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Dr. William J Mallon M.D.
Past President,
Florida Society of Ophthalmology.
general concern for the state of the economy and changes in technology affect ophthalmology just as much as any other field. Ophthalmology Business has devoted this issue to exploring new technologies, considering how to utilize them in your practice, and planning for the future of your practice.

You may be surprised to learn that the 46- to 64-year-old population is spending more money on technology than any other age group. In addition, the fastest growing demographic for social media use is the baby boomer generation. Use of the big social media networks has reached 42% among the 79 million-strong baby boomer age group. Senior writer Erin L. Boyle explores how these trends could help ophthalmologists find new ways to reach their biggest demographic (page 20).

Contributing writer Vanessa Caceres talks to experts who warn about the hazards of accepting a contract before becoming familiar with the details. Make sure you are “Checking the employment contract” (page 8) and looking at factors such as compensation and what happens if you decide to leave. It’s important to consider what to do when you’re ready to sell a practice as well, and Brad Ruden, MBA, details “8 steps to prepare your practice for sale,” (page 24). With money as a general concern, we’ve asked Certified Financial Planner W. Ben Utley, CFP, to answer your personal finance questions (“Eye on your money: Insightful answers in your interest,” page 12).

Practice management consultant John B. Pinto comments on the changing times (“That was then, this is now,” page 16) in the ophthalmology world with seven approaches to moving forward. Along with the changing times, ophthalmologists are going to be “Facing the challenges of stinging cuts,” (page 6). Contributing writer Enette Ngoei addresses some of the updates in 2013 and how ophthalmology practices can thrive despite these.

In “Integrating the femto for cataract surgery into your practice” (page 14), contributing writer Michelle Dalton talks to experts about the costs of owning the laser.

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Facing the challenges of stinging cuts

by Enette Ngoei Contributing Writer

Ways that practices can continue to thrive and achieve high-quality patient satisfaction despite reimbursement decreases

All over the U.S., the Medicare reimbursement cuts detailed in the 2013 Medicare physician fee schedule will affect ophthalmology practices, large and small. The 13.6% reduction in reimbursement for cataract surgery and the 26.5% reduction in physician reimbursement are particularly stinging.

On March 1, the automatic sequestration of federal spending was triggered. The sequester was originally scheduled to take effect on Jan. 1 under the provisions of the Budget Control Act of 2011, which charged a Joint Select Committee on Deficit Reduction (the so-called “Super Committee”) to develop a comprehensive proposal to reduce the federal debt. Sequestration was put into place as a backup plan and reduces the overall debt through automatic, across-the-board spending cuts. Medicare FFS claims with dates-of-service or dates-of-discharge on or after April 1 will incur a 2% reduction in Medicare payment, according to the Centers for Medicare and Medicaid Services.

Still, there are several ways that practices can tackle these changes, said Eric Donnenfeld, MD, founding partner, Ophthalmic Consultants of Long Island, and clinical professor of ophthalmology, New York University Medical Center, New York, N.Y.

“The partners, the associates, the staff, and the management in the practices have to realize that these changes in healthcare are occurring, and they have to change or adapt to meet the challenges of the cuts in Medicare and at the same time deliver quality ophthalmic care in the new healthcare environment,” he said.

Reducing expenditure

One of the first things practice owners can do is look at their expenses and see where they can make cuts, said Derek Preece, MBA, BSM Consulting Group, Orem, Utah.

“Part of reducing expenses is making sure the processes within their office are as efficient as possible,” he explained.

Having a budget in place generally helps to reduce expenses, he added.

Charles Heaton, MD, Heaton Eye Associates, Texas, said his practice had the chief financial officer run different scenarios to see what it would mean for a certain percentage cut in reimbursements. For example, in a 20% reimbursement cut, they would cut capital expenditures by delaying buying equipment, putting off non-essential consulting agreements, cutting back to some degree on staffing with a hiring freeze, and basically cutting immediate expenses such that the partners might face a 15% cut in their personal income, he said.

Once the reimbursement cuts get up to 40%, they would get into structural changes in the practice and probably 25-30% cuts in partner reimbursement levels, Dr. Heaton said.

Private practice owner Ken Miller, MD, California, said he and his partner met about a month ago and went through each item on their profit/loss statement from last year in anticipation of the reimbursement cuts.

“We’re looking at everything,” he said. In fact, Dr. Miller and his partner met with their IT company
representatives and managed to get a 50% drop in price just by asking because the company didn’t want to lose them as a client. "It is essential in all offices utilizing EHR, and the costs are high and often unanticipated when looking into the purchase of EHR."

**Increasing revenue**

After looking at reductions in expenditure, Mr. Preece said the next step to overcome the reimbursement cuts is to try and increase revenue. This can be done by taking on more work or by diversifying the work, Mr. Preece said. Diversifying revenues can help especially if the doctors are already seeing as many patients as they can, he said.

For practices that do a substantial amount of surgery and do not own an ambulatory surgery center, it wouldn’t be a bad idea to consider either buying into one or building their own, Mr. Preece said.

Some practices have added hearing aid services, and that can work to some degree if there is a high enough volume of patients, Mr. Preece said. Other practices have expanded into oculoplastics.

Dr. Heaton’s practice is increasing its optical services and adding medical retina, something they haven’t done before.

“If there are ways to continue to delegate and maximize our reimbursement by employing our optometrists better or hiring optometrists to handle increased volume, we want to do that,” he said.

**Improving patient satisfaction and quality of care**

There are many things that can be done to improve patient satisfaction and quality of care while meeting these new government regulations, Dr. Donnenfeld said.

These include adding physician extenders such as optometrists, technicians, and physician assistants.

“Adding optometry to a practice is a cost effective way to improve patient care and provide physician extenders to your practice where optometry and ophthalmology can work together in an integrated model to provide quality care; the ophthalmologist spends more time in surgery and less time doing medical ophthalmology, less time doing pre- and postop care, which can be done equally well by a qualified optometrist,” Dr. Donnenfeld explained.

Another thing practice owners can do is add new technologies that increase efficiency in the office, he said.

While the electronic health records system is a big hurdle for many practices, the information obtained from electronic health records can be used to search for patients who may meet certain criteria to offer them elective services such as cosmetic and refractive surgery, Dr. Donnenfeld said.

“So you can take what many physicians perceive as a negative and turn it into a positive,” he said.

Many ophthalmologists are also starting to do premium IOLs, which they might not have been comfortable doing before, Dr. Donnenfeld said. New technologies like the Optiwave Refractive Analysis (ORA) System (WaveTec Vision, Aliso Viejo, Calif.) and femtosecond laser cataract surgery add precision to cataract surgery that allows ophthalmologists to enter the world of premium IOLs and achieve quality outcomes, he said.

In his practice, Dr. Donnenfeld said, “We’ve added a dry eye center of excellence where we are treating patients who haven’t received answers before. We’re adding point-of-service testing like tear osmolarity and LipiView [TearScience, Morrisville, N.C.], which allows us to diagnose dry eye more accurately.

We’ve added premium dry eye management services such as LipiFlow [TearScience]. In a similar line, we’ve been big believers in oral nutrition for more than a decade, and we’ve started working with a company called PRN [Physician Recommended Nutriceuticals, Plymouth Meeting, Pa.]. [The company] provides a premium fish oil omega-3 supplement that we believe is the best product on the market and has a model in which practices can benefit from the time and effort they spend talking to patients about dry eye disease.”

Adding new surgical services in the OR is another thing practice owners can do. Dr. Donnenfeld said his practice has added minimally invasive glaucoma surgery (MIGS) as part of their surgical treatment options.

“We’re implanting iStents [Glaukos, Laguna Hills, Calif.] in our cataract surgery patients with glaucoma, which significantly increases our revenue and more importantly provides a tremendous service to our patients,” he said.

Like Mr. Preece, Dr. Donnenfeld said he thinks it’s important with the reimbursement cuts in cataract surgery to have ownership in an ambulatory surgery center, if possible.

“This is a big opportunity for many ophthalmologists and can help recoup some of the lost revenue,” he said.

Editors’ note: Dr. Donnenfeld has financial interests with Alcon (Fort Worth, Texas), Glaukos, PRN, TearScience, and WaveTec. Drs. Heaton and Miller and Mr. Preece have no financial interests related to this article.

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In the excitement to take a new job offer, physicians may fall prey to employment contract provisions that are not the best arrangement in terms of compensation, bonuses, or what happens if they have to leave the practice.
Checking the employment contract

by Vanessa Caceres Contributing Writer

Make sure your agreement is reasonable

Are you reviewing your employment contract close enough? In the excitement to take a new job offer, physicians may fall prey to employment contract provisions that are not the best arrangement in terms of compensation, bonuses, or what happens if they have to leave the practice.

Here are some common areas you’ll want to review closely in an employment contract, according to several healthcare attorneys.

Compensation

Naturally, compensation is an area of the contract that physicians examine closely. However, “there are a lot of nuances to it,” said attorney Andrew S. Bogen, Arnold & Porter LLP, New York. Physicians want fair compensation for the work that they will do, and the practice wants to incentivize the new employee to be productive, but at the same time does not want to overpay, Mr. Bogen said.

When reviewing the salary, physicians should make sure they compare the dollar amount to colleagues in similar geographical areas, said Daniel M. Bernick, vice president and principal attorney, The Health Care Group and Health Care Law Associates PC, Plymouth Meeting, Pa. For instance, an ophthalmologist in a rural area may have a high salary, but he also may be paid more because he works in an area where it’s hard to recruit physicians, Mr. Bernick said.

Ophthalmologists in popular urban areas may make less. Mr. Bogen pointed out that when comparing compensation, benefits and costs, such as whether the physician or practice will pay for professional liability insurance, should be factored in.

Ophthalmologists often receive a base salary with a bonus or incentive. One kind of bonus is tied to actual collections made—not just money that the practice is slated to receive. “You don’t want to tie compensation to money you don’t actually collect,” Mr. Bogen said. A common formula spelled out in contracts related to this may be a percentage of collections received that are in excess of three times the physician’s base salary. For example, if the base salary is $200,000, the physician receives a bonus based on the collections that are greater than $600,000.

Attorney Matthew Keiser, Arnold & Porter LLP, Washington, D.C., also sees bonuses tied to certain procedures performed. He finds this especially common at concierge practices.

The contract should make clear all specifics related to bonuses, such as what percentage the physician gets when collections of a certain amount are achieved, Mr. Bernick said.

Another common area to review under compensation is when the ophthalmologist will acquire equity in the practice, Mr. Bogen said. For a new physician coming to a practice, particularly someone who is new to medicine, “there’s usually a romance period where they will get to know each other for one to three years,” Mr. Bogen said. The employment contract may state that after that initial period, some sort of equity in the practice is possible.

Ophthalmologists reviewing their contract can ask if, after that initial trial period, an ownership interest in any ancillary businesses is possible, Mr. Bogen said. This could be something like an optical shop or a clinic.

Physicians can also request that their salary or bonus be increased sooner if the practice does particularly well financially, Mr. Keiser said.

Termination and restrictive covenants

Mr. Bernick sees contracts that state the physician can be terminated without cause by either party with 30- to 90-day notice. A newer physician will want to aim for 90-day notice so there is more leeway time to find another job, Mr. Bernick said.

When employment contracts specify termination with cause, healthcare attorneys can help review any related language to make sure it is not too ambiguous, Mr. Bernick said.

continued on page 10
If a physician is relocating for a job and plans to stay in the area, he should make sure the contract weighs in favor of him staying at the practice as long as possible, Mr. Bogen said.

A number of employment contracts include restrictive covenants or limitations on what a physician can do if he is no longer working at the practice, Mr. Keiser said. Some covenants, such as not revealing confidential information about the practice, are usually clear-cut, Mr. Bogen said. Other covenants, such as ones relating to competition, are harder to enforce. “Generally, courts don’t like restrictive covenants and will look favorably at arguments against enforcing them,” he said. This is because they can appear to be a restriction on competition, he added.

For example, a judge may rule in favor of a younger physician who worked at a practice for two or three years and decided to open a new practice in the same city as his former practice, Mr. Bogen said. On the other hand, a judge may not feel the same way about a seasoned physician who has sold his practice to another well-established practice and receives $2 million in compensation for the transaction and the restrictive covenant.

If a contract has restrictive covenants regarding the ability to practice in a certain area upon leaving the practice, Mr. Keiser said it would benefit the physician to negotiate for severance pay.

Restrictive covenants in employment contracts often address non-solicitation, or an agreement to not solicit employees to work at a new practice and not solicit former patients to come to the new practice. It can be hard to enforce restrictions that have the effect of dictating whether patients can or cannot follow the physician to a new practice, Mr. Keiser said.

Restrictive covenants also commonly address limitations on where physicians can set up a new practice—for example, this covenant may state that they cannot participate in another practice within 5 to 10 miles of the existing practice for a two-year period.

“This may not be an issue if you don’t like the area or plan to leave town, but what if your family is there?” Mr. Bernick said.

While this is a standard agreement, Mr. Keiser cautions ophthalmologists to make sure there is still room for the exiting physician to establish a practice within the same general area to avoid having to relocate.

Also, the actual mileage involved in this covenant can vary greatly depending on the geographical area—say a rural area where patients drive longer distances versus a city, Mr. Bernick said.

Other areas

Ophthalmologists are often involved in outside projects, Mr. Keiser said. This can be as diverse as inventing a new eye drop dispenser to consulting for a pharmaceutical company. Make sure your contract indicates that you are allowed to consult on these other projects in your personal time, he said.

Another area to negotiate for clearly in your contract is what it means to be on call. “When can you expect to be on call, how often are you on call versus other physicians in your practice, what does it mean to be on call, and how are you compensated when you are on call if you are compensated for it?” Mr. Keiser said.

Unless a practice provides “occurrence based malpractice insurance coverage,” physicians nowadays will also want to make it clear who will pay for their tail coverage, which is the coverage for any malpractice claim brought against physicians even after they are no longer with a practice, Mr. Bernick said. Tail coverage may be for 3 to 5 years after leaving the practice, or it can be indefinite. Although Mr. Bernick prefers indefinite coverage, he also said the steep price for this can be tough for a newer physician to manage. This is why it’s good to negotiate with the practice over who will pay for this.

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Question: I just became a partner in a small group practice. My tax person tells me the bump in pay is going to mean a lot higher taxes. I am maxing out my 401(k) but still I got a huge tax bill last year. The agent who sold me my disability insurance policy says I should buy some variable universal life insurance from him because it will save me taxes, but I already have $2 million in term coverage from USAA for my wife and kids. One of my partners thinks VUL is a bad deal. What do you think?

Answer: Since it’s early in your career and you have a family to think about, it makes sense to have life insurance. Based on what I have seen in similar cases, $2 million is a good start but it’s not enough to provide everything your family might need to pay off the house, send kids to college (or private school), and pay ongoing costs of living without you. So I do think you need more coverage, but I do not believe variable universal life insurance is the answer.

As a form of cash value insurance, VUL combines the benefits of life insurance with the features you might find in a mutual fund investment. The word “variable” refers to the fluctuations in the cash value as a result of changes in the value of the investments it holds, while the word “universal” means that premium payments are flexible (like a universal joint is flexible).

I would have named this product “variable flexible life,” or VFL for short, but I figure the “F” might be misinterpreted to stand for “fallacious” since misguided physicians who buy this stuff suffer from the mistaken impression that they will save taxes while making a great investment that will protect their families.

The promise of tax savings is more fiction than fact. Sure, the cash value has potential to grow tax-deferred and the death benefit might be income tax-free, but these benefits are not the same as true, permanent tax savings. Since Congress closed most of the loopholes with the Tax Reform Act of 1986, permanent tax savings have grown increasingly scarce, particularly for medical specialists and other taxpayers in the top brackets.

A VUL policy’s tax deferral feature—arguably the only attribute of any value to an investor—may actually cost physicians more money in both the short and long term.

Under current tax law, long-term capital gains and qualified dividends are taxed at a lower rate than ordinary income, but the gain on complete withdrawals from a VUL policy will be taxed as ordinary income. Given that the top federal tax rate on ordinary income is fully 23 per-
answers in your interest

centage points higher than the capital gains rate, equity-based investments made in a variable universal life product may result in taxes that are twice as high as those paid on gains from investments in an after-tax account (a jointly held mutual fund account, for example).

To be clear, a VUL policy will not save you a dime in taxes but it may cost a fortune in fees. The mutual fund-like “separate account” investment options available inside these policies are laden with costs, including operating expenses for underlying funds, management fees layered on top of that, plus an annual policy fee. “Paying those expenses is like rowing a boat with a hole in it. No matter how fast you row, you’re gonna sink,” says Lawrence Keller, an insurance expert with Physician Financial Services, Woodbury, N.Y.

There’s a huge incentive to push these policies. Since it’s common for agents to receive at least half of the first year’s premium as commission, your $50,000 investment means the agent will walk away with $25,000. Not a bad payday... for him. But when you try to walk away from the policy yourself, you will trip over one last expense that physicians often overlook: the surrender charge. Since the insurance company pays the agent up front, it can only recoup the cost by locking you into the policy or charging you heavily if you pull out before they’re done, which may be 10 or 15 years.

“Buying a VUL policy is a lot like buying a new car,” said Mr. Keller. “The day after you buy it, it’s worth less than you paid for it.”

Your partner had it right when he cautioned you against VUL, especially when there are so many other vehicles that might be a better fit for you.

Consider term life insurance. Like auto or homeowner’s coverage, term life is pure insurance without cash value. Term life costs far less than VUL on a dollars-per-thousand basis, so every premium dollar buys you more coverage than it would with VUL. You will send less money to the insurance company and keep more for your family.

What can you do with the money you save?

Look into a Section 529 college savings plan. Contributions grow tax-deferred (just like VUL) but withdrawals from a 529 plan are free from income tax when used for qualified higher education expense. Some states will even give you a break on your state income taxes when you contribute—a real, permanent tax savings. (See “Section 529 plans: The best way for doctors to save for college” in the July 2012 issue of Ophthalmology Business.)

Check out a “back door” Roth IRA contribution. Given the average physician’s income, it’s unlikely that you can make a direct contribution to a Roth IRA, and you probably cannot deduct contributions to a Traditional IRA (not unlike VUL). However, you can still make non-deductible contributions to a Traditional IRA, and your spouse can too. After you have made your contribution, ask your tax advisor if it makes sense to convert your Traditional IRA to a Roth, where those contributions can grow tax-free for retirement, no matter how much Congress amps the pain on taxpayers in the top brackets.

After you have maxed out your 401(k), your IRAs, and your 529 plan, think about investing in low-cost, tax efficient equity index funds or exchange-traded funds (ETFs) from companies like Vanguard, Barclays, or Dimensional Fund Advisors. To keep the balance right (and avoid the dreaded Medicare sur-tax on unearned income), you might also pick up some tax-free income from a municipal bond fund. Finally, you and your partners might want to adopt a defined benefit retirement plan (a “pension plan”) to soak up excess cash that can grow tax-deferred for the long haul.

Keep an eye on your money

The key to financial security is vigilance. Get curious. Ask questions! Dig for answers ... or email your questions to eyenourmoney@physicianfamily.com so I can do the digging for you. If you use your question in “Eye on your money,” I will send you one of my favorite personal finance books to feed your head and a cool “Eye on your money” coffee mug to satisfy your thirst for answers. OB
Economics, logistics, patient considerations should all be weighed evenly before purchasing device, experts say

The cost of owning a femtosecond laser for cataract surgery goes beyond just purchasing the device, said Kevin M. Miller, MD, Kolokotrones Professor of Clinical Ophthalmology, Jules Stein Eye Institute, Los Angeles. Practices need to consider the service agreement, patient interface/procedure fees, power supplies to ensure uninterrupted power, software/hardware upgrades, and the geographic location of the laser (which may mean giving up an exam room or an OR).

“Don’t rush into making the decision,” Dr. Miller said. “Prices are dropping rapidly. Increasingly, there’s more clarity on how to bill for the services. And that’s going to continue to change for the next several years.”

Take the time to evaluate the device and “be convinced of the efficacy of the procedure,” said Robert P. Rivera, MD, in private practice, Hoopes Vision, Draper, Utah. Early in the decision-making process the group had a “lack of confidence in our ability to deliver on our promise,” but the quality of the current generation femtosecond lasers has completely overcome those initial worries.

“Our cataract surgery patients are accepting the femto to the tune of about 60%,” he said. “The patient is walking away with a much better and quicker recovery.”

According to Robert J. Weinstock, MD, in private practice, Eye Institute of West Florida, Largo, the center had the volume to support the purchase, but “it was a multifactorial decision for us. We have three very busy cataract surgeons in our practice, and it’s growing. Next, patients are coming in and expecting laser cataract surgery.” Like any piece of equipment, these lasers may have glitches that prevent them from working properly, however, and surgeons need to consider that as well.

“In today’s world, you can’t reschedule,” he said. “It’s unacceptable to your premium patients.” The group chose to purchase a second machine, he added.

Acknowledging the physical space constraints of an ambulatory surgery center (ASC) may limit some placement options, “if you have a higher volume practice, flow may end up being an issue,” said William Soscia, MD, Center for Sight, Bradenton, Fla. His group took two full years before deciding on a laser, and evaluated everything from outright cost to marketing issues to physical constraints of the ASC.
“It’s not like buying a phaco machine because these devices may not last as long as our phaco devices do,” Dr. Miller said. “With the service agreements currently out there, practices are going to have to do a significant amount of procedures just to pay the agreement fees.”

Dr. Miller said the number of patients that elect to have the laser aspect of cataract surgery is probably the most important financial consideration—if a practice has 250 patients/year who opt for the service, the practice will need to charge around $550 plus a $400 procedure fee in order to break even in five years (providing for a 7% financing over the life of the laser and a base price of $450,000), but those numbers drop to $93 plus the $400 procedure fee per patient if the practice is performing 1,500 a year.

And, unfortunately, “most practices don’t know what their volume is going to be until they actually sign on the dotted line and get their femtosecond laser and then start trying to sell it to patients,” Dr. Miller said.

Dr. Weinstock said he wanted to position his practice as an early adopter and decided to purchase a laser early on “and just jump in with both feet.” When one laser didn’t offer all the features he wanted, Dr. Weinstock waited and purchased a second system.

In Utah, Dr. Rivera said many physicians are contracted to perform cataract surgery in the hospital because private pay patients “cannot have surgery in an ASC.” And hospitals are notorious for having limited funds that need to be spread over disciplines that are deemed more profitable than ophthalmology.

At Jules Stein, Dr. Miller said the financial model where the laser will bring in money above and beyond what insurance pays is “something hospitals don’t know how to deal with very well.” He’s been negotiating for a femtosecond laser for more than two years and still has not been able to convince hospital management it’s in the best interest of patients.

“In an ASC setting, the few principals make the purchase decisions. So it’s easier for them,” Dr. Miller said. “Learn from your colleagues in the area who have already gone through this process, and don’t be so quick to jump into it, and really get a sense of your volumes.” If surgeons have not begun to offer premium IOLs, “the first thing they have to do is get used to charging for premium services: premium lenses, astigmatism management, whatever; get into that first before you buy a femto laser because you’ll get killed financially otherwise.” He also advises surgeons to get comfortable discussing the finances of femto for cataract and not delegate it to practice personnel.

ASCs have plenty to evaluate as well, Dr. Weinstock said. “There are so many compliance issues and regulatory issues that go hand in hand,” he said. Patient flow will slow as they undergo an additional step under a different machine. If a practice serves an area where patients simply do not have the means “to invest in their vision and their cataract surgery and their outcome financially,” surgeons will have a difficult time upselling, he said.

“That’s a very important consideration in this equation,” Dr. Weinstock said.

“I really am afraid that those who don’t pick up [how to use this technology] will be left behind,” Dr. Rivera said.

SightPath Medical (Bloomington, Minn.) recently announced its intention to offer a mobile femtosecond (MoFe) laser for cataract service. The MoFe service

**Patient considerations**

Dr. Rivera’s patients “are coming into the office and demanding femto-phaco,” he said. “They’re telling me they’ve done the research and this is what they want.”

Dr. Soscia’s group conducted several focus groups to gauge interest, to try and define patient financial thresholds, and to determine how to market the technology to their patient base.

“That involved everything from our advertising to rewriting our brochures to revamping parts of the website,” he said.

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**Editors’ note:** Drs. Miller, Rivera, and Soscia have no financial interests related to this article. Dr. Weinstock has financial interests with Alcon (Fort Worth, Texas) and Bausch + Lomb (Rochester, N.Y.).

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That was then, this is now

by John B. Pinto

Seven approaches to the challenging times ahead

“I don’t think of the past. The only thing that matters is the everlasting present.”

W. Somerset Maugham

“Bring the past only if you are going to build from it.”

Doménico Cieri Estrada

This month’s column is written in response to a surgeon who wrote to me recently, saying, “I became an ophthalmologist 20 years ago. It seemed so easy back then. Sure, fees were falling and technology was changing and our charts were being audited, but things felt manageable, even in our two-surgeon office. Even our retirement investments were growing nicely. Now it seems like we’re in this perfect storm. Fees are certainly going to be heading down, regulations are going up, it’s hard to know what technology to adopt, and my retirement investments are going sideways. Even though we’ve grown to an eight-surgeon practice, I’m having a hard time seeing how the last third of my career is going to be

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The short answer to this surgeon's dilemma is, "Don't count on as much fun or security."

The long answer is more braided and perhaps more hopeful. Here is a seven-point rejoinder to this surgeon's all-too-common concerns.

1. Bigger is not always better or easier. The general trend today in ambulatory healthcare is consolidation—smaller practices merging into larger ones, larger practices acquiring the stragglers, and institutions getting back into practice acquisitions at a pace not seen since the 1990s. Even when a practice slowly, organically grows and adds providers, staff, and office locations, operational complexity generally increases at the size of the practice squared. Even though larger practices can play strength-to-strength to payers, regulators, and local market forces, this surgeon-writer's frustrations are very common. A practice with four times as many doctors probably needs eight times as much leadership, eight times better management, and eight times as much communication to stay organized, harmonious, and productive.

2. Lower fees could once be fixed by "one big idea." In the past 30 years, the three largest business revolutions in ophthalmology have been the development of private ambulatory surgery centers, the addition of optical dispensing, and the employment of larger numbers of non-partner optometrists as sources of passive income. This low-hanging fruit has now been plucked by most contemporary practices and has allowed surgeon owners to preserve and even advance their incomes. On the road ahead, it will take an ensemble of much smaller tactics. Mitigation of the anticipated, much larger cuts ahead will require a practice to execute numerous small tactics all at once to have the same profit-preserving impact of any one of the last three business revolutions. Examples of these include:
   • Unaccustomed levels of frugality in hiring, technology upgrades, and facility development;
   • Sharing resources with former market competitors and collaborating more closely to secure managed care contract access;
   • Pushing the envelope to optimize surgical volumes and testing utilization; and
   • Personal sacrifice to see more patients per hour or work more hours per week.

3. Technology turnover velocity. A generation ago, how one did cataract surgery, with or without phaco, was the prominent technology quandary. Making the go/no-go decision with electronic health records has been the headline grabber for nearly the last decade. All things femto is the technology debate du jour. It's all confusing and it's all increasingly expensive, right? But the same simple rule of thumb that guided surgeons in the transition from extracapsular surgery to phaco can guide you today: "What's the crowd doing?" The transition to a preponderance of phaco took less than five years because it was a very good idea. Many contemporary transitions are taking a lot longer. Simply decide whether you’re the kind of surgeon who will adopt a new technology when the first 15% have made the shift, the last 15%, or somewhere in between.

4. Keeping up with the regulatory and procedural churn. If Starbucks had to run their coffee shops like your eye clinic, the customer would sign five forms before they could privately whisper to their java-technician, “I’d like a venti, sugar-free, non-fat, vanilla-soy, double-shot, decaf, white chocolate peppermint mocha, please.” And then it would take the barista an extra 15 minutes to get authorization. Forty years ago, a fairly complete patient

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record (on a 3” x 5” card) said all that was needed, tersely: “Left eye doing better.” Twenty years ago, SOAP was sufficient on a full sheet of paper. In the future, the nexus of EHR, ICD-10, and progressively narrower payer care pathway algorithms will constrain today’s youngest surgeons to an environment where a lot of medical decision making will result from artificial intelligence instead of the medical arts. Lay staff, to the extent that they have not been replaced by robotics, will be similarly directed by machines in their support of the doctor. Rather than fight this trend, embrace it, and harness technology that will soon be emerging from the most vanguard software providers to help you make and record faster clinical decisions, see more patients, and stay CMS-safe.

5. Provider harmony will take more work. Control equals happiness. And the private group practice of the future will almost certainly involve less control. So as an administrator or managing partner, you are going to have to work hard to preserve surgeon-owner happiness. From past study and observation, we know that surgeon happiness and collegial relations within a group setting correlates most closely with a surgeon’s ability to earn an income that is significantly higher than his or her lifestyle costs. Under best-case scenarios, even the best mitigation efforts to respond to coming +/-15% top-line cuts will result in the typical partner in the typical practice receiving a 10-25% cut in income. Three mitigation strategies are essential in the coming era:

- Surgeon-owners need to know that they—and their managers—are doing everything reasonably possible to preserve profitability.
- Surgeon-owners need to double down on communication, especially frequent, face-to-face, board-level sessions, which go beyond the dry monthly economic statistics to explore each doctor’s feelings about his/her present and projected earnings.
- To the extent feasible, as an administrative or medical leader in your practice, you need to urge both owner and non-owner providers to plan ahead, taper their lifestyle costs, and get real about their retirement calculations before the most difficult revenue adjustments arrive.

6. From a “weak leader” to a “strong leader” model. In a misplaced desire to avoid conflict, many group practices still operate with little more than a figurehead physician leader and the insistence on 100% consensus for all decisions. This was fine in the softball era of ophthalmology. In today’s environment, where decisions are going to be tougher and come at you faster, a formal managing partner should be selected and empowered, even if there are only two practice owners. This leader’s role is NOT to take over for the board, but to help assure that the board’s will and policies are being briskly translated into action by the management team.

7. The shift from “any plan or even no plan works” to “we had better choose the right business plan.” Most practices still go “bare” when it comes to writing a formal strategic business plan. They daisy chain from one tactical business opportunity to the next (Buy this laser! Hire this doctor! Open that satellite!) without the basic underpinning of a strategic context for their decisions. The smartest practices today are taking the time to discuss and formalize their long-term goals.

In closing, and in response to the surgeon whose note to me kicked off this discussion, we are in the early stages of a profound phase shift in the business and profession of eyecare. The future environment will oblige more teamwork and less rugged individualism, more planning and less shoot-from-the-hip, more leadership (and good followership) and less freestyle management. OB
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Are you prepared ...

by Erin L. Boyle Senior Staff Writer
What is the average age of a person spending money on and adopting new technology, such as a smartphone or a tablet?

If you thought it was someone in his or her teens or early 20s, you would be wrong, research shows. And this fact could aid ophthalmologists in finding new ways to reach their biggest demographic—baby boomers.

“Technology use is no longer the young man’s game—24% of active Facebook users are 55 to 64 years old. Baby boomers are dedicated to riding the cutting edge of technological innovation to improve their quality of life and enhance their connectivity,” said Richard M. Awdeh, MD, director, Technology Transfer and Innovation, Bascom Palmer Eye Institute, Miami. “Fifty-five to 64-year-olds have the fastest growing adoption rate of tablets.”

The same age group likely to have cataracts or be interested in refractive surgery or presbyopia-correcting lenses—the 46- to 64-year-old population—is spending more money on technology than any other age group, according to Forrester Research’s annual benchmark technology study.

“Healthcare represented 18% of GDP in 2010, so it stands to reason that it has emerged as a rapidly growing area for technological innovation. Twenty-nine percent of American adults have downloaded a health app, and Google estimates that 26% of all U.S. prescription searches in 2012 were done from a mobile device,” Dr. Awdeh said.

The numbers of those using new technologies and social media to connect, find information, perform tasks, and pursue interests are growing daily. According to information from Lookout Mobile Security’s The Lookout Blog, in 2012, global smartphone unit sales had expected growth rates of 25%, from 472 million in 2011 to 630 million.

Social media has significance in healthcare

The fastest growing demographic for social media use is the baby boomer generation, and the use of multiple technology platforms is increasing as well. Use of three of the big social media networks—Facebook, Twitter, and LinkedIn—has reached 42% among the 79 million-strong baby boomer age group (or 26% of the U.S. population), according to information at BabyBoomerGold.com. The community site for the age group cited Nielsen data that approximately 15% of baby boomers now also use smartphones.

According to Facebook, nearly one in seven people is an active user, with 901 million active users as of a year ago. Other social media platforms are exploding in use as well. People are not accessing their media in the same way as they did in the past. In 2010, YouTube exceeded 2 billion views a day. By 2012, it had

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reached 4 billion. A total of 800 million unique users visit the site every month. A total of 86% of mobile internet users are using their devices while also watching television.

Companies have seen the light: In 2010, 79% had at least one social media platform, and by 2012, that number had risen to 87%.

Physicians are also using the new technology; more than 80% of doctors report that they are using or will use tablets in their organization. “[This] indicates that as a group, we are recognizing the importance of staying ahead of the curve,” Dr. Awdeh said.

**Smartphones and tablets have become ubiquitous**

“Eighty-one percent of adults use the internet, and in low-income households, smartphones are the primary source of internet access,” Dr. Awdeh said.

And there is no turning back: Smartphones are predicted to outsell feature phones this year, for the first time on an annual basis, the International Data Corporation found. Around the world, more than one in four mobile phones are smartphones. Soon, the desktop computer will no longer be the primary way people access information on the internet. By 2014, mobile internet use is expected to surpass desktop internet use.

The ubiquitous Apple iPhone, while still showing very good sales numbers, has been surpassed in sales by the Android smartphone. The Android also has more predicted app downloads, at 58 billion annual app downloads by 2016, while the projected number for the iPhone is 27 billion.

**Mobile healthcare is a growing market**

Attitudes toward the use of technology are changing within medicine as more and more patients adopt the technology and physicians are realizing its full potential, Dr. Awdeh said.

“It is particularly exciting to me to witness burgeoning institutional endorsement of digital technologies in healthcare delivery and education,” he said. “The American Medical Association (AMA) used to think that the internet was dangerous, even issuing a press release in 2001 suggesting that Americans ‘trust your physician, not a chat room,’ because using the internet as a source of health information ‘puts lives at risk.’ Now, the AMA has three apps and recently launched an initiative encouraging innovation in
mobile healthcare development.”

He said the mobile health market is expanding quickly and could vastly enhance and enlarge the system of healthcare delivery for countless patients.

**CheckedUp: A mobile health platform beta launches in ophthalmology**

“As humans, we can get excited about the potential for huge gains in disease prevention and management with the proliferation and widespread adoption of educational and diagnostic apps,” he said. “As doctors, we can use apps to educate and connect to our patients, capture compliance, and promote patient satisfaction. As ophthalmologists, we can connect to each other and access the latest in educational content. Enter CheckedUp, which beta launches in ophthalmology at the [2013 ASCRS•ASOA Symposium & Congress in San Francisco] and will revolutionize the patient/doctor relationship.

“Given the trajectory of smartphone and tablet adoption and social media uptake, it is time that physicians step out of the antiquated role of ‘doctor knows best’ and into the more patient-centric role of accessible, interactive partners in customized healthcare delivery,” Dr. Awdeh said.

Ophthalmologists can benefit from the new technology and patient use, but should be cautious in their approach.

“We should work toward a careful and strategic integration of new technologies into our practices, and beware of quick fixes or door-to-door one-size-fits-all app salesmen. It’s important for branding as much as liability that mobile health and technology adoption work for patients, doctors, and practices,” he said. “Equally important is that the regulatory compliance standards—including those of HIPPA, the Federal Trade Commission, and the International Organization for Standardization—are met. In the case of CheckedUp, the platform was validated in pilot trials with patients, and the product team made an investment in the platform architecture—from the beginning—to ensure adherence to regulatory standards and to respond to patient needs.”

**Eric Donnenfeld, MD**, founding partner, Ophthalmic Consultants of Long Island, and a pilot investigator for CheckedUp, expressed his excitement at being at the cutting edge of patient care. “We are thrilled to be in a position to harness the power of mobile technology to write the future of healthcare delivery.”

Editors’ note: Dr. Awdeh has financial interests with Cirle (Miami) and CheckedUp. Dr. Donnenfeld has no financial interests related to this article.

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8 steps to prepare your
D  uring the Great Recession, many practitioners held off on retiring for various reasons. Now that the economy is recovering, Wall Street is booming so their stock holdings are stronger, and with the cost of converting to medical records, more and more practitioners are considering selling their practices and retiring. In this article I will discuss eight simple steps one can take to prepare a practice for sale and position it for maximum value.

Be prepared to discuss why you are selling

The first question one is likely to be asked is “Why is the practice for sale?” There are many reasons for selling a medical practice including retirement, burnout, illness, family reasons, relocation, etc. All potential buyers want to know there is a legitimate reason behind the sale before they pursue the opportunity. If you cannot honestly and clearly explain why you are selling, it is unlikely you will receive an offer for the practice’s maximum value.

Visual impressions matter

Visual impressions are important. Two practices can have similar revenue diversity, gross collections, overhead and profitability. According to valuation formulas, their numbers would dictate similar values. However, the practice that has a more attractive “curbside appeal” will likely receive a higher offer.

In most cases, one needn’t undertake a major project to improve the look of the practice. It can be little things such as having the carpet steam cleaned, increasing the frequency of lawn mowing, having daily “trash pickup inspections” of the office and parking lot, etc.

If your staff is aware of the sale, you may find it useful to assign one or more employees to keep certain areas of the office neat and presentable (more so than normal), especially in the days immediately preceding a buyer’s visit.

Financial diligence

Soft issues such as location, visual impressions, etc. can influence an offer, but basic value comes from a practice’s financial performance. As such, make sure you are collecting all that you can collect for the work performed. Not collecting all you can has a two-fold result in that the gross revenues look lower and the practice’s overhead will artificially appear to be higher (when the expenses are applied to the reduced collections).

Medicine is a service industry. The value of any business entity in a service industry is related to the amount of revenue and profits generated from performing that service. It then follows that the more cash generated from performing the service, the greater value your business will have. If you do not accurately collect and report all income, you inadvertently undervalue your practice.

Additionally, most buyers (and lenders) will want to see three years of financial statements. More scrutiny tends to be paid to the 18-24 months prior to a sale. During this time, it helps to make an extra effort to maximize your productivity/collections and minimize discretionary expenditures. Although a professional valuator or experienced practice broker will account for discretionary expenditures when examining cash flow, in most buyers’ eyes, a dollar of net income is still more attractive than a dollar of adjusted cash flow.

Discretionary expenses most easily targeted for review are travel, entertainment, all forms of insurance coverage (property, health, auto, professional liability, etc.), and any inflated family wages. If you own the practice and real estate through separate corporations, you should match the rental payments to the current market rates. As for updating equipment, minor expenditures can be justified but any significant equipment purchase decisions, unless vital to ongoing operations, should be put off and left for the new owner’s input.

Accurate financials

When one purchases a practice he or she is purchasing a job, an anticipated revenue stream. As such, a potential buyer needs to identify the true financial health of a practice. Any discrepancy in your financial statements and/or federal tax returns will need to be clearly and accurately explained to the prospect’s satisfaction. Anything less raises doubts and could result in no sale or a reduced offer.

Have supporting documents and other pertinent information readily available

The financial statements and any appendices should provide an overview of the practice’s monthly/annual operations and portray an accurate picture of the financial health of the practice. To accomplish this, you should have complete, accurate, and neat financial statements as well as other supporting documents for the buyer’s review.

Areas to address in supporting documents are:

• number of active medical records
  (i.e., a patient seen in the past three years)

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• a breakdown of patient visits, by year, over the past three years
• a breakdown of revenue by service line, by year, over the past three years
• a breakdown of volume by procedure code, by year, over the past three years
• a background of key staff members:
  • who will be staying
  • who may be leaving
  • job description
  • number of years with the practice
  • compensation and benefits
• an overview of contracts to be assumed (i.e., leases, service contracts, etc.)

The point is to “tangibilize” the intangible, to paint a picture of business operations that does not appear in the financial statements and show that the ownership transfer can be relatively “turn key.”

Identify a reasonable sale price
Don’t try valuing the practice yourself. First, most physicians and administrators have little or no background in practice valuations. Second, the lack of experience and personal interest in the outcome will render the self-valuation almost useless.

An independent professional will provide more credibility and the experience to utilize different techniques to establish the fair market value. However, a valuation report is only as legitimate as the person conducting the valuation. Practice valuation is an unlicensed profession and, as such, can lend itself to abuse. Almost anyone can claim to be a practice valuator, so the abilities and competencies can greatly vary depending on the training and experience. When it comes to business valuations, the major credentialing agencies and their certifications are:
• American Society of Appraisers: Accredited Senior Appraiser (ASA)
• Institute of Business Appraisers: Certified Business Appraiser (CBA)
• National Association of Certified Valuation Analyst: Certified Valuation Analyst (CVA)

Using a valuator who is certified doesn’t guarantee a report will be sound. A valuator can be certified but have little to no experience with medical practices (or specifically with ophthalmology) so the report can contain errors in judgement or assumptions.

Placing a value on any business, especially a service business like a medical practice, is as much an art as a science. Even among experienced, certified professional evaluators, there can be disagreement as to the value of a given practice. However, a professional valuation is a strong step, not only for establishing the sale price, but also for the purchasing physician to use in qualifying for a loan or in the case of IRS review.

Understand the tax consequences
One of the most important factors to consider, but often the last one addressed, is the tax consequences resulting from the sale. Once you identify a reasonable sale price, you can make an estimate as to the likely allocation and your possible tax obligations. For more on this, see “The tax consequences of selling your practice,” in the February issue of Ophthalmology Business eZine.

Use a specialist
The sale of a practice is one of the largest transactions in which most will likely engage. Furthermore, for some, the proceeds of a sale will go a long way toward funding their retirement. Because of this, if you use a broker, it should be one who specializes in eyecare and focuses on practice sales.

Just as a general business valuator may not be qualified to value a medical practice, a general business broker may also lack the expertise and database of contacts to sell a medical practice. Even if a broker has some medical practice sale experience, the profession of ophthalmology can differ greatly from that of other medical professions (for example, general surgery, otolaryngology, etc.). Because of this, one should use a broker who has substantial experience in eyecare, one who understands the nuances of the specialty.

Additionally, some recruitment agencies—enticed by the potential fees—have begun holding themselves out as practice brokers. The sale of a practice is substantially more complex than the recruitment of an associate. An experienced broker knows how to put together a proper prospectus, screen and qualify a buyer for the ability to purchase, analyze and break down the financials for presentation to a buyer, be able to thoroughly discuss the financials and answer a buyer’s questions, negotiate all the terms of the sale (and any post-sale employment), deal with the buyer and/or the representative, work with the buyer’s lender to facilitate the loan, etc.

One should not entrust the sale of the practice to an agency that cannot reasonably perform all the services necessary.

Summary
No one can guarantee the sale of a practice or guarantee the price one may receive. However, if you follow these eight simple steps, you will have put yourself in a position to better sell your practice and achieve the best possible price.

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