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It's no secret that the way health care is being delivered in the U.S. is changing.

The Patient Protection and Affordable Care Act and the related Health Care and Education Reconciliation Act, which were signed into law in April, may have drastic implications for consumers. The new laws claim to give patients expanded coverage, free preventative care and added protections against being denied coverage. But what do the rules, which are scheduled to be implemented from 2011 to 2018, mean for those who provide health care services?

Some physicians are poised to take advantage of incentives for implementing electronic health records, but many ophthalmic surgeons are still trying to figure out where they fit in the EHR “meaningful use” puzzle.

Additionally, the promise of dwindling funds from Medicare has many physicians considering either a break from the government program or finding a way to survive cuts and still provide quality patient care. Now, more than ever, healers have to instantly focus more on the business side of their practices.

Ophthalmology Business (OB) uses its November issue to delve into those concerns and the decisions practices will need to make to position themselves in this new frontier.

This issue’s articles take us step-by-step through the federal overhaul rules that most affect ophthalmic surgeons, explain why expanding services to elective procedures may be the key to survival in Medicare and explore Medicare participations options, including opting out.

Other related articles consider marketing mistakes many practices make and how to manage and grow a practice, even in tough economic times.

We hope you enjoy this very important debut issue of OB and welcome your ideas, comments and suggestions.

Sincerely,

Donald R. Long
Publisher, Ophthalmology Business
Ophthalmology Business

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Provisions to be implemented over the next few years will offer some financial incentives, add penalties, change payments based on specialty and location, require public reporting of physician data, and create a new entity to order wide-ranging cuts.
Ophthalmologists are expected to see a range of changes in their practices in the coming years—especially related to Medicare services—as the numerous provisions of the sweeping health care overhaul law are implemented.

Many of the provisions of the Patient Protection and Affordable Care Act (P.L. 111-148) and the related Health Care and Education Reconciliation Act (P.L. 111-152), which were signed into law in April, that affect physicians are scheduled to be implemented from 2011 to 2018. Regulators will issue rules over the next few years that will spell out the details of the laws’ provisions. Those rules may end up amending or easing some of the requirements in the law if the American Society of Cataract and Refractive Surgery (ASCRS) and other physician advocates are successful in ongoing efforts to inform those implementation rules. However, as written, the new laws spell out significant changes.

The new laws will offer some financial incentives, add penalties, change payments based on specialty and location, require public reporting of physician data, and create a new entity to order wide-ranging physician payment cuts as a cost-saving measure. Those measures add up to significant changes for most ophthalmology practices.

Early requirements

Among the earliest physician-related provisions scheduled for implementation is a 2012 start date for physicians to voluntary organize as accountable care organizations (ACOs) to meet quality thresholds. This move would allow physicians to potentially increase the payments through Medicare if they are able to achieve cost savings. The ACO provisions are part of an overall push in the health care overhaul to urge physicians to merge their practices to better coordinate patient care.

“There’s going to be a change in the delivery of medical care,” said Nancey McCann, director of government relations, ASCRS. “There’s also the move toward [ACOs] and integrated delivery systems, whereby the small practices and the solo practitioners are going to be a thing of the past—at least that’s what [the law] envisions. It’s certainly something that our members should be looking at because they have to position themselves for the future.”
The new laws aim to encourage physicians to join or form groups similar to the Geisinger Health System in Pennsylvania, which is an organization of over 500 physicians in Pennsylvania that emphasizes adherence to evidence-based standards, a fixed-price financial mechanism, and greater patient engagement.

Other provisions slated to begin rolling out in 2012 that will also affect clinicians’ Medicare payments include creation of a “budget-neutral payment modifier.” New rules—due January 1, 2012—will detail the different Medicare payment levels that a physician or group of physicians will receive based on the quality of care provided compared with its cost. These rules will announce the date that the modification will go into effect and specify the initial performance period, but they will apply to all physicians by 2017.

Such patient outcome-based quality payments have drawn criticism and concerns from physicians that these could create incentives for surgeons to avoid complex cases because they are prone to complications that could skew surgeons’ overall outcomes downward.

Also concerning is that this modification in physician payments will be “budget-neutral” and fund increases in payments for high-quality physicians through cuts to other physicians.

**Midway requirements**

By 2013, the new laws will require physicians to begin disclosing financial relationships with manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies. Public reporting of physician performance information also will begin this year.

Physicians may also see impacts from a new 2.3% excise tax on medical devices that begins in 2013 if it raises the cost of the numerous devices they use in surgeries or causes manufacturers to slow the development of new medical technology.

By the next year, one of the most controversial aspects of the law, the Independent Payment Advisory Board (IPAB), is set to launch. Physicians widely opposed this 15-member panel because it will have the authority to reduce Medicare physician payments by a certain percentage it deems necessary to achieve savings needed to maintain the overall solvency of Medicare. [The aforementioned “certain percentage” would reduce the per capita growth in Medicare in years when spending exceeds a targeted growth rate.] Any cuts approved by the board would become effective unless Congress approves another source of savings of an equal amount within 90 days.

The IPAB “will have the ability to make draconian cuts,” said Brock Bakewell, M.D., chair, ASCRS Government Relations Committee.

The far-reaching power of the IPAB has led many ophthalmology advocates to focus on ensuring physician representation on it, among other efforts.

“If you allow others to determine your future, then you are turning your future over to others who don’t know medicine as well as we do,” said Sandra Yeh, M.D., member, ASCRS Government Relations Committee, about the need for both physician representation on the IPAB and for ophthalmologists to increase their involvement in political advocacy.

**Late stage**

By 2015, other highly controversial provisions will begin to take effect. Specifically, Medicare will begin adjusting individual physician payments based on cost and quality data it will begin to collect in 2012.

Another quality-focused program, the Physician Quality Reporting Initiative (PQRI), which currently provides bonus payments to physicians who opt to participate in its quality reports program, will become mandatory. After 2015, physicians who opt not to participate will face escalating annual penalties based on a percentage of their gross Medicare payments.

Despite the size and scope of the health care overhaul, the measures did not address looming cuts physicians continue to face through Medicare’s payment system. Congress has repeatedly overruled these scheduled cuts for physicians through increasingly short-lived “patches,” including two extensions of the current payment rates this year that were retroactive because they had already gone into effect. Physicians will continue to face the uncertainty in the Medicare payment system until this is addressed.

“This has a huge impact because we have repeatedly faced these last-minute situations where there is uncertainty about whether anything is going to be done,” said Priscilla Arnold, M.D., member, ASCRS Government Relations Committee.

“We are continuing to urge our members to contact Congress about this problem.”

Physicians also will not see their legal liability concerns reduced by the health care overhaul. The new federal laws allow only for pilot projects to study several possible approaches on a limited basis. Nationwide implementation of any tort reform effort would require further Congressional action.

The lack of tort reform will likely continue to add to overall medical costs as physicians feel the legal environment forces them to practice defensive medicine.

“I’m sure doctors would order fewer tests if society allowed us to be wrong on occasion,” Dr. Bakewell said.

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For most surgeons, opting out of the system just doesn’t make sense. But, they say, expanding services to non-reimbursed procedures is the key to survival.

By definition, a Medicare “participating physician” means the physician agrees to accept whatever the Centers for Medicaid and Medicare Services (CMS) determines is the proper fee for a particular covered service. The physician bills Medicare directly for that service and CMS reimburses the physician directly for 80% of the billed amount (less any deductible). Medicare additionally pays participating physicians a 5% increase in fees over the non-physician rate, according to the agency. A non-participating physician can still file claims with Medicare, but will also need to solicit full pay-
ment from the patient up-front; CMS reimburses the patient, not the physician, for that portion of the fee. Non-participating physicians, however, are not really at liberty to set their own fees but are limited to charging 15% of the 95% Medicare allowable charge. However, Medicare-approved rates for the non-participating physician are 95% of the rates for the participating physicians; so the 15% limiting charge is effectively 9.25% above the participating-approved amounts.

To the patient, however, a “non-participating provider” suggests the physician doesn’t accept Medicare at all.

In order to opt out, physicians have to file an opt-out affidavit 30 days prior to the end of the quarter. If a physician opts out of the Medicare system altogether, there is a two-year waiting period to re-enroll.

Conversely, physicians can opt back in any time between November 15 thru December 31 of the calendar year.

For ophthalmologists, the debate is ongoing. As Medicare continues to implement its various percentage cuts—the latest a 23% cut in payments due to begin Dec. 1, followed by a cut of nearly 30% to begin Jan. 2011—the question remains: how to maintain any kind of profitability while continuing to offer patients access to quality care.

“If you run a spreadsheet on how this will impact our cash flow and profitability, it goes something like this: if you’ve got 60% overhead and 50% of your patients are Medicare, the practice is suddenly earning 26% less than last year after these cuts, and that’s with seeing more patients and before we do our employees’ reviews,” said J. Trevor Woodhams, M.D., Atlanta.

Dr. Woodhams has previously stated the only way an ophthalmologist with a heavily Medicare-based practice can continue to earn a living is to reduce the proportion of Medicare patients seen in a day, find a non-reimbursable ophthalmic business (i.e., refractive, oculoplastics, or “medical” optometry), or disenroll completely from the system.

“Doing the latter is not impossible, albeit certainly very inconvenient,” he said. “Optometrists have earned pretty decent livings for a decade with no access to Medicare enrollment privileges. Of course, you’d be working at a level well below what you paid to be trained to do.”

In Dr. Woodhams’s case, he remains a participating physician mainly because Medicare patients comprise only 10% of his clientele.

“I perform a lot of LASIK, but I do not personally perform routine eye exams or oculoplastic surgery,” he said. “But most of our surgical income is the non-Medicare IOL (i.e., refractive lens exchange).” In his practice, the average age of his premium lens patients is 58.

In Florida, the issue is somewhat more complicated by the excessive number of patients enrolled in Medicare, said Michael Loeffler, M.D., Lighthouse Point, Fla.

“The main problem in a region like mine is that there is an equally dense number of potential providers as there are patients, so unless everyone would agree to stop accepting Medicare, we’re stuck,” he said. “If one physician opts out, patients will just go down the street to the one who’s still in.”

Both Dr. Woodhams and Samuel Masket, M.D., clinical professor of ophthalmology, Jules Stein Eye Institute, David Geffen School of Medicine, Los Angeles, and in private practice, said they saw these kinds of cuts in Medicare reimbursement coming.

“If I hadn’t made changes in my practice, with the threatened 21% reduction I would have opted out,” Dr. Masket said. With his children already grown and on their own, “I could take the hit of reduced volume and drop Medicare and all the other insurers,” he said. However, over the past few years, Dr. Masket has attained another specialty practice to increase his scope and has brought in a partner, both of which he deemed necessary as 90% of his practice involved Medicare patients.

“Unfortunately, I no longer have the option of opting up,” he said. “There’s a cost shifting in the office. If your practice overhead is somewhere in the 70 to 80% range, a 21% cut means you’re no longer profitable. Your options are to close your doors, or increase your scale of operations so you can theoretically be more efficient by using the same space with economies of scale.”

Although Medicare patients

Continued on page 12
comprise only 50% of his patient population, Dr. Loeffler said all physicians are going to “be scrutinizing the reimbursement levels and at some point, it will stop becoming a medical decision and start becoming a business one as to whether or not you take on more Medicare patients.” Older physicians will be pushed into retirement with fewer “replacement” physicians available, he said. At his practice, a fellowship in oculoplastics coupled with the advent of premium IOLs has enabled Dr. Loeffler to keep other options available.

Opting in—
a good choice

When economic times were better (pre-9/11), Marguerite McDonald, M.D., in private practice with Ophthalmic Consultants of Long Island, Lynbrook, N.Y., clinical professor of ophthalmology at NYU Langone Medical Center, and adjunct clinical professor at Tulane University Health Sciences Center, New Orleans, opted out of Medicare. It was a “great idea for the first year, while times were good.” After one year, however, Dr. McDonald ended up regretting the decision.

At the time that Dr. McDonald opted out, her LASIK business was so robust, she was scheduled several months in advance and was starting to lose “cash” patients because she was spending so much time caring for Medicare patients. At first, the decision to opt out seemed to be wise, and profits were up. Post-9/11, however, travel to New Orleans and the local economy both languished; suddenly Dr. McDonald was no longer booked in advance for LASIK. She was forced to downsize her staff and began actively hunting for patients.

“Luckily, pterygia and kerato-conus are common in the New Orleans area,” she said, somewhat jokingly. “In the downturn economy, I had to expand both the number and the percentage of essential though non-Medicare services that I was offering. The moral of my story is that it’s better to earn a little bit of money than no money. I learned the hard way that you have to structure your practice so it’s more than just one specialty, so that you can remain nimble in the face of unexpected change.”

As soon as she could opt back into the Medicare program, Dr. McDonald did so; her financial situation improved fairly quickly. Now relocated to Long Island after Hurricane Katrina ravaged New Orleans, Dr. McDonald is still accepting Medicare.

“When you’re losing money in a business model, you can’t just make up for it in volume,” Dr. Loeffler said. “If you’re barely getting by, additional volume is just giving you a cushion. From our perspective, if you’ve got a patient with private insurance and one who’s only got Medicare, you’re more inclined to want the private insurance patient in your practice.”

A worst-case scenario, he said, closes out Medicare patients from receiving or accessing quality care in a timely manner. He’s seen it happen in his native Canada, where the socialized medicine gives physicians little incentive to increase the number of patients seen.

“Speaking to some of my Canadian colleagues, they lament about the long waiting lines of patients, and those affluent enough will seek medical care elsewhere. The U.S. is rapidly heading toward that type of scenario,” he said, and added the question in the U.S. is rapidly becoming whether or not health insurance is a privilege or a right.

There are some positive reasons to stay enrolled in Medicare, Dr. Woodhams said. For instance, the country is in a non-inflationary economy currently, so every dollar being spent on goods is actually buying more rather than fewer goods compared to several years ago. If the enrollment eligibility age for Medicare is raised (as appears probable), it’s likely that more people will be off the rolls rather than on when they first present needing cataract surgery, he said.

“Technology should make things less expensive, but that hasn’t been the case in the past,” he said. “Most payments for technology have been cost-plus. So developers of new or improved technology could pass the new expense onto the public through insurance or out-of-pocket from the patient. This may no longer be the case.”

Any surgeon who performs cataract surgery “has learned about the benefits of multifocal IOLs to the practice and the patient,” Dr. Masket said. “We have turned to the patient to increase the revenue stream. When the 21% loomed a little while ago, we looked at the services we provide for which we do not charge.” So although every patient has topography, Dr. Masket did not charge the patient, believing that while not medically necessary, it added significant value to patient care.

“Now we’re presenting patients with letters telling them that a number of services we were able to provide without charging would be ending. That’s one way we’re making patients aware of the problem with the cuts in Medicare,” Dr. Masket said.

Stay or go?

The negatives of staying in the Medicare system “are more philosophical,” said Dr. Woodhams. Being in the system means “you are basically surrendering the best and proper way to determine delivery of good services in a free market exchange,” he said. “If you’ve got two patients with identical diagnoses but one has
a much higher potential for complications or extended post-op care, you’re not paid any differently for the patient with all the excess work.”

One thing preventing physicians from being able to opt out of suffering imposed fee cuts is that the country currently has an excess of suppliers (cataract surgeons), but that won’t always be the case, Dr. Woodhams said.

Another negative about the program overall is that it lacks an outcomes analysis, he said. There’s no additional physician payment for patients with serious complications or those who need longer-term follow-ups.

Furthermore, the best and most efficient surgeons are paid the same as the bottom 20%—and there’s no current way for the public to know which surgeon is on which end of the scale. Inevitably, this will impact future pay for performance.

“I don’t think the system is bad enough to opt out, but it’s bad enough not to rely upon it for a living,” Dr. Woodhams said.

“I keep wondering what might have happened if I’d not opted out of Medicare, if I’d run a practice with one good LASIK surgeon, a good cataract surgeon, and a good retinal surgeon,” Dr. McDonald said.

Dr. Masket said he’d been

“loathe to consider services that are outside my area of expertise or knowledge.” Add-ons such as hearing aids, for example, had “no historical place in my office,” he said. The practice he attained had those kinds of services—optical goods and its own excimer laser operating as a freestanding center.

“We’re expanding those services. We’ve hired more physicians to provide more services and we’re passing the costs, when possible, onto the patient,” he said.

Surgeons these days only have so many options available to maintain profitability, Dr. Masket said. In 5 to 10 years, there will be an

“explosion of baby boomers who need services,” he said, and added younger surgeons interested in performing cataract surgery are likely unable to opt out of Medicare.

“Opting out is really only an option for the very established practitioner who can afford to take the reduction in pay, perhaps those winding down their careers,” he said.

Dr. Woodhams advised physicians to continue enrollment in the program, but to “make sure you are never dependent upon Medicare for the majority of your income. Find something else to supplement the practice’s income—oculoplastics, pediatric ophthalmology, etc.”

He added ophthalmology’s professional societies need ‘to do more’ by avoiding the possible course of advising members to reconsider Medicare participation. This is not price-fixing; it is the proper consideration of opting out of an economically unsustainable, price-fixed model.”

While it’s always been risky to open a solo practice, “we’re not allowed to let free market forces allow us to do what we want,” Dr. McDonald agreed. Whereas medicine used to be self-regulating, it no longer is. The public still believes that all physicians are “fat cats,” but walking any major medical convention hall will quickly alter that belief, she said.

“I know too many physicians who have sold vacation homes, pulled kids out of private schools, and have been driving the same cars for years. The average doctor is not pulling in thousands in consulting fees,” she said.

The bottom line? “When reimbursement becomes challengingly low, each of us will determine when it makes sense to stop participating,” Dr. Loeffler said. “The Medicare system is broken, and we all know it. It’s a crisis that needs to be resolved.”

“Until physicians create an environment where there’s limited access to Medicare physicians, the federal government is going to continue to ratchet down costs.”

Dr. McDonald said even within the house of medicine, there are tremendous resentments. “When one of the first big cuts came through, other specialties called Congress to hammer home that we needed the cuts so that their specialties could be spared,” she said. “No matter what Congress does, we have to accept it or break the law and unionize.”

In Massachusetts, for example, a state bill is being considered that would tie a physician’s license to acceptance of Medicare, Dr. Loeffler said.

“We need to continue to ask patients to assume more of the financial responsibility for their health care,” he said. If Medicare insurance was operated similarly to auto or home insurance, with deductibles and rising premiums when used, more people would think twice about using the insurance altogether, he said.

“If there’s a leaky faucet that is causing cabinet damage in your house, you pay out of pocket to fix it,” he said. “If you have a major flood, you call your insurance company to fix it. Medical insurance—and Medicare in particular—needs to work more like those scenarios.”

Editors’ note: None of the physicians has a direct financial interest related to their comments aside from being participating physicians in the Medicare system.

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Opting out of Medicare mayhem

by Maxine Lipner Senior Contributing Editor

Why some practitioners are considering this or have already taken the plunge

It’s something that many practitioners these days at least fantasize about doing—throwing off their financial “shackles” and opting out of Medicare once and for all.

Plummeting reimbursement remains a key issue. Potential looming Medicare reimbursement cuts of $500,000,000,000 worry practitioners who are concerned that with such diminished compensation, they won’t be able to provide the quality of care that they would like and have the practices that they want, according to Daniel S. Durrie, M.D., clinical professor of ophthalmology, University of Kansas, Overland Park, Kansas.

Fantasies of opting out aside, the truth is ophthalmology is hip deep in Medicare reimbursement. “Ophthalmology is very dependent on Medicare and third party insur-
“Potential looming Medicare reimbursement cuts worry practitioners who are concerned they won’t be able to provide the quality of care that they would like”

Dr. Durrie said. “Third party pay is really 80% of the dollars that flow into ophthalmology.” As a result, Dr. Durrie sees it as a big deal for someone to want to drop out; it’s a decision that should not be taken lightly.

**Opting out in practice**

Despite this admonition, back in 2002, he took the leap and opted to run his refractive practice as a cash-based one. His reasoning was two-fold. “I looked at the types of patients that I was seeing and they weren’t in the Medicare age group,” he said. “I also looked to the future and looked at where I thought lens-based surgery was going to go. I thought that more and more people were going to have their lenses replaced long before they got a cataract so they wouldn’t qualify for insurance or Medicare anyway.”

Dr. Durrie ran the numbers and found that it was more cost effective for his practice not to be in the system. “We had all of the billing, the insurance, and the people, and we weren’t doing enough (Medicare-related) business to justify having all of the infrastructure to do that,” he said.

By opting out Dr. Durrie found that he was able to concentrate more on patient wellness rather than disease and enhance quality of care with the concierge approach. “A busy half day for me is 15 to 16 patients,” Dr. Durrie said. “Whereas, within the Medicare system you may have to see 30 or 40 patients because you are only taking care of the disease process and billing for the chunk of your time that relates to that disease.”

Dr. Durrie sees the fact of opting out as currently geared mainly to those with refractive or oculoplastic practices. “If you’re a retinal, cataract, glaucoma, or corneal surgeon, the majority of diseases you take care of are aging diseases, and the volume of patients that need your care are in the Medicare age group,” he said. “It would be very hard for someone who specializes in macular degeneration to drop out of Medicare—he or she wouldn’t have any patients.”

He recommends that those considering making the move sit down and assess their current patient base, as well as the type of clientele they hope to see in the future. For those whose practices are replete with oculoplastics or refractive surgery patients or who want to opt for a concierge-type wellness approach, Dr. Durrie sees dropping Medicare as a viable solution. For others, however, he warns this may be a difficult road.

**On the precipice**

Currently, many ophthalmologists continue to weigh the options. Brad E. Oren, M.D., Lakeworth, Fla., falls into this group. His practice focuses on anterior segment work, mixed with oculoplastics. Dr. Oren is drawn to the idea of opting out but is not yet ready to commit to this. “The appeal is to be able to better control your finances, your collections, the timetable of your collections, and not having the variability of Medicare change the financial outlook of your practice,” he said.

“We’re at the point now where based upon the SGR [sustainable growth rate] issues, pretty much all of the time we have absolutely no idea what we’re going to be collecting from Medicare.”

He sees the advantages of opting out as boiling down to enhancing control. “You have the ability to be paid what you’re worth,” he said. “This allows you to have some sense of how you can build your business, when you can build your business, and how you can finance new equipment to take care of the patients,” Dr. Oren said.

One area of concern for him is the potential reaction of his patients. “It’s difficult for doctors to understand what it means to opt out or to partially opt out,” he said. “On the other hand, it is nearly impossible for most patients to understand.” Dr. Oren is concerned that if he makes this choice, he may have to spend exorbitant amounts of time explaining the situation to patients.

Still, he is spurred to consider it by ever-falling reimbursement rates. “I started practicing in 1999 and most of the average codes, the average collections have gone down every year since I have been in practice,” Dr. Oren said. “They have gone down 2 to 5% annually.” He acknowledges that this is nothing compared to the double digit drops experienced by his predecessors. “They went from making well over $2,000 in most markets for a cataract in the mid-90s to less than $1,000 [now],” Dr. Oren said. “You’re talking about a 50% cost cut in your most performed CPT code—doing that it’s impossible to plan.”

David M. Kwiat, M.D., Amsterdam, N.Y., is likewise on the fence. The lure for him is the idea of independence with decreased regulation and oversight. He wants the ability to treat a patient based on what he thinks is appropriate and

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not on what the insurance will pay for the claim. Also, he’s tired of insurance wrangling involving appeals and denials. “We have to pay our staff to deal with all this stuff,” he said. “Whereas if we moved to a more cash-paid system it wouldn’t be as difficult—we wouldn’t necessarily need a whole billing office.” He is also troubled by what seems to be the ever-shrinking payments. “I am seriously considering opting out if the current trend of unpredictable payment continues,” he said. “We are threatened with potential cuts every three to four months it seems now.” This, he finds, makes it difficult to provide consistent care, maintain a consistent staff, or to consider buying new technology to benefit patients.

Dr. Kwiat is aware that there could be a price to pay for opting out of the system. “The downside would be a potential dip in revenue, definitely for the short term but possibly for the long term as well,” he said. “That’s why I think that it’s important for each practice to look at their demographics individually.” In his own case, he hopes that potential cost savings from no longer dealing with Medicare billing issues can offset the dip.

At this point, he thinks that any negative reimbursement rates will probably be enough to cause him to opt out. “Everything else is increasing: the wages of our staff, the cost of equipment, and the cost of rent,” he said. “You have to think long-term, where are the payment system and health care going in this country.”

Overall, Dr. Kwiat sees the decision as highly individualized. “Not every practice is going to benefit from it,” he said. “Certainly if you have more of a cosmetic or cash-based practice you may find the transition much easier.” Also, area demographics cannot be forgotten. “If you are in a situation where there are three ophthalmologists and you decide that you’re not going to participate, the other two will gain all the business,” Dr. Kwiat said. “If you opt out you’re shooting yourself in the foot.”

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Medicare rebound

Back in 2000, one surgeon was optimistic about her future sans Medicare. Marguerite B. McDonald, M.D., professor of ophthalmology, New York University School of Medicine, New York, and adjunct clinical professor of ophthalmology, Tulane University Health Sciences Center, New Orleans, was at the time a solo practitioner in New Orleans. She was spurred to consider opting out after reflecting on her divergent patient base, which included both refractive and corneal patients. “My office manager looked at our appointments and the surgery and she said, ‘You’re starting to lose LASIK patients because you’re booked so far in advance for either pre-operative examinations or surgery that they’re just giving up and going elsewhere,’” Dr. McDonald said. “Instead you’re doing all this Medicare work and you’re getting paid a pittance.”

Armed with this information and after careful financial analysis, Dr. McDonald opted to extract herself from the Medicare system. “We looked into the legality of it and I sent out letters to my Medicare patients,” she said. “I made arrangements for each and every one of them to be seen by another ophthalmologist in town.” While she knew that there would be a two-year period before she could opt back in to Medicare, Dr. McDonald was fairly confident that her refractive work would fill her schedule.

Dr. McDonald still continued to treat some cornea and external disease patients (i.e., those without Medicare), but the volume shifted decidedly in favor of refractive surgery. “Everything was just great. Profits went up and everything that we predicted would happen actually did, until 9/11,” she said. “We had been out of the Medicare system for one year when 9/11 hit and the economy rocked.” Tourism, which usually brought a major influx of cash to the New Orleans area, all but stopped during that period. “No one was having LASIK and there was not much to fall back on; it was a difficult time,” Dr. McDonald said. She cut back on personnel and essentially limped through the second year without Medicare.

As soon as the two-year period was up, Dr. McDonald opted back into Medicare with a new perspective. “What I learned is you have to prepare for the unexpected and the very bad times,” she said. “Just because things are OK or even great right now does not mean that they’re going to be that way tomorrow.”

Dr. McDonald advises those who are now considering opting out to reconsider. “Think twice because the road is rocky ahead,” she said. “Maybe we’ll have to unionize some day if we feel things are really out of control, but for now I would stay in the pack and keep your eggs in as many baskets as possible.”

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Manage and grow your practice in tough times

by Vanessa Caceres Contributing Editor

Bottom line growth is possible even with Medicare, economic turmoil
You can grow your practice despite a tough economy and declining Medicare reimbursements.

A number of ophthalmic practices across the country are taking an opportunity to cut costs, operate more efficiently, and grow business in areas where patients tend to pay more out of pocket.

The current economic strain on many practices feel comes from the double whammy of Medicare changes and the still-ailing economy, said ophthalmic consultant John Pinto, J. Pinto & Associates, San Diego. Although this causes more regulatory constraints and reduced payments, it also brings opportunity, he said. “All will be well if you work hard, manage the business well, and take it from there,” he said.

Here are three possible approaches you can consider to help grow your bottom line.

Operating lean

One area that will help practices’ pocketbooks the most is within physicians’ and administrators’ control—monitoring costs, Mr. Pinto said. Here are a few tips to try:

1. Evaluate staffing needs, recommended Keith Casebolt, CEO, Medical Eye Center, Medford, Ore. For example, on a day with a light schedule in the past, his staff might devote more time to cleaning the office or organizing supplies. Now, administrators are more likely to send a staff member or two home early on those lighter days, Mr. Casebolt said.

By looking more closely at staffing hours, the practice has reached an approximate 20% reduction in labor costs, he said. This has been done with the help of staff hour benchmarking in the front office and with technicians.

Managers in those areas usually have the best sense of where staffing needs are greatest (or lowest) on a given day, Mr. Casebolt said. Managers in these areas also benefit from knowing the staffing hour goals they need to meet to help contain costs.

2. Expand your schedule. Scheduling can also help with the cost issue, Mr. Pinto said. However, instead of containing costs in this area, Mr. Pinto actually advocates a bit of growth. “If the average anterior or segment surgeon sees three more patients every day, he will generate $100,000 more a year in net profit,” he said. Conversely, if a surgeon cuts three patients a day out of the schedule, that cuts into the net profit by $100,000. So how to accommodate a growing number of patients in an already tight schedule? Mr. Pinto has seen ophthalmologists who might have taken a half day or full day off at certain points in the past now choosing to see patients at those times. Others are offering weekend or evening clinics to see patients who work during the day.

3. Make sure your schedule is filled. Another way to help with scheduling is to stay in contact with patients who have annual or other regularly scheduled appointments, said ophthalmic consultant Maureen Waddle, BSM Consulting, Incline Village, Nev. “Keep your current schedule full,” she said. You can do this by maximizing reminder cards and calls. Although many practices may send out one appointment reminder card, it’s more effective to send out multiple cards, Ms. Waddle said. Such a plan might include one card sent two months before the appointment, then one month before, one card sent the month of the appointment, and then a phone call the following month if an appointment was not set. Phone calls to remind patients about their appointments can also make sure schedules are filled and appointments are kept, Ms. Waddle said.

There are programs available to help practices keep up with appointment reminders, she added.

4. Respond swiftly to your patient base on a given week. The use of a voice over internet protocol system (also called voice over IP) has helped administrator Vonda L. Syler, C.O.E., McDonald Eye Associates, Fayetteville, Ark., and staff better respond to the kinds of patients the practice will see in a given week. The voice over IP monitors incoming phone calls and tracks whether patients are calling for LASIK, cataract, a general eye exam, or other needs depending on the phone menu extension choice that they make. Based on this, staff members can be prepared to see more refractive patients one week (or cataract, general eye exams, etc.), Ms. Syler said. Technicians can work in different practice areas as needed; this diversification has helped the practice not feel as much of an impact from any particular area that may not be as busy.

Marketing premium IOLs

If surgeons at your practice feel strongly about the benefits of premium IOLs, then you have an ideal area to grow your business, especially in light of the 2005 Centers for Medicare and Medicaid Services decision to allow patients to pay out of pocket for premium technology.

By emphasizing premium IOLs, your patient base becomes younger, which means less reliance on Medicare, Ms. Syler said.

Sandra Yeh, M.D., Springfield, Ill., feels strongly about premium IOLs and starts to educate patients early on. “I show patients and their family members a video about them, even if they are going to get a regular implant,” she said. She said she wants patients to know exactly what they are getting and what is available.

Continued on page 20
“Ophthalmic practices across the country are taking an opportunity to cut costs, operate more efficiently, and grow business”

able. Her premium IOL conversion rate is 30 to 40%, a range that did not dip even during the ailing economy.

Although staff help indicate to Dr. Yeh who might be good candidates for premium IOLs, she is ultimately the person to tell patients, “This is the lens I’d like you to have.”

This kind of passionate backing from the physician is key, Ms. Waddle believes. “In the end, it’s the doctors’ strong recommendation [that’s important],” she said. “If the doctors believe in the technology, then it goes more smoothly.”

Here are a few more ways to make sure you maximize your premium IOL market:

1. Educate all staff—right down to those who answer the phones. “A lot of people forget that the patient has more contact initially with the laystaff,” said John Swencki, CEO, The Eye Associates, Bradenton, Fla.

For this reason, the information patients get about IOL technology from those other than the physician may influence their decision to purchase it. Staff at The Eye Associates have received training in what premium IOLs are, the benefits of each one, and the costs of these IOLs compared with the ongoing costs of wearing classes, Mr. Swencki said.

2. Educate patients. Mr. Swencki’s practice sends out educational information about IOLs prior to the actual appointment. Physicians at his practice also do 1½-hour cataract marketing seminars. For the most part, these seminars become interactive Q & A sessions instead of lectures, he said.

The success of seminars depends on the geographical market and the popularity of a given service, Mr. Pinto said. In some markets, seminars are very common while in others, they are not. While LASIK or RK seminars were once in vogue, you don’t hear much about them anymore, he said.

3. Find out why patients say no. Many times, patients who say they do not want premium IOLs—they just want to know why the technology costs a premium price or may have other questions, Dr. Yeh said. She believes practices might take a “no” at face value when they should instead do a better job of explaining how premium IOLs can help patients more than standard IOLs. In fact, Dr. Yeh feels so strongly about premium IOLs that when patients tell her they’re not sure they want them in both eyes, she will encourage patients to try it in one eye (if clinically appropriate).

Dr. Yeh believes the actual resistance to premium IOLs may come from physicians, not patients. “You need to get past that psychological hump—and many times, it’s the doctor’s psychological hump,” she said.

Expanding services

Oculoplastics. Dermatology. A spa. Hearing services. These are just some of the ways that ophthalmic practices are expanding their business base. Considering that these services bring back the same patient several times a year, this leads to more revenue per patient.

Try to evaluate what services your patients want, and see if your practice can provide those services, said Mr. Swencki.

Prepare to make the capital investment that these kinds of additional services require, and don’t expect to break even for several months, cautioned Mr. Casebolt. Additionally, businesses such as a spa require first-class service (and hence, first-class employee training), he said. You’ll also want a full-time point person to help grow your new expanded service(s)—it’s not the kind of project that an existing administrator can tackle when it’s 6 p.m. and she’s tired from a long day, Mr. Casebolt said.

Considering much of the business for your expanded services will come from existing customers, you want to be careful not to destroy your core business or change patients’ opinions about your practice, Mr. Swencki said.

Here are some details on service expansion ideas from those who have made them work:

1. Oculoplastics/cosmetic services/spas. The Eye Associates now offers services ranging from Lumenis laser skin rejuvenation to eyelash transplants, brow lifts, Botox, Juvederm, and a number of other oculoplastic or cosmetic services, Mr. Swencki said. The practice advertises these services through educational material in the lobby, by making sure staff are knowledgeable about these procedures, and through open houses. Additionally, ophthalmologists at the practice might make referrals.

“People who want surgery also want Botox, fillers, Latisse, and high-end cosmeceuticals,” Mr. Casebolt said. His practice encourages existing patients to come by the spa for a free gift bag. The gift bag makes patients aware that their spa exists. Once patients are aware of the spa and its various services, they might decide to come in for a skin evaluation, massage, facial, or a cosmetic service, Mr. Casebolt said.

To offer these services, make sure that your practice has not only the staffing but also the right atmos-
phere. “If your building doesn’t lend itself to a high-end experience, then it’s harder to make a go at it,” Mr. Casebolt said. For this reason, his practice invested in a well-designed and well-decorated spa that is on a different floor than the ophthalmology office. “The spa costs as much per square foot as the OR,” he said. Some of the bigger expenses included custom cabinetry, lighting, special walls, and high-end products.

Once you feel you have marketed your cosmetic/spa services to existing patients, you can roll out marketing to those outside your patient base, Mr. Casebolt said.

2. Dermatology. Mr. Swencki’s practice knew they could serve a need for dermatology when they found out that the 1,200 employees at a nearby hospital had to drive to another town to see a dermatologist because no dermatologist in his town would accept the employees’ particular insurance. The practice started with a part-time dermatologist and then moved on to hire a full-time one due to demand. The dermatologist accepts private insurance, in contrast to some other local dermatologists who accept no insurance or who only work with Medicare.

Mr. Swencki said his Florida-based practice has a large market due to the many skin conditions related to sun exposure. However, there is also some nice crossover between ophthalmology and dermatology, and specialists at the practice from the two areas often work together or refer patients back and forth.

3. Hearing services. Mr. Swencki’s practice also can provide comprehensive hearing tests and fit for hearing aids. As there have been some problems in the state with shady businesses selling hearing aids, The Eye Associates focuses more on the value of testing and has a very liberal return policy on the hearing aids it sells.

When patients come in for their annual eye exam, the patient screening form they fill out includes eight questions that relate to hearing in restaurants, when watching TV, and in other hearing-related scenarios. “If the patient answers ‘yes’ to any of these questions, that is flagged,” Mr. Swencki said. An audiologist can do a quick screening and determine if additional screening is necessary. Additionally, physicians sometimes might suggest that the patient consider a hearing screening if they think it is necessary, he said.

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10 common marketing mistakes

by Brad Ruden, M.B.A.
Advertising the services of a medical practice can be a difficult task. For starters, many practices do not understand the difference between advertising and marketing. Advertising is content and where to run an ad (newspaper, radio, internet, etc.). Marketing is the overall picture, how the practice is promoted, the services provided, how a practice is positioned compared to its competitors, types of advertising, etc.

“Marketing is the overall picture, how the practice is promoted, the services provided, how a practice is positioned ...”

There is no single “right” way to advertise or market a practice. Each practice will have its unique hurdles due to its individual circumstances (i.e., practice services, location, competition, etc.). That being said, there are some common mistakes that should be avoided. In no particular order, they are:

1. **Failing to understand the big picture.** If you don’t understand the general message you are trying to convey (i.e., the services you offer, how you differ from the competition, etc.) then how can you expect a potential patient to understand?

2. **A shotgun/scattergun approach (i.e., spray and pray).** Advertising needs to have a purpose and measurable results. Advertising for the sake of advertising, without tracking effectiveness, it simply wasting energy and money.

3. **Not tracking results.** If you don’t track your results how will you know what works and what doesn’t? How will you know where to smartly spend your budget and what to avoid?

4. **Cutting the budget.** In tough economic times a marketing budget is often one of the first items to be cut. This is usually because a practice hasn’t tracked results and therefore doesn’t know what worked and what didn’t.

5. **Not involving staff.** Your staff can serve you in two capacities. First, they are the front line of the practice, often spending more time with the patient than the doctor does. The staff can sometimes gather feedback from the patients as to what advertising worked and what didn’t. Also, the staff are consumers, patients. As such they can provide feedback as to what may appeal to them as patients (and what won’t).

6. **Disjointed communication** (failing to integrate all aspects of marketing/communication). You will get the most from your marketing and advertising efforts if all aspects of your marketing program are integrated and support each other. While different advertising medians can convey different messages, all must be done under the umbrella of a cohesive marketing program. You don’t want to send competing messages or conflicting signals.

7. **Incomplete or incoherent message.** Make sure any advertising you do clearly and completely conveys the message you intend. Don’t try to do too much with a single ad, but don’t skimp and leave one guessing.

8. **Lack of networking.** Don’t assume your fellow practitioners are automatically kept up with any changes in your practice or services. Stay in touch and remind them. Also, look for causes within the scope of your practice and be visible with those events.

9. **Being too rigid and inflexible in your approach.** Just because what you’ve done has always worked in the past doesn’t mean it will continue to work in the future. Always be on the lookout for a better way of delivering your message.

10. **Not investing enough and guaranteeing failure.** Because most practices don’t track the results of their marketing efforts, a common mistake is to make general budget cutbacks. This has the effect of starving a marketing effort that is successful and continuing to feed one that isn’t successful. While money may have been saved, it wasn’t saved wisely.

To avoid the mistakes above, make sure you differentiate between advertising and marketing. Remember, there is no “right” way to advertise or market a practice. What works for one practice in one geographic area may not work for another practice elsewhere. What doesn’t work this year may be modified to work next year. Track your results to see what works and what doesn’t, then invest wisely in those that provide the best return.

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Seeing eye-to-eye

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

Malpractice: just mention the word and most physicians immediately become concerned. Some physicians have “war stories” to share, having already been defendants in a lawsuit, while others fear becoming a defendant because of a recent unhappy patient. This article will discuss the necessary elements of a malpractice suit. Unfortunately, a “bad outcome” in ophthalmology often has significant visual consequences. This potentially increases the exposure of the physician. As such, when applicable, illustrations specific to ophthalmology will be provided.

As physicians, we all have had the experience of a patient having a bad or unintended outcome. Fortunately, not every bad outcome is malpractice. I was unaware of the elements required to win a malpractice claim while still practicing full-time medicine (prior to starting law school) but believe an understanding of the process would have allayed many of my concerns about malpractice.

Although each state is unique in its requirements to file a malpractice claim against physicians, there are generally four elements a plaintiff must prove to successfully recover in a malpractice claim against a physician. Individual states may have additional requirements. A medical malpractice attorney in your state will be able to verify that these requirements are also met.

A medical malpractice claim essentially means there is an allegation that a physician’s care and treatment of a patient was negligent and that the physician’s negligence caused harm to the patient.

Distilling this down into legal terms, the four elements in a malpractice claim are: 1) the physician must owe a duty to the patient, 2) the physician must breach that duty, 3) the breach must be the cause of the harm alleged, and 4) the patient must suffer damages. To prevail, a plaintiff must show that all four elements exist. If the plaintiff fails to prove any one of the four elements, the entire claim fails.

Duty: Courts universally will find a duty from a physician to a patient whenever a doctor-patient relationship existed. In general, it is not difficult for the courts to find the existence of a doctor-patient relationship for the majority of our routine patients. However, in most states, the law carries the notion of doctor-patient relationship further than just this traditional one. For example, an ophthalmologist taking call for another ophthalmologist
who provides only phone advice to a patient may have established a doctor-patient relationship without ever having seen the patient. Additionally, the courts in some states have found a doctor-patient relationship existed, and therefore a duty to the patient, between an on-call attending physician for the care and treatment provided by interns and residents without direct attending contact with the patient. Similarly, this duty can be argued to extend to physician extenders providing care and treatment to patients that physicians did not personally see.

In this context, the courts find an independent duty of a physician who did not physically evaluate the patient rather than vicarious liability of a physician for the actions of another he or she supervises.

**Breath of duty:** The plaintiff must prove the physician breached the duty of care to the patient. This essentially means proving the physician failed to meet the applicable standard of care. The requirement to prove a breach in the standard of care varies from state to state, but in general requires a showing that the physician either did something a similarly situated physician practicing reasonable medicine would not do or did not do something a similarly situated physician practicing reasonable medicine would do under similar circumstances. Some states include alternative ways to demonstrate negligence. For example, in North Carolina physicians can be negligent if they did not use their “best judgment” or if they failed to use “reasonable care and diligence” in the care provided to a patient.

To determine whether the standard of care has been met, courts look to many different sources. Most often standard of care issues are decided by expert witness testimony by a physician in the same specialty as the defendant—an ophthalmologist testifying against another ophthalmologist.

However, some states permit physicians to serve as expert witnesses against a physician of another specialty if the procedure at issue is one the other specialty also performs. For example, it is possible that a plastic surgeon could qualify as an expert witness for or against an ophthalmologist if the claim against the ophthalmologist alleges negligence in the performance of blepharoplasty as long as the plastic surgeon performs blepharoplasty as well.

The specific qualifications of expert witnesses vary from state-to-state but challenges to expert witness qualifications should be argued when possible.

Other sources often considered by the courts and juries to determine whether the standard of care was breached include violations of hospital or office policies, procedures, and protocols; violations of practice guidelines or protocols published by leading organizations in the field (for example, Preferred Practice Patterns published by the American Academy of Ophthalmology); and treatment that differs from recommendations in textbooks and authoritative journals in the defendant’s specialty. Generally, none of these will conclusively establish a breach in the standard of care, but often require the defendant to explain why he or she deviated from the policy, procedure, protocol, or guideline. These documents are most often used to bolster the opinion of a retained expert’s opinion rather than as stand-alone evidence of a breach in the standard of care.

**Causation:** It is not enough to prove that a duty existed and the physician breached that duty and violated the standard of care in performing that duty. The plaintiff must also prove the violation in the standard of care caused harm to the patient. In other words, there must be a causal link between the breach of the standard of care and the damages alleged.

For example, consider insertion of the incorrect IOL power in which a patient is left with unintended monovision. The patient refuses an IOL exchange (pleased with the monovision outcome). Subsequent to the cataract surgery, the patient develops CME—a known non-negligent complication of perfectly performed cataract surgery. The court or jury may find there was a breach in the standard of care (“breach of duty”) for insertion of the incorrect IOL power despite this being one of the most commonly reportable preventable ophthalmologic errors.

Even so, there is no causal link between the breach (insertion of the incorrect IOL power) and the alleged harm (CME). As such, there will be no recovery under this circumstance because the breach did not cause the patient the harm complained of. On the other hand, if it was determined there was a breach in the standard of care for failure to diagnose herpes keratitis and the patient subsequently requires a corneal transplant due to the scarring, it should be easy to link up the breach in the standard of care (failure to diagnose) and the damages alleged (corneal transplant).

**Damages:** If the court or jury finds a duty existed, that a breach of the duty occurred, and the damages complained of were caused by the breach of duty, then the plaintiff only has to show the value of the damages. The courts will consider both economic and non-economic damages.

Generally included in economic damages are the costs of additional medical treatment to attempt to correct or mitigate the damages stemming from the negligent act, future medical expenses associated with

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treatment as a result of the negligent act, low-vision devices and training where applicable, and lost wages both for the initial corrective procedures as well as all subsequent procedures.

Lost wages can be significant if the vision loss associated with the negligence does not permit the patient to return to his or her usual occupation or makes it impossible to work at all. Fortunately many states cover many services for the blind so often times the economic damages in complete blindness claims are less than would be expected. Non-economic damages include pain and suffering and punitive damages.

Depending on the severity of the vision loss (considering whether the loss was unilateral or bilateral, what the residual usable visual acuity is, the age of the patient at the time of the negligence, etc.) the pain and suffering damages in ophthalmology claims can potentially be extremely high. Rarely are punitive damages recovered in malpractice claims unless the plaintiff can prove there was evidence of willful, wanton, and reckless disregard in the care of the patient.

Summary: Although in most states any patient can file a claim against any physician, the plaintiff bears the responsibility of proving a doctor-patient relationship existed, the physician breached the duty to the patient by violating the applicable standard of care, the breach of duty caused harm, and the value of the damages alleged.

In upcoming articles of “Seeing eye-to-eye,” I will discuss methods to decrease your risk of being sued, methods to increase your chances of being dismissed from a suit sooner rather than later, the life of a malpractice claim, the defendant physician’s responsibilities during the litigation process to obtain a better outcome, deposition tips, as well as guidance if you elect to serve in the capacity of an expert witness. If you are interested in a particular legal topic you would like discussed in this forum, please contact me and I will be happy to address it in future issues.
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