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From the Publisher

From Medicare reimbursements and malpractice lawsuits to patient retention and equipment investments, money matters are at the core of every ophthalmology practice. The Great Recession and healthcare reform have altered our industry’s terrain, and this issue of Ophthalmology Business is here to help you navigate it.

Find yourself confused by Medicare cataract surgery reimbursements? You’re not alone. Kevin J. Corcoran makes sense of it all in “Non-covered services associated with cataract surgery.” He makes a compelling case for charging patients the remaining balance.

“Final refraction following cataract surgery is not bundled with the global surgery package and not covered by virtue of the Medicare law,” he wrote. “While some surgeons prefer to provide the final refraction at no charge, there is no reason to believe that Medicare obliges them to do so.”

Brad Ruden also talks money, covering practice owner compensation plans. These partnerships, which begin with the best intentions, can turn ugly if they aren’t fair and fail to reward performance. Although there’s no fixed model for these plans, Mr. Ruden provides some pearls applicable to any practice.

In an article not to be missed, doctor and lawyer Lori Abel Meyerhoffer gives an overview of the legal pitfalls of electronic medical records from her unique professional perspective in “EMR—friend or foe.”

“More patients are demanding e-mail communications with their physicians,” Dr. Meyerhoffer wrote. “These communications, should, at a minimum, be retained in their original format. Failure to retain this information within the EMR increases the likelihood that e-mail communications will be an issue in the malpractice setting.”

No one expects to be hit with a malpractice lawsuit, but preparing for that worst-case scenario is imperative in these changing times. As the geography of our industry evolves, OB will be your roadmap.

Thanks for reading.

Donald R. Long
Publisher, Ophthalmology Business
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CHICAGO 2012
American Society of Cataract and Refractive Surgery
American Society of Ophthalmic Administrators
Non-covered services associated with cataract surgery

by Kevin J. Corcoran, C.O.E., C.P.C., F.N.A.O.
A look at the non-covered services that justify a legitimate charge to the patient above and beyond Medicare’s reimbursement

Not long ago, two ophthalmologists had an animated debate about cataract surgery and Medicare’s regulations. Their difference of opinion centered on the beneficiary’s financial obligation. In this case, neither surgeon had firsthand knowledge of the pertinent laws or regulations, but they each had strong convictions about right and wrong. It would also be fair to say that their philosophies differed markedly: one averse to charging patients added fees and the other in favor of added fees for extra work. Before long, one hinted darkly about the other’s conduct and possible fraud. A professional conversation deteriorated to disparaging comments and malicious innuendo. Worse yet, allegations of fraud bred cynicism and defensiveness, which act as a corrosive on professionalism.

Yet we can learn something from this quarrel. This article will describe those non-covered services that justify a legitimate charge to the patient above and beyond Medicare’s reimbursement.

Most items and services associated with routine cataract surgery are covered under Medicare’s national policy (NCD 10.1). They include an exam to determine the need for surgery, biometry to select a suitable IOL, and sometimes other tests, such as B-scan for dense cataract. There are some things that are not covered, and the beneficiary is financially responsible for payment in addition to the usual deductible and co-payments.

The Medicare law (Social Security Act, Title XVIII) limits healthcare coverage. Medicare does not pay for everything, not even care covered for post-cataract eyeglasses following cataract surgery with implantation of an IOL. Nevertheless, Medicare does not pay for the refraction to prescribe those eyeglasses (Medicare Claims Processing Manual, Chapter 21, §50.26.1).

In addition to refraction, corneal topography is very helpful for assessing corneal astigmatism hinted at by lensometry or detected by keratometry prior to cataract surgery. It is considered a covered test for indications such as post-penetrating keratoplasty, keratoconus, corneal dystrophy, or keratopathy, but not for regular astigmatism. To achieve excellent unaided vision following cataract surgery, astigmatism must be minimized, and corneal topography is helpful for that purpose.

Additionally, screening for potential disease, such as macular degeneration or epiretinal membrane, using scanning computerized ophthalmic diagnostic imaging of the retina is not covered because prophylactic testing is not a Medicare benefit, unless specifically authorized by Congress. In contrast, testing patients with a history of AMD or other retinal pathology is a covered service. Likewise, specular microscopy prior to cataract surgery to evaluate corneal pathology is a covered service under the Medicare national policy (NCD 80.8).

Some surgeons offer pseudophakic monovision as an option when the patient desires spectacle independence. In these cases, there are several other pre-op tests, all refractive in nature, that guide the surgeon. They include: ocular dominance, stereopsis, and interocular defocus threshold. Again, these are non-covered services where Medicare

continued on page 8
and most other third party payers are concerned. Patients with a prior history of LASIK or other corneal refractive surgery can be particularly challenging. In such cases, a trial fitting with contact lenses may be useful. Again, the extra work is all refractive in nature and intended to minimize diopter surprise after cataract surgery.

An important part of the debate between the two surgeons described at the beginning of this article concerned equal treatment for all patients. Patients need to be fully informed about their care and any financial obligations. It’s the patient’s choice whether to proceed—the patient cannot be forced. If the patient places too many limitations or unreasonable expectations on the surgeon, the ophthalmologist has the option to refuse to provide care.

Because patient choice is an individual matter, it’s important to document it in the medical record. Just as importantly, the beneficiary’s financial responsibility needs to be memorialized in writing. While payment for non-covered services is the beneficiary’s obligation, the Medicare law (Social Security Act, §1879) contains a provision that waives that liability if the beneficiary is not likely to know and did not have a reason to know that the services would not be covered.

An Advance Beneficiary Notice of Noncoverage (ABN) is a written notice given to a Medicare beneficiary when the provider believes that Medicare probably or certainly will not pay for some or all of the items or services. However, an ABN is only required if something might be covered. Items and services that are never covered by virtue of exclusions in the Medicare law do not require an ABN because the beneficiary does have a reason to know the statutory exclusions (and is expected to know them). Nevertheless, to avoid buyer’s remorse, it’s a good idea to obtain proof that the beneficiary understands and accepts financial responsibility for non-covered items and services. Either an ABN or a Notice of Exclusion from Medicare Benefits may be used for this purpose. Simultaneously, providers should get payment from the patient prior to rendering care.

As a practical matter, the non-covered pre-op tests described above are bilateral in nature and are performed prior to the first cataract surgery. Repeating the same test(s) prior to the second cataract surgery, particularly a short time later, would be rare. So a single charge, not two, is usually warranted. Furthermore, the professional fees for ancillary testing are modest and do not necessarily include surgical services.

Non-covered services are not solely the physician’s bailiwick. The facility fee associated with performing limbal or corneal relaxing incisions for the surgical correction of corneal astigmatism is non-covered. Intra-operative wavefront aberrometry is likewise non-covered when performed in the operating room to measure refractive errors in association with cataract surgery.

Patients with clinically significant astigmatism (≥1.00 D cylinder) represent about 35% of those desiring cataract surgery. Such patients may be good candidates for surgical correction of corneal astigmatism, which is usually offered as a global surgery package that includes pre-op tests and possible enhancements. Typically, there are two discrete charges for this non-covered service: a professional fee and an institutional facility fee for the ambulatory surgery center (ASC) or hospital outpatient department (HOPD). For the sake of reference, in the rare case that Medicare pays for corneal relaxing incisions (CPT 65772), the surgeon is allowed about $429 (for the surgery alone as a primary procedure), the ASC is allowed about $694 (as a primary procedure), and the HOPD is allowed about $1,233 (as a primary procedure). Recall that secondary procedures are allowed 50% of the fee schedule amount. Provider charges are almost always higher than Medicare’s allowable payment amount.

Cataract surgery has evolved tremendously since the first IOL was implanted in 1949. Modern techniques combine non-covered refractive services with cataract extraction. Surgeons achieve better patient outcomes with reduced reliance on post-cataract eyeglasses due to reduced residual refractive errors. For patients who understand and choose these added refractive services, an additional out-of-pocket expense is fair and not prohibited by Medicare’s laws or regulations.

References
How should practice owners be compensated?

Brad Ruden, M.B.A.

Partner compensation plans should always acknowledge fairness, risk of ownership, and rewarding performance

When it is a question of money, everybody is of the same religion

Voltaire

I have helped design and review many partnership arrangements. One important point I make when discussing partnerships is that the practice owners are the last to get paid. The employees get paid and the bills get paid, and what is left over goes to the owners. My experience has shown me that partner compensation methodologies often become points of contention. When I design partner compensation plans, I try to address three areas: fairness, the risk of ownership, and rewarding performance.

Many different partner-compensation models exist, each with their own advantages and disadvantages. That being said, almost all compensation models can be placed into two broad categories: compensation by sharing profits or compensation by allocating overhead.

Share profits

The sharing of profits is simple. The accounts receivable (A/R) is combined to pay all of the practice’s expenses. What is left over represents the profits of the practice. Those profits are then allocated among the owners by an agreed-upon formula. This allocation can be by ownership share, by productivity share, or by a combination of the two. I have found a combination approach works best. The key is the size of each pool. For example, one practice may choose 50% by ownership and 50% by productivity, while another may choose 30% ownership and 70% productivity. Spreadsheet models can be run to test different allocations to ascertain which is the best for a particular practice.

Taking the above a step further—and to provide more detail—one must account for those expenses that are personal in nature (car, trips, etc.) and incurred by each partner. Those personal expenses, along with the doctor’s salary, are removed from the practice’s expenses before ascertaining profits. When each doctor’s share is determined by the compensation plan, his or her salary and the cost of personal benefits are considered a draw against the derived partnership share. Any remaining amount would be the actual cash bonus.

I like the split approach versus an all-allocated-by-ownership-share or all-allocated-by-productivity approach for two reasons:

• An approach based entirely on ownership stake doesn’t reward higher levels of productivity.
• An approach based entirely on productivity can create too much inter-office competition.

I would suggest putting in certain safeguards, such as a partner must generate a minimum level of revenue to remain as a partner and participate in the profit sharing. This will ensure one doesn’t get paid for doing nothing while still getting monies from his or her ownership stake.

Allocate overhead

In an overhead allocation system, the practice’s overhead is allocated to each partner based on an agreed-upon formula. Each doctor keeps his or her own A/R and then pays the subsequent share of the overhead as allocated to him or her. Whatever is left over is that partner’s compensation for that period.

Just as with the profit-sharing methodology, the overhead can be allocated in three ways: by ownership share, by productivity share, or by a combination of the two. If a practice is going to use this methodology, I believe a combined approach works best. In this model, one can also set the ownership and productivity allocations wherever he or she chooses, such as 50%-50%, 30%-70%, etc. Again, spreadsheet models can be run to test different allocations to ascertain which is the best for a particular practice.

Just as with the profit sharing, when allocating overhead, one accounts for those expenses that are personal in nature (car, trips, etc.) and directs those full amounts to each partner’s overhead share. Any remaining amount would be that partner’s profits for the term.

The advantage to allocating overhead is that it obligates each partner to cover a share of the practice’s expenses no matter what. This type of approach should weed out less productive performers. However, there are a couple of potential pitfalls to this approach.

It can create an intense “eat what you kill” mentality that could result in too much inter-office competition that some may not find appealing.

Beware of overhead allocations based entirely on productivity. What happens if one partner suddenly becomes substantially less productive? For example, I had a situation years ago where two doctors were partners and got along well. They had fairly equal productivity but one—through foresight or luck—pulled his money out of the stock market before it tanked. The other kept his money in the market and saw a huge loss. The doctor who pulled out of the stock market was flush with cash and dropped his work schedule down substantially while the other was forced to keep working full-time. A substantial amount of the overhead for a two-doctor practice was pushed onto the productivity of one (in this case, he became responsible for 80%+ of the overhead). While one lived comfortably and had an easy work schedule, the other was working incredibly hard just to keep the doors open and received no compensation. This untenable situation continued for 6+ months until the practice ultimately went bankrupt.

As I stated under the profit sharing approach, I would suggest putting safeguards in place, such as a partner must generate a minimum level of revenue to remain as a partner or suffer forfeiture of his or her ownership stake.

Allocation pitfall

No matter if the profit sharing approach or overhead allocation methodology is used, one must keep in mind that a simple allocation based on collected revenue may not work in all cases.

Patient mix can be a divisive factor, as there could be a reluctance to treat patients who are uninsured, covered by Medicaid, enrolled in a low reimbursing plan, or covered under a capitated plan, as such patients would not generate much in collections and have a negative impact when the allocation is performed. For example, a physician whose patient base consisted primarily of Medicare or Medicaid patients would earn less than a counterpart whose patient base was primarily commercially insured, as Medicare/Medicaid reimbursement tends to be the lower of the two.

In most cases, using an allocation based on collected revenue will suffice. However, in a practice that has capitated plans or in which one partner sees a disproportionate amount of lower-paying patients, an allocation based on the resource-based relative value scale units could instead be utilized.

Summary

This article does not address all of the issues in designing a partnership compensation plan. No single article could ever cover such a broad-based topic. There is no fixed model for partner compensation. Each practice must adopt a model that fits its needs. A well-designed compensation plan will not only account for the risk of ownership, but will also reward hard work and top performers. However, even the most well-designed compensation plan may have to be modified as the practice evolves.
Social networking?
Avoid these five mistakes

by William B. Rabourn Jr.

Your competitors are out there blogging, Facebooking, and Twittering, and you are wondering if you should jump in, too. Before you make the leap, be aware of these five social networking mistakes.

Mistake No. 1: Failure to take advantage of social networking opportunities
You already have a website—isn’t that enough? A good website remains a valuable resource, but it is no longer enough. Whether you want them to or not, people will be using social networks to talk about you. You need to be part of the conversation. Properly used, social networking presents excellent opportunities for you to achieve “digital eminence”—that is, to stand out in a competitive online environment.

Mistake No. 2: Failure to observe professional boundaries
In November 2010, the American Medical Association (AMA) published a policy statement that drew those boundaries (“Professionalism in the Use of Social Media”).

The AMA policy acknowledges the many opportunities social networking offers to physicians in the way of personal expression, having a professional presence online, fostering collegiality and camaraderie within the profession, and providing a channel for disseminating public health messages and other health communications. At the same time, the policy points out that legal and ethical duties to maintain patient privacy and confidentiality apply to your online presence, too, and that your social networking behavior can and will have consequences with regard to your reputation and your career. Your duty to adhere to professional ethical guidelines when interacting with patients via social networking channels remains the same as in any other context. Among
other things, the policy also recommends that you consider separating your personal and professional content online.

This policy is short—only seven paragraphs—and to the point, and it’s posted on the AMA’s website (www.ama-assn.org). Take a look at it before you leap.

Mistake No. 3: Failure to control the conversation

The AMA policy also cautions physicians to monitor content they post—as well as content posted about them by others—to ensure it is accurate and appropriate.

One of the beauties of social networking is its immediacy, how it makes it possible to conveniently interact in real time with a widespread community of users. That immediacy can work for us or against us because information, opinions, and interactions—good and bad, helpful and unhelpful—travel at the speed of light. You can’t “be there” 24 hours a day, but you should commit adequate resources to timely monitoring of your presence so problems can be promptly addressed. You must stay on top of this by frequently checking the social networking conversation. Small fires can rapidly grow into conflagrations, and the earlier they are put out, the less damage they will do.

These small fires sometimes present opportunities to engage in old-fashioned good customer service. Your measured and concerned response to a negative or inaccurate posting can turn a lemon into lemonade in front of onlookers. On the other hand, a defensive response can compound the problem.

Take the example of a patient whose comment on a blog posting aired her unhappiness with what she felt was harsh bedside manner and treatment received from her doctor. The physician in question responded with an interperate and ill-considered comment that ended with a personal attack on his patient’s lifestyle. While he did not disclose the patient’s name, he included confidential information on her condition and treatment. Followers of the blog immediately recognized that a line had been crossed. They didn’t need an AMA policy to tell them that this physician’s response was inappropriate and unprofessional. What began as one unfavorable comment quickly exploded into scores of negative responses to his posting. The doctor clearly lost control of the conversation.

Mistake No. 4: Doing it yourself

You don’t have time to keep your finger on the pulse of the conversation, so you must delegate someone else to do it for you.

Your 17-year-old niece may live in the land of Facebook and Twitter and will no doubt be able to give you the grand tour, but you cannot ask her to “keep an eye on things” for you. Delegating this responsibility to a member of your office staff usually works only as a short-term solution. When the office is busy, taking care of your patients and delivering good customer service will be that employee’s focus, as it should be; even with the best of intentions, monitoring will become haphazard and inconsistent. It’s simply not economical for most physician practices to bring on a new employee expressly for the purpose of managing all aspects of your social networking, but you can probably afford to hire an outside service that has the expertise to monitor the conversation for you and help you to participate more actively. Take care, however, to select a social networking service familiar with the medical field.

Mistake No. 5: Thinking that social networking will be your “free lunch”

Alas, the free lunch remains a mythical creature. Social networking will probably not save you money by making it possible to cut your budget for marketing and advertising. You should expect to spend much the same as before because it cannot, by nature, take over the function of advertising. Traditional print, radio, and television advertising broadcasts your message to a wide range of people, and that’s still where the numbers are. Typically, the audience segment that your advertising drives to Facebook, Twitter, and your blog already has some affinity with you so, to some extent, networking with them is like preaching to the choir. Designate a portion of your budget for an outside service to manage your social networking, and use your advertising to cast your net for more like-minded followers who can turn up the volume on their good word of mouth.

You can’t afford to put all of your eggs in the social networking basket, but that doesn’t mean that it won’t be profitable. The bottom-line benefits of social networking come not from shrinking your budget, but from expanding your practice’s revenue.

So go ahead and jump in. The water’s fine, but take care that you don’t get in over your head.
EMR—friend or foe

by Lori Abel Meyerhoffer, M.D., O.D., J.D.

Legal perspectives from one physician to another

The “incentives” to make the change to electronic medical records (EMR) are compelling for any physician providing healthcare services to Medicare patients. Given these incentives and abundant articles in various journals regarding EMR currently, I am covering this potential legal malpractice trap. As a physician, whether you like EMR or not, you have to accept it is here to stay. As an internist, I have dictated “RRR without m/r/g” and “PERRLA” my fair share of times. EMR represents a solution to repetitive dictations and documentation present in the majority of our patients. It also provides vast amounts of information that can be tabulated in multiple formats in minimal time and with minimal effort. However, there
are legal pitfalls unique to EMR with which physicians must be aware. This article will detail the specific areas of EMR that pose issues when defending malpractice claims.

**Official medical record: Testing and diagnostic procedures**

There is currently no uniform definition of what constitutes the “official medical record.” In the paper chart era the answer was clear—everything related to a particular patient was placed into the paper chart and became the official medical record. In the electronic world, it is far more difficult to define the outer limits of information within the “official medical record.” For example, an orbscan obtained as part of a pre-op evaluation for laser vision correction surgery may also contain abundant additional data that can be analyzed in a number of different ways. These electronic data, regardless of whether the data are analyzed while caring for the patient or whether the ophthalmologist reviews or relies on these data, could be considered a part of the medical record. Plaintiff attorneys are asking for production of this information and are successfully obtaining it. Their experts then utilize the data to show the patient had an abnormality (for example, some form of a higher-order aberration) that was a “contraindication” to the procedure the defendant ophthalmologist performed. In the broadest sense, the medical record incorporates all electronic data obtained on a patient. This information is discoverable once litigation begins. Ophthalmologists should ensure that their EMR are regularly backed up and that all of the data is obtained on specialized equipment (including orbscans and digital photography, which are relatively unique to ophthalmology). Additionally, these data should be retained in color and not printed in color and then scanned into an EMR in black and white format.

**Official medical record: E-mail communications**

More patients are demanding e-mail communications with their physicians. These communications should, at a minimum, be retained in their original format. The better practice is to convert this type of communication into the patient’s medical record either by direct elec-

“As a physician, whether you like EMR or not, you have to accept it is here to stay”
Electronic conversion into the EMR or by printing the correspondence and then scanning it into the EMR. Failure to retain this information within the EMR increases the likelihood that e-mail communications will be an issue in the malpractice setting. There is a substantial risk that the e-mail will either be deleted or will not be recoverable years later should the ophthalmologist become a defendant in a malpractice claim. Some e-mail correspondence could provide defenses to the allegations within the plaintiff’s complaint. Alternatively, this communication could bolster the plaintiff’s allegations. The substance of all e-mail communication must be known from the onset of litigation as it may be critical to decisions regarding the merits of the claim and the defense thereof.

**Official medical record: Shadow chart**

Some physicians resort to keeping two charts: the “official medical record” (the EMR) and a shadow paper chart. When kept, shadow charts tend to contain some of the information within the “official medical record” (the EMR) plus other information including e-mail communications with patients, research information collected on patients, and other non-electronic correspondence and information not scanned into the EMR. The practice of maintaining shadow charts should be discouraged. There should be only one medical record and it should include all information obtained or acquired on the patient.

**Auto-populated fields**

Many EMR fields are auto-populated—the EMR template is pre-populated with the “usual” clinical finding. If the patient does not fit within this pre-populated description, the physician must change it by selecting another option from a drop-down menu or by free texting the examination finding. For example, “deep and quiet” may automatically populate the anterior chamber examination. If auto-populated as deep and quiet, and on a subsequent examination the office staff dilates a patient with narrow angles who develops acute angle-closure glaucoma, the medical record documentation will make defending the claim more difficult.

The auto-populated fields may not even be related to the subject matter of the plaintiff’s claim. The plaintiff and experts will capitalize on these situations. For example, something as simple and inconsequential as selection of the incorrect iris color from a dropdown menu in a suit alleging failure to diagnosis acute angle-closure glaucoma leading to significant vision loss can become problematic. The plaintiff’s counsel and the retained experts will allege because of this one innocuous error that the remainder of the documentation should be called into question. These situations are difficult to overcome and are entirely unnecessary. While this type of error is more frequently seen with an EMR than in the paper chart, it is also more frequently seen in EMRs that have auto-populated fields than those requiring selection from drop-down menus or with free texting fields. With the understanding that auto-populated fields save time in busy practices, this type of EMR should be carefully utilized or completely avoided.

Although dropdown menus are preferred to auto-populated EMR fields, there is a tendency to select the “closest” match rather than free-text. The time savings of drop-down menus cannot be overstated. As such, it is imperative that free-texting is encouraged, rather than selecting the closest match, to ensure documentation is accurate.

**Copy and paste**

Another pitfall seen in litigation is the situation of an incorrect history or physical finding repeatedly documented in the medical record. This frequently occurs in the inpatient setting but can occur in the outpatient setting as well. For example, a neuro-ophthalmologist in a large multispecialty group evaluates a neurosurgical patient with a meningioma. The neurosurgeon documented the patient’s symptom of decreased visual acuity started 2 months prior to the office evaluation. In fact, the symptoms started 2 days prior. The neuro-ophthalmologist discusses the patient’s history with the patient and understands the acute onset of symptoms but copies and pastes the neurosurgeons erroneously documented history. Despite
all of the physicians being aware of the timing of the symptoms, the documentation will open the door for the plaintiff to argue there was another disease process that caused the bad outcome that was not considered by the defendant ophthalmologist. It is imperative to obtain and document your own history for each patient into the EMR. If possible, the copy and paste feature of EMR should be disabled.

**Standard dictations**

In ophthalmology particularly many surgical procedures are performed repetitively. As a convenience, standard dictations for certain procedures are created. For example, a cataract surgeon may have a standard dictation for her cataract extractions since each is performed in the same general manner and most are uncomplicated. The problem arises when there is a complication during surgery that is not dictated or, even worse, when another procedure is performed but the standard dictation is still utilized. For multiple reasons, an IOL must occasionally be removed and replaced. The procedure is flawless but the dictation reflects that the patient underwent another cataract extraction on the same eye that previously had the cataract extraction. Inevitably, this dictation is signed and made a part of the EMR. Only when litigation ensues does the ophthalmologist recognize the error and then dictates a revised operative report detailing the actual surgery performed. This is generally years later. The plaintiff’s counsel will quickly point out that the defendant ophthalmologist not only dictated the wrong procedure on the day of the actual procedure, but also subsequently signed it and only dictated the actual procedure performed years later and then only from memory. This opens the door for plaintiff’s counsel to suggest that the treating ophthalmologist was not paying attention. Even worse, plaintiff’s counsel may allege an operative complication occurred that the ophthalmologist does not recall due to the passage of time between the surgery and the dictation. Counsel may even utilize the medical staff bylaws to demonstrate that the requirements placed on ophthalmology by the bylaws require timely dictation of the actual procedure performed and that the physician violated this requirement. This documentation issue is difficult to overcome at all levels of the defense of a claim.

**Digital fingerprint**

One of the most difficult problems created in medical malpractice defense by the EMR is the digital fingerprint. Every time someone accesses a patient’s EMR, the information is stored electronically whether you realize it or not (a digital forensic examiner can easily recover this type of tracking information). Information recoverable generally includes date, time, specific information accessed, time spent in each section, and often whether any modifications were made to the medical record. This information becomes important in a number of ways. First, and most obvious, if the defendant makes any changes or modifications to the medical record, this is easily identified. This would be insurmountable in the defense of the claim. Second, if the ophthalmologist is aware of a bad outcome shortly after the provided care and treatment to the patient and then reviews the EMR and in hindsight believes something was done incorrectly, the plaintiff will have proof of review of the medical record subsequent to the defendant becoming aware of the bad outcome. During the defendant ophthalmologist’s deposition, the plaintiff’s counsel will question the defendant about his/her impression of the care provided after review of the medical record subsequent to becoming aware of the bad outcome. The sworn deposition testimony is generally adverse to the defense because the ophthalmologist reviewed the data retrospectively. Third, this information can be utilized to demonstrate that some piece of information pertinent to the care and treatment of the patient was either reviewed and ignored (for example, a pre-op hematocrit demonstrating profound anemia) or was not reviewed although ordered (a pre-op CXR or INR) and should have been reviewed. All of this creates abundant issues in the defense of a malpractice claim.

Electronic medical records are not going away. Ophthalmologists need to educate themselves on the most appropriate system for their practice and how to efficiently and effectively utilize EMR. Extensive training for the physician and staff as to the proper use of EMR is essential to successful defense of malpractice claims.

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**Lori Abel Meyerhoffer**

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Perceptions of industry consultants

by Douglas Koch, M.D.

What the changing environment means for ophthalmologists

As ophthalmologists, many of us find consulting with industry to be a stimulating, challenging, and, to a lesser or greater extent, profitable activity. The term “consultant” used to carry with it the connotation that one was selected for his or her expertise and insights to assist manufacturers in developing the best products for patients.

However, in recent years, there has been a shift in the perception of consultants, no doubt precipitated by some highly publicized and egregious events, but also fed by the perception that perhaps too many consultants “tow the company line” and do not act as independent agents in representing commercial products. The media has widely publicized instances in which consultants were shown to be lying about huge conflicts of interest with companies. Several prominent physicians have spoken out about these abuses, large and small.

Nefarious case

One particularly egregious example involved Charles B. Neumeroff, M.D., Ph.D., chair of the psychiatry department, Miller School of Medicine, University of Miami, when he worked at Emory University, Atlanta. As reported in an article by Marcia Angell in the January 15, 2009, New York Review of Books, Dr. Neumeroff received a $3.95 million mental health grant for his work as a principle investigator slated to study several drugs manufactured by GlaxoSmithKline (Research Triangle Park, N.C.). A $1.35 million portion of this grant was applied directly to Emory for overhead.

Dr. Neumeroff was required, as per University and government regulations, to disclose and subsequently eliminate any additional income from GlaxoSmithKline above $10,000 per year. When Senator Charles Grassley, who has been spearheading new industry regulations, asked for some fact-checking on this, he found that Dr. Neumeroff failed to disclose approximately $500,000 in speaking fees.
Meanwhile, in June 2004, a year into the grant, when Emory University had done its own investigation, Dr. Neumeroff sent a memo assuring the University that he had collected just $9,999 in fees from GlaxoSmithKline and so was within the letter of the law. In reality, investigators later found that that year alone he had received $171,031 from the company—well above the $10,000 cutoff. There was some innuendo that Emory University also benefited, potentially giving it a motive not to dig too deeply into this.

**Shading opinions**

Unfortunately, this sort of case has cast a cloud of doubt over all medical consultants. Both the profession and the public are looking more skeptically at consultants’ objectivity and are less convinced that ophthalmologists who work with companies play an important role and guide the company toward the best products for patients. To understand this better, let us look further at what consultants actually do.

**The consultant as advisor**

Consultants serve in two main roles: advising the company and presenting company data. The former is critical to the development of the best products for patients. Most manufacturers now involve their ophthalmic consultants early and frequently in product development. In this capacity, consultants often work closely on the research that is done and advise the company on various aspects of product development, clinical trial design, and, if indicated, the FDA approval process.

An example of this is the AcuFocus (Irvine, Calif.) corneal inlay, a small aperture device that is implanted in the cornea. Several ophthalmology consultants worked closely with the company from the device’s inception through CE market approval and beyond. These consultants have helped on an ongoing basis to develop the device, the accompanying surgical procedure, the clinical trial, the clinical indications, and the management of complications.

There was superb collaboration between the company representatives and the key physician consultants as this product was taken through clinical trials and brought to market (outside the U.S. to date). This product would not be where it is today had it not been for the input of that core group.

A good consultant will also tell the company when the product is flawed. An example occurred several years ago when a major IOL manufacturer was conducting clinical trials on a new IOL design. A unique complication occurred, and the company convened several investigators and consultants. Based on their feedback, the product was abandoned.

**The consultant’s public role**

The other major role of the consultant is to share the company’s data with the public, which can include ophthalmic colleagues, the press, or prospective investors. In this role, the consultant can face tough ethical challenges, feeling pressure to serve as a spokesperson for the company while desiring to maintain integrity and honesty in the presentations.

There is obviously a spectrum in the types of presentations that are given by consultants. While it is the convention of the ophthalmic industry to offer consultants talking points highlighting a given product, in the ideal world these can be accepted or rejected. Ideally, consultants will prepare their talks based on their own review of data.

However, companies own their internal research and clinical trial data and are understandably protective of how these data are presented. In this scenario, consultants are called upon to develop presentations based upon company data in conjunction with company input. This is certainly appropriate if the consultant has final say on content. Also, with FDA trial data, presentations must strictly adhere to FDA requirements, and consultants must rely on the company and its regulatory staff to know what can and cannot be shared with the public.

The opposite end of the spectrum is the extreme “speaker’s bureau” presentation in which one presents data/slides from the company on material of which he or she has no personal knowledge or with which he or she might even disagree. Fortunately, this is coming under increasing scrutiny, and the majority of “speaker’s bureau” talks in my experience (as a listener—I am not on a speaker’s bureau) are accurate, informative, and helpful.

I believe that physicians are savvy about the conflict that exists in this area and that there is a range of views on how one should interpret these presentations, depending on the presenter, the company, the topic, and the context. In general, I sense that most people view consultants’ presentations as simply conveying the facts accurately and ethically, but there are also instances in which consultants are viewed as “talking heads” who are promoting products in a way that is one or more steps beyond the strict science of the matter. It is certainly disheartening to be able to note the speaker and topic and derive the conclusion without hearing the talk.

As I mentioned above, a good advising consultant will tell the company when it is on the wrong path, but for several reasons, not all companies heed this advice. The consultant’s other option, therefore, is to state these concerns publically. One

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individual who exemplifies this level of honesty and forthrightness is Edward E. Manche, M.D., director of cornea and refractive surgery, and professor of ophthalmology, Stanford University School of Medicine, Calif., who was involved in clinical trial work with scleral implants for treating presbyopia. Dr. Manche found that the same effect was seen in both the fellow and the treated eye and said so publicly. In another

The non-consultant’s arena

by Maxine Lipner Senior Contributing Editor

When it comes to holding companies true to their principles, non-consultants can at times play important roles. One practitioner who has stepped up several times is Edward E. Manche, M.D., director of cornea and refractive surgery, and professor of ophthalmology, Stanford University School of Medicine, Calif. Dr. Manche, who serves as a consultant in some cases, has a philosophy of not doing so when he is an investigator.

Pointing true north

It was in his capacity as a study investigator that he came up against two cases that tested his mettle of objectivity. The first case involved the Presby Corp Scleral Expansion Band. Dr. Manche was serving as an investigator for the Phase I FDA clinical trial. Under the supervision of the company’s medical monitor he had placed the bands in patients’ eyes. “Six investigators and I put them in,” Dr. Manche said. “The medical monitor of the company supervised me putting them in and he said, ‘Everything went according to plan to get the maximal effect.’” Unfortunately, the results did not reflect this. “What we found was that there was no effect whatsoever in the treated or the untreated eye,” Dr. Manche said.

Based on these results, Dr. Manche made a number of presentations detailing what he found here. “There were a couple of others who were not consultants who brought this to light as well—one investigator in particular was Kerry Solomon, M.D. [director, Carolina Eyecare Research Institute at Carolina Eyecare Physicians, Charleston, S.C.],” Dr. Manche said. “Both of us did not elect to participate in the Phase II clinical trials. We severed any further ties with the company.”

In another instance, Dr. Manche was initially serving as a medical monitor shepherding conductive keratoplasty through the FDA approval process. “It was approved as safe and effective for the temporary reduction of farsightedness,” Dr. Manche said. “But what we discovered when we followed patients long-term was that 3, 4, or 5 years later all the effect had worn off.” Dr. Manche published this data a year or two ago. “It was moot in the sense that the company had already fallen on hard times,” he said. “It’s as if the market figured it out on its own like it has with many other technologies that had a lot of promise but failed to deliver.”

Changing policies

As a rule, Dr. Manche’s philosophy has been to stay true to the data. He feels fortunate that Stanford University’s stance on avoiding conflicts of interest has helped him uphold this. “Any time you do an FDA clinical study there are a number of boilerplate agreements that companies try to get you to agree to,” Dr. Manche said. “Some of these contracts or agreements have clauses that say you’re not allowed to present data unless the company approves it, and Stanford almost always modifies or removes that wording.”

Stanford requires strict disclosure from investigators, with any conflicts posted on their webpage as well as in the informed consent in clinical trials. “If you’re a consultant for any company, that has to be stated so that patients know what your conflicts are,” Dr. Manche said.

On the other hand, Dr. Manche has concerns that some efforts on the part of states to legislate may cross the line. He pointed to an experience he had when he arrived late for a talk only to find a spot at a table with no plates set out. When he quietly asked why he was not being offered so much as a cup of coffee, he was told that the table had been reserved for practitioners from states where practitioners were not allowed to accept even a token hospitality from a company. “So the pendulum swung a little bit to the other side,” Dr. Manche said.

Overall, he thinks that finding a happy medium here would be a good thing. “Rather than simply saying ‘I’m a consultant,’ it might be useful to say ‘I’m a consultant and I have made $5,000 this year from this company, defraying the cost of trips to give lectures,’ or ‘I’m being paid $250,000 per year,’” Dr. Manche said. “But making it so that you can’t have a cup of coffee or pastry because it’s a company-sponsored lecture is a bit silly.”

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instance he spoke out on the regression of effect ultimately seen with conductive keratoplasty, and he wrote a paper that showed nearly complete regression of effect by 3 years post-op.

What about “non-consultants”?

In theory at least, non-consultants should be more at liberty to hold the company’s feet to the fire. However, we must remember that an absence of financial payment does not exclude conflict of interest. Money is just one type of reward that is offered. Non-consultants may feel a tug of conflict with regard to becoming a consultant in the future or of possibly being selected to take part in future clinical trials. Companies will often select users of their own products to do clinical trials as a way of compensating them. Clinical trials are interesting and can be practice-builders, and participating in them gives consultants a kind of scientific presence, so these are sought-after slots. This is certainly not to impugn non-consultants, but it serves as a reminder that all of us must be mindful of potential conflicts.

Challenging environment

When it comes to conducting research, it is ironic that, in the midst of this emerging cloud, it is harder for would-be investigators to obtain funding for studies outside of industry. External noncommercial funding is increasingly scarce. Unfortunately, all practitioners have to work harder in clinics and see more patients. We do not have as much time or as much disposable income to hire technicians to conduct our own detailed clinical studies. As a result, in this financially challenging environment, industry-supported research becomes even more attractive.

Resolving conflicts of interest

Going forward, I think that it is going to continue to be an evolving environment for consultants. Medical schools are tightening their conflict-of-interest policies, and some have banned speaker’s bureau participation and stipulate that if you consult for a company or have any sort of equity position, however small, then you cannot participate in their clinical trials.

This situation has come up for me personally. For my consultation with a company, I was given stock options but was also able to participate in clinical studies. I needed to resolve this conflict. Since I wanted to participate in the trial, I designated that all payments be directed to a charity so that I received no payment and no tax write-off. I think that this is just one of many steps that consultants are going to have to take in order to maintain their integrity and keep their platform from needlessly eroding.

Consultants’ scientific advisory efforts are tremendously important to the evolution of our field, and their presentations are critical in bringing new information to physicians and the public. With more people evaluating the ethics involved and trying to “do the right thing,” I look forward to a time when the term consultant will be regarded with distinction and when consultants’ dedicated contributions to our field are accorded the respect they deserve.

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ASIK surgery is a luxury good, a premium service for sale. Refractive surgeons, although excellent in the operating room, aren’t always the best business people. It’s easy to forget that laser correction surgery is a part of the customer service industry as well as the medical field.

Although refractive surgery volume is down nationwide, there are laser vision correction practices that are growing. What are their secrets to success? Every surgeon has his or her own personalized sales strategy, but there are a few common dominators—effective communication, establishing realistic expectations, and the ability to say “no” to a problem patient—that any practice can implement.

One practice that has mastered this is Durrie Vision, Overland Park, Kan., which had its seventh record month in a row, up between 77% and 177% over last year’s numbers.

“In general, the refractive surgery market has been down significantly,” said Daniel S. Durrie, M.D., clinical professor of ophthalmology, University of Kansas, Overland Park. “In my particular case, I think we have succeeded and grown in this market because we’ve focused on our overall business model.”

Durrie Vision has seen success from the simple formula of concentrating on customers and trying to meet their needs. Surveys have allowed the practice to determine its demographics’ goals, objectives, and questions about the procedure.

“We have good data within our practice of what our patients want to know,” he explained. “When discussing the options with patients, we make sure we are answering their questions, not the questions we think they have.”

Communication is a major part of a successful laser correction surgery center. Dr. Durrie’s surveys revealed that cost was a minimal factor in the decision to have LASIK. Interestingly, the two major reasons for passing, at least in Dr. Durrie’s area, are fear of complications and confusion over the options.

“Many ophthalmologists think that if they have a two-for-one special or payment plans, it will increase their LASIK business, but that’s not really what people are concerned about,” Dr. Durrie said. “Patients are concerned about something going wrong, fears of the procedure being done too soon, or wondering how they are going to keep their eye open.

“It’s a lack of education,” Dr. Durrie continued. “Once patients are educated on how the procedure works they say, ‘Why was I so worried? That was easy. I’m glad I had this done.’”

Good customer service begins with the front desk staff. Dr. Durrie
has learned that a smile goes a long way in creating a positive experience for the patient overall.

“We have a motto in our office where we want to exceed expectations with every contact,” he said. “Staff members look the patient in the eye, introduce themselves, call the patient by name, and smile. It’s about putting yourself in their shoes, their chair, looking in the waiting room, seeing what they see, and asking ‘Is this impressive?’”

Thinking like a patient is one strategy Emil Chynn, M.D., refractive surgeon, Park Avenue Laser Vision, New York, has also adopted. For example, Dr. Chynn understands that patients are nervous and need to be put at ease, but might not be comforted by the paid staff because of the perceived conflict of interest. He’s tackled this in a couple of different ways, starting with the front desk staff.

“The front desk staff plays a heavy role,” he said. “I don’t hire people unless they want to get lasered, and then I laser them for free. Most centers don’t do this, and I have no idea why not. Clearly if you’re a shopper and you’re on the fence, walking in and seeing a bunch of people in glasses or contacts isn’t that great.”

Dr. Chynn performs LASEK, and his is the only non-cutting center in New York City, which he’s found to be a big selling point. According to Dr. Chynn, Park Avenue Laser Vision is the only practice in New York City that’s had volume growth over the last 5 years, despite the economy.

Because Dr. Chynn’s front desk staff has had the surgery, they can easily relate to the patients’ nervousness and fears, and they show prospective clients that the procedure turned out well. Patients are also encouraged to watch an actual procedure and ask post-op patients questions.

“It demystifies the whole process,” he said. “It’s hard for the staff to sufficiently reassure the patients because patients think staff members have a conflict of interest and want everyone to get lasered. Patients may not have the medical knowledge, but they have no conflict of interest. It’s a neutral third party.”

“It’s true that this could backfire if a post-op patient with a negative attitude starts grumbling about any of the normal discomforts right after surgery, such as the initial dry eye, itchiness, or blurred vision. But Dr. Chynn wants new patients to fully understand all the potential ups and downs of the procedure, within reason.

“It’s better to get the realistic outcome from the other patient,” he said. “And it saves us a lot of time. The staff doesn’t have to sit there and tell perspective patients things that a patient can tell them. Not only is it more believable because it’s directly from the horse’s mouth without a financial bias, it also frees up the staff’s time.”

This only goes so far though, which is why it’s important for the front desk staff to introduce a prospective patient to a post-op patient with a good attitude. The staff needs to pay close attention to these discussions because if, for example, the post-op patient starts erroneously overstating the negatives, the staff can redirect the conversation.

“The free consults are only introduced to the bubbly, happy, sunny people,” said Dr. Chynn. “Sometimes we’ll get a post-op patient who is kind of a jerk. We have to be careful. We have to know who the patients are for this situation to work.”

This strategy is a way to make sure you’re not overpromising to your patients, which is extremely important. During consultations, you have to make sure that patients understand that the goal is to get their post-op vision as good as their pre-op vision in glasses or contacts.

“When people come in with unrealistic expectations, saying they want to see better than they did in their glasses or contacts, you have to give them a reality check,” said Dr. Chynn. “Achieving better vision is the icing, not the cake. You have to clearly explain to the customers what the heart of the procedure is, which is seeing like they do with glasses or contacts, and what the extra kicker is, which is better vision.”

That being said, you don’t want to purposely mislead a patient or come off as unsure. For example, Dr. Durrie has no problem telling a patient he is an ideal candidate for surgery, if in fact he is.

“Patients are coming in to make sure you’re confident,” said Dr. Durrie. “If someone is a good candidate, I’m going to tell him so. It all goes back to the pre-op exam. If you do it right and educate patients correctly, you can meet their expectations. It’s about being realistic and individualizing.”

For example, you can’t say no one is going to have halos and glare at night, and you can’t say everyone is going to have halos and glare at night. Instead of speaking in generalities, you must use the pre-op exam results to give patients the most likely scenario for their eyes. Dr. Chynn has banned general superlatives like “best” and “most” from his office entirely because they don’t actually mean anything. After all, every surgeon is going to claim he and his center are the “best.”

“We focus on quantitative things,” Dr. Chynn said. “For example, we send patients to the New York State website, tell them to put in a doctor’s name, and see how many lawsuits that doctor has.”

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Considerations for adopting laser cataract surgery

by Jena M. Passut Staff Writer

Femtosecond-assisted cataract surgery is exciting and good for business

Femtosecond-assisted cataract surgery may be the hottest topic in research and talk among top surgeons today, fueled by the “wow factor” of the emerging technology.

But some experts say investing in the platform makes good business sense, too.

Surgeons need only look at the success of the LASIK femtosecond platform to see where the future lies, especially for early adopters, said James Dawes, M.H.A, C.M.P.E., C.O.E., chief administrative officer, Center for Sight, Sarasota, Fla.

“We’ve had great success in terms of outcomes as well as our growth in the market because we are one of the only practices in the area that offers all-laser LASIK,” Mr. Dawes said. “We’ve seen it grow our volumes, and we’ve seen it improve our outcomes, so we think that will translate into cataract surgery as well.”

A faith in lasers

Much of the business decision to adopt femtosecond-assisted cataract surgery will be influenced by the benefits of the technology, said William W. Culbertson, M.D., professor of ophthalmology, and director, cornea and refractive surgery services, Bascom Palmer Eye Institute, Miller School of Medicine, University of Miami.

“It potentially gives patients a better outcome in terms of what their vision will be after cataract surgery because it does a lot of the performed parts of the operation automatically and very precisely,” Dr. Culbertson said. “The second compelling aspect to the procedure is the added safety. Patients perceive that the laser would be more precise and dependable than a procedure done manually by a human. Patients have a certain amount of faith in lasers, and they’re right.”

Cataract surgery performed manually is a relatively safe procedure now, with only a small percentage of patients experiencing complications. But a patient with a complication is bad for a practice, Dr. Culbertson said.

“From an economic standpoint, the doctor would rather not have a situation where he has to do extra surgery because of a complication or spend a lot of time dealing with a complication. (With the laser), he’s also lessening the vulnerability to a lawsuit.”

Value-based proposition

Shareef Mahdavi, president of SM2 Consulting, Pleasanton, Calif., said the perception of value of a cataract procedure has declined over the years.

“The most obvious signal has been the level of Medicare reimbursement, which has steadily eroded from north of $2,000 to the $640 range currently,” Mr. Mahdavi said.

One way to reverse that trend is by enhancing the cataract procedure to make it more valuable to patients.

“In doing so, we can also recapture some of the lost value that has occurred monetarily,” he said.

The first offering in that direction was presbyopia-correcting intraocular lenses. The femtosecond
laser represents another wave of value restoration to the cataract procedure, he said.

“The reason that it is so exciting is that it’s a safer procedure,” Mr. Mahdavi said. “Consumers value safety. The belief is that people are willing to pay for that safety. The baby boomer generation will demand better cataract surgery in terms of outcomes and services. That we can bank on.”

Who should adopt?
Mr. Mahdavi said he believes the perfect candidates for adopting the technology are “all surgeons, unless they’re retiring in the next year or two, who understand their patients are also their customers and who are willing to make the investment to create a customer-centric practice.”

Richard L. Lindstrom, M.D., adjunct professor emeritus, department of ophthalmology, University of Minnesota, and founder, Minnesota Eye Consultants, Minneapolis, said Minnesota Eye will get its laser by midsummer.

Dr. Lindstrom said practitioners should consider the same rules for adopting any new technology.

“I think you need to take a look at your surgical volume and decide what percentage of patients you believe would be motivated to have refractive surgery and be willing to pay for it,” he said. “Number two, you have to decide if you’re an innovator.”

Dr. Durrie and Dr. Chynn both actively turn down patients for various reasons. Neither will operate on a patient who isn’t an ideal candidate for surgery.

“I tell patients and myself every day that this is elective surgery. It’s elective for patients, and it’s elective for me,” Dr. Chynn said. “I don’t have to do it, and not everyone is a good candidate.”

“It’s not worth it to the practice to operate on patients who aren’t ideal,” said Dr. Chynn. “We’re doing about 1,000 cases a year. Clearly, I don’t have to do 1,001 and have a problem.”

Dr. Durrie also eliminates patients if they aren’t willing to educate themselves on the procedure or the seriousness of the surgery.

“Sometimes I cancel people on the day of surgery because they are not educated yet, and they appreciate it,” said Dr. Durrie. “If they are too nervous because they didn’t get their questions answered, then we need to talk more.”

Similarly, Dr. Chynn will turn down a patient with unrealistic expectations or one who treats the surgery as a joke.

“That’s the kind of patient you want to lose,” said Dr. Chynn. “We’re happy not to have someone as a customer if he or she isn’t willing to accept any risk or responsibility.”

Whatever your strategy when dealing with new patients, remember to manage their expectations the whole way through. This includes not only the initial consultation, but compliance with post-op procedures as well. Communicating effectively and choosing the right patients to operate on will not only keep your reputation intact, but also ensure your patients leave your office happy for their lifetime.

Editors’ note: The physicians have no relevant financial interests.

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Dr. Durrie has prospective patients go through an extensive pre-op exam, probably more than other refractive surgeons, because he doesn’t want to operate on people he doesn’t know everything about. He’ll order a retinal OCT on everyone and doesn’t charge extra for it. He also does an evaluation of the tear film, lids, and lashes.

“We have a built-in process so that I know if someone is going to go on to surgery, I’ve done everything I can think of to make sure that he or she is the best candidate and educated,” he said. “It improves the outcomes and helps to make sure you don’t operate on the wrong patient, using the wrong procedure, at the wrong time.”

Dr. Durrie and Dr. Chynn both actively turn down patients for various reasons. Neither will operate on a patient who isn’t an ideal candidate for surgery.
A practice transformation

Mr. Mahdavi said ophthalmology practices will need to transform in the same way that other specialties have been able to adapt in the wake of declining Medicare reimbursements.

“Look at dermatology. Look at plastics. Look at cosmetic dentistry. Look at orthodontics. Look at these other specialties where there are significant elective self-pay components. You don’t find those people complaining that their patients don’t want to pay.”

Mr. Mahdavi said one way to do that is to get out of the efficiency mindset.

“While the technology available to us with femto is very efficient, you can’t take a factory-like approach, particularly with the demanding baby boomer customer. If you try to swap out technologies and do femto instead of phaco, you’ll never capture the value because people want to be treated better. This whole notion of customer experience as applied to medical patients is where doctors need to focus their time and energy.”

Success depends on the market and the practice’s ability to sell the procedure to patients, Mr. Dawes said.

“Practices need to look at what their volumes are and if they can support the technology with enough volume to pay for it,” he said. “In doing that, they need to look at how successful they are going to be at educating patients about astigmatism and refractive error and how effective they’re going to be at counseling those patients toward increased out-of-pocket costs.”

Mr. Dawes said the Center for Sight employs six patient care counselors with that duty.

Let’s talk cost

The cost of the refractive cataract surgery is not set in stone.

First, there would be the added expense of bringing in a new device, whether it is purchased or leased. Much like with a LASIK femtosecond laser, there will likely be a per-use cost associated with the device.

“Let’s say the capital cost of the equipment is $400,000, and the per-eye treatment is $300,” Dr. Culbertson said. “The extra cost to a doctor might be $400 or $500 per eye that he treats. Let’s say that the extra work the doctor goes through to perform this might be worth something. You could imagine that this could cost an extra anywhere from $600 to $1,000 per eye that insurance typically wouldn’t pay for. That cost would be passed on to the patient.”

Mr. Mahdavi agreed. “We should assume it’s not going to be inexpensive,” he said. “It is going to require an upcharge. I think there’s going to have to be an upcharge between $500 and $1,000 to cover the cost of the equipment and usage fees.”

Dr. Lindstrom said the equation for charging patients could be simple.

“The classic retail marketing, if you are selling hats or computers or whatever, is to take what it costs you and multiply by two,” he said. “People who want to do really well should take what it costs them and multiply by three.”

Laser in focus

Mr. Dawes said the Center for Sight recently assessed how much potential patients would pay for laser cataract surgery.

In the first group, without any education about cataract surgery, 30% said they would be willing to pay $2,500 for both eyes.

In the second group, which was counseled about the differences between traditional and laser cataract surgery, the numbers went up dramatically.

“More than 80% of people, after they were educated about laser cataract surgery, said that they would be willing to pay 2,500 or more out-of-pocket to have the surgery,” Dawes said. “We were shocked by that, in a good way.”

When patients learn that a laser is available for cataract surgery at a practice, Mr. Dawes said that practice should see a substantial growth in volume.

“This will create additional profitability, even after the cost of the laser,” he said.

Editors’ note: Dr. Lindstrom has financial interests with Abbott Medical Optics (Santa Ana, Calif.), Alcon (Fort Worth, Texas), and Bausch and Lomb (Rochester, N.Y.). Dr. Culbertson has financial interests with OptiMedica (Santa Clara, Calif.).

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“O
ne thing a lot of people don’t understand is that even if you find an experienced administrator with a business background, most people don’t understand ophthalmology business. ASOA is a real conduit into what is going on in ophthalmology, CMS, Medicare, and politically in medicine. ASOA Membership allows my administrator to find out crucial information in advance by ASOA’s online resources and Government Relations updates. He updates us very early and very fast in the way that we bill medicine and the ways that we get accredited. My administrator has become omniscient through ASOA.”

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