.

Before I conclude the conversation, patients understand that there is a 92% chance that we will be able to achieve their goal of spectacle independence if I use LACS. In the remaining 8%, human factors such as variations

in healing response and other considerations may necessitate a touch-up. I also explain that there is a very small chance that a lens exchange may be necessary. In this case, I will optimize vision for distance or near with a monofocal IOL, depending on the patient's preference.

Patients with a very short eye (less than 22.0 mm), longer axial length (greater than 26.0 mm), or who are post-LASIK/PRK/RK have a higher chance of a missed refractive target, and I stress that to these patients.

If an enhancement is necessary, I emphasize that it is part of the package. It may take a little extra time to fine-tune their outcomes, but I promise to help them achieve their goal and have them use light spectacles or a contact lens in the interim.

### Contagious enthusiasm

The enthusiasm for advanced technology IOLs and LACS is contagious. Patients and staff will be excited about this technology if surgeons are passionate about it. Having almost 4 years of experience with LACS and seeing the reliable, reproducible outcomes and the high patient satisfaction continue to feed into the entire process.

In addition, from the practice's perspective, being well-informed, up-to-date, and educated on our own results helps maintain the integrity of what we offer our patients.

### Increased opportunities

Half of cataract surgeons do not perform relaxing incisions, based on results from the 2015 ASCRS Clinical Survey.<sup>3</sup> However, LACS

**“In our practice, we have ‘Cat Chats’ with staff about three times per year in order to familiarize the clinicians and the cataract team of counselors, surgical schedulers, and technicians with the evolving technology and techniques.”**

**–Elizabeth Yeu, MD**

is an excellent way to perform limbal relaxing incisions for patients with low levels of astigmatism (less than 1.0 D), for whom a toric IOL is not available, and for patients with mixed astigmatism after surgery.<sup>4</sup> Patients are extremely pleased if we can correct their suboptimal outcomes.

Being familiar with technology that provides that extra level of precision and can help our patients achieve their refractive goals is a worthwhile and worthy pursuit.

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**CME questions (circle the correct answer)**

**1. Which factor is LEAST important when deciding to buy a femtosecond laser?**

- A. Total number of cases performed per year
- B. Current infrastructure: What will you have to pay to build out to place it?
- C. Percentage of premium cases where you will use the femtosecond laser, and then total number of those cases
- D. Costs of the laser (including service, extra time spent, click fees, and upgrade costs)

**Questions 2 & 3: A 55-year-old teacher presents for a cataract surgery evaluation, with well-controlled diabetes mellitus (DM) type 2 without retinopathy, and she desires greater spectacle independence.**

**2. What is the best approach for the staff to take before you meet the patient?**

- A. Dissuade the patient from any option apart from manual cataract surgery because she has known DM type 2
- B. Provide a standardized approach with appropriate diagnostics, including a macula OCT, basic education regarding cataract surgery, and potential options for cataract surgery
- C. Have the staff make a firm recommendation on what approach (manual vs. LACS) and IOL technology to proceed with
- D. I look forward to the day that I can have enough organization with my clinic staff to have a standardized approach for cataract surgery evaluations

**3. As the surgeon, what is your best recommendation for this patient?**

- A. The recommendation depends on the patient's refractive goals, hobbies, profession, and ocular and systemic comorbidities. This also has to be balanced with the available technologies and the patient's financial considerations
- B. Monofocal IOL and manual cataract surgery—she has DM type 2
- C. Easy decision—the patient says she wants spectacle freedom; thus, she should only consider a presbyopia-correcting IOL
- D. Not LACS if it does not benefit the majority of my patients in my practice

**4. Surgeon and facility efficiency are best achieved with laser-assisted cataract surgery when:**

- A. Patient education is consistent throughout the clinic
- B. Patient flow model matches the surgical facility's
- C. Pricing appropriately compensates the surgeon and facility for time invested
- D. All of the above

**5. For an ophthalmology practice that is considering LACS but does not have its own ambulatory surgery center, which femtosecond laser acquisition strategy likely offers the fewest financial risks?**

- A. Purchase of a new laser by the practice
- B. Purchase of a used laser by the practice
- C. Purchase of the laser by surgeons who practice in the same area
- D. Contracting with a mobile access company

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City, State, Zip, Country: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Please print email address legibly, as CME certificate will be emailed to the address provided.