

Combining the Best Clinical & Financial Considerations for a *Winning Practice*



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Informative Tools for Cataract Treatment

Technologies that provide fast and accurate data guide key treatment decisions.

BY FAISAL HAQ, MD

One of the most important aspects of professional growth for ophthalmologists involves the adaptation of technology. Cataract surgery in particular has been completely revolutionized over the past two decades due to numerous technological advances. New surgical techniques, better IOLs and increasingly sophisticated diagnostic equipment have all contributed to the cataract surgery revolution. With the advent of the baby-boomer era, the demand for our services and the demands of our patients for precision will only increase. We all face the challenge to provide top-notch eye care while retaining efficient processes. Once again, technology has come to the rescue.

I work in a practice with multiple office locations where we see several hundred patients a day. The technologies that we've invested in have enabled us to not only provide ever-improving patient outcomes, but have also been instrumental in optimizing our efficiency and improving our patient flow. The EPIC refraction system (Marco) has been a key addition to our practice that has helped us achieve this improved quality of care while simultaneously improving our efficiency. We purchased our first EPIC system 8 months ago and were so impressed with it that we added a second unit 3 months later. The system, comprised of the TRS digital refractor and the integrated OPD-Scan III (Marco) component, gives us a reliable, fast refraction as well as a detailed corneal analysis that aids us in multiple ways in the pre- and post-operative management of cataract patients.

Refraction and Pre-Op Exam

The EPIC system allows our technicians to obtain an accurate refraction in 2 to 3 minutes. The OPD takes about 30 seconds for autorefractometry, keratometry, pupillometry, corneal topography and wavefront aber-

rometry. Additionally, if the patient has a glare complaint, we can perform a quick glare test with the EPIC system that takes another 30 seconds.

With the data obtained by the EPIC system, we can quickly access information that is useful in determining a patient's need and eligibility for cataract surgery or for a YAG capsulotomy. In addition, the OPD device provides me with a wealth of information that I can use to determine a patient's eligibility for a specific type of IOL. For example, if the corneal aberration profile shows significant higher-order aberrations, I won't recommend a multifocal lens. Also, if the OPD shows a high angle kappa, I will be less likely to implant a multifocal lens due to difficulty centering the lens over the visual axis. The OPD also allows me to separate the aberration profile of the cornea from the lens. It's helpful to show patients the degree of their aberration coming from their cataract versus that originating in other parts of their eyes.

Some patients require "fine tuning" post operatively with laser refractive surgery to achieve the desired refractive outcome. With the OPD axial corneal topography, I can determine patients' eligibility for laser vision correction. If they're not good candidates, I can have a candid discussion with them regarding their potential final outcomes.

Glare Testing

Consistent, reliable and reproducible data derived from the glare testing feature on the EPIC unit aids in determining a patient's eligibility for either cataract surgery or YAG laser capsulotomy. Previously, we used the Brightness Acuity Tester (BAT, Marco) to measure the degree of glare related impairment in our patients. We found that there was significant technician- and patient-related variability with this test. With the EPIC glare test, the patient and the doctor can both

An OPD-Scan III Q&A

By Mitchell A. Jackson, MD, Medical Director of Jacksoneye in Chicago and Lake Villa, Ill.

Q Does the OPD-Scan III help you choose the right IOL?

"I often speak on the three 'hidden threats' to patients' satisfaction with their IOLs: pupil size, spherical aberration, and angle kappa. The OPD III measures photopic and mesopic pupil size, wavefront data to 9.5 mm, and angle kappa in easy-to-interpret mm or degrees, all in a single, fast sitting 20 second bilateral diagnostic evaluation. With this data I will know if I should insert a multifocal lens based on angle kappa data as I presented at the recent ESCRS meeting in Milan, Italy. I can select a lens implant based on spherical aberration data as well. I have all the data I need to choose the most appropriate IOL implant based on OPD III data, which relates directly to satisfied patients after surgery."

Q Do you use the OPD to educate patients?

"One great way to use the OPD III is to show a patient a map of the astigmatism created by both the lens and the cornea, and then easily demon-

strate in the exam room what corneal astigmatism will remain by removing the lenticular portion during cataract surgery. The OPD III graphic in this setting saves a lot of chair time especially when trying to upgrade a patient to a toric IOL implant. I basically tell the patient, 'After we remove your cataract lens, we need to correct this remaining corneal astigmatism. We could do it with glasses or a toric lens implant.'

Q Using one multipurpose device is efficient. Is there a clinical advantage?

"In addition to pupil size, spherical aberration, and angle kappa, the OPD III performs blue light corneal topography and measures lenticular astigmatism, and it only takes 20 seconds for both eyes. That helps patient flow, but it also means we get greater accuracy. With older (especially less mobile) and/or dry eye patients, using multiple devices can dessicate the ocular surface and eventually compromise the accuracy of later diagnostic tests. In contrast, most patients are fine with keeping each eye open for 10 seconds with the OPD III."

quickly ascertain how much impairment a patient faces when exposed to glare in real-life situations. We're in a better position to determine the level of impairment that the patient faces due to glare, and this allows us to make better clinical decisions regarding the need for cataract surgery or for YAG capsulotomy.

Post-operative Assessment

I perform an OPD and EPIC refraction on all of my patients that have a presbyopia-correcting lens or a toric IOL. Beyond the obvious refraction and topography data, the OPD provides an aberration profile that separates the cornea from the lens. That way, if a multifocal IOL patient is having difficulty with his vision, I can quickly determine if there are any significant aberrations present in the IOL itself (for example if there is subtle lens tilt or decentration) or if the problem is purely refractive in nature. This information helps me decide between an IOL exchange or laser refractive surgery.

Similarly, for a Crystalens (Bausch + Lomb) patient, if there's significant astigmatism that is lenticular in nature, I very carefully look for any asymmetric vaulting that may need to be corrected prior to any consideration of laser refractive surgery. For patients with a toric IOL, I can quickly assess the level of their

corneal astigmatism and compare this to the level of lenticular astigmatism. In an ideal case, the two numbers should be similar in magnitude and exactly 90° away from one another.

A Wise Investment

The EPIC system provides our practice with a diagnostic tool that helps not only to improve our clinical outcomes, but also improves our patient flow and overall efficiency. It's an investment that we feel easily pays for itself. Patient wait times have been reduced, we're seeing more patients than before and we're performing more surgery than we did in the past. Also, a larger percentage of our patients are choosing presbyopia-correcting lens implants because we're able to actually show them the results of their OPD scans and talk to them about customized lens choices based on their unique eyes. The dual clinical and financial benefits of this technology have made it an integral part of the pre-operative and post-operative management of our cataract patients.

Faisal Haq, MD, specializes in cataract, vision correction surgery, corneal disease and glaucoma management at Key-Whitman Eye Center in Dallas and Plano, Texas.



Clinical Advantages of the OPD-Scan

When a high level of evaluative technology becomes routine, outcomes for cataract and LASIK surgeries improve.

BY JAMES J. SALZ, MD

Imaging and diagnostic technologies continually expand our understanding of ocular pathologies. In just a few minutes, we can get more information than ever before about the state of our patients' eyes. The OPD Scan system (Marco) is just such a device, providing refraction, corneal topography, optical path difference and wavefront analysis in one brief sitting.

The data, including mapping and other analyses, help us diagnose patients and make treatment decisions, particularly for patients who are candidates for cataract surgery or laser vision correction. The visual nature of the reports also illustrates the situation for patients, which means their treatment makes sense to them and they know what to expect in terms of outcomes.

Clinical Advantages

The OPD helps me achieve the desired outcomes for both cataract and laser refractive surgeries. Before I choose an IOL or decide on limbal relaxing incisions, I need answers. Does the patient have astigmatism? Is it corneal or lenticular? Is it symmetrical or asymmetrical? What size is the pupil? Are there corneal aberrations?

The OPD answers these questions. For example, if a patient has astigmatism, I can plan to use a toric implant or limbal relaxing incisions with the femtosecond laser. Because the system arms me with all the relevant information, I'm very confident about my IOL choices, and outcomes are excellent. Patients pay a premium for a premium lens, and they are happy with their resulting vision. The technology helps me achieve that primary goal of surgery.

When it comes to laser refractive surgery, the OPD's routine refraction helps me identify candidates. If a patient is a candidate and has an interest, we also collect data on the patient's higher-order aberrations (spherical, coma, trefoil and tetrafoil). The device's ability to measure pupil size is as important for these patients as it is for those undergoing cataract

surgery who want multifocal IOLs. The instrument also has a printout that's specifically for LASIK, so it's convenient for my evaluation and for carrying into surgery.

Teaming with Patients

The OPD lets you educate patients graphically, bringing abstract or complex concepts firmly into their grasp. And when patients and surgeons are both on the same page, we can all work toward the same goals.

For example, it's most impressive to show patients what their astigmatism looks like on the topographic map. Because they can visualize the astigmatism, they have an easier time understanding the decisions related to the problem. I explain the effect that the treatment will have, so they can see why we need to use a toric lens, or why we'll use a multifocal lens and correct the astigmatism with limbal relaxing incisions.

The system also lets me show patients a map of the aberrations in their visual system. They see how much spherical aberration they have, and I explain what that means in terms of halos and glare, which helps us agree on an appropriate treatment.

After cataract surgery in which we've successfully corrected astigmatism, it's nice to show patients the difference in the pre- and post-op topography. They can see how the aspheric lens has reduced spherical aberrations. With a toric lens, they can see how astigmatism is still present in the cornea, but the lens negates the total astigmatism. Patients understand and appreciate just how effective their surgery was.

Although much of this data was available before the OPD-Scan, it required us to move patients between four different instruments. The system makes it practical to routinely use this high level of testing.

James J. Salz, MD, is clinical professor of ophthalmology at the University of Southern California and President of Laser Vision Medical Group in Los Angeles.



Time, Money, and the Patient Experience

Top technology purchases meet three strategic goals, while delivering a distinct clinical advantage.

BY ERIN MURPHY, CONTRIBUTING EDITOR

Feeling today's economic pressures and facing changing regulation, ophthalmologists have been forced to find ways to increase their practices' profitability. There are many ways to approach this, including some relatively simple changes with major benefits.

Dr. J.C. Noreika, the managing partner of Excellence in Eyecare in Medina, Ohio, has taken a very straightforward approach. "I'm one of my practice's revenue generators. The more tasks I can delegate, the more energy I can expend on high-level, well-compensated work and the more profitable the practice will become. New technologies like the EPIC make this possible," he says. "I purchased the EPIC because it offers sophisticated clinical advantages while meeting my three strategic criteria for evaluating the purchase of new technology. The results have been rewarding and can be replicated in other practices."

Achieving the Big 3

Economic pressures make purchasing decisions weightier than ever. Dr. Noreika approaches his decision with a concrete set of criteria in mind. "For new technology to justify investment, first and foremost it must improve patient outcomes compared to our existing devices," he says. "Beyond that clinical advantage, the investment only makes sense if it meets three measurable objectives: it saves time, saves money and enhances value and satisfaction for the patient."

According to Dr. Noreika, the EPIC improves outcomes and it excels at all three goals. The clinical advantages include not only very accurate refractions, but also enhanced data for diagnosis, surgical decision-making and post-operative evaluation.

It's clear to Dr. Noreika how the EPIC saves time and money. "We use it on all new patients, saving time over manual refraction. Surgical workups also take less time because patients are afforded a variety of tests at a single workstation. The need to move

patients, a measurable source of wasted time, is kept to a minimum," he explains. "Money is saved in many ways with the EPIC – most notably in time saved and the ability to use staff with less expertise to perform the straightforward yet sophisticated procedure."

The EPIC also meets Dr. Noreika's third goal, enhancing the patient experience with the technology's "wow factor." When people come in for their exam and see the EPIC, they recognize that the practice embraces cutting-edge technologies. This helps differentiate it from the competition, particularly commercial vision care providers. Dr. Noreika finds that this also results in referrals, as patients tell their family and friends. In this sense, the EPIC is part of the practice's internal marketing efforts. It impresses patients and attracts new customers through word-of-mouth without the added cost of media advertising.

Opticians Performing Refractions

"Staffing is my largest cost center," Dr. Noreika observes. "Cross training is a way to make the most of that cost by enabling staff to work where they're needed during periods of downtime or when a coworker isn't available. The ease of training and use of the EPIC has allowed me to take cross training to a new, more profitable level."

Dr. Noreika has trained all three opticians in his practice to perform refractions with the EPIC, a task which they have readily adapted because of their familiarity with optics. By performing the refraction, the opticians have an unprecedented opportunity to "own" the vision correction process from start to finish. They spend about 10 minutes preparing the patient and performing the EPIC refraction – 10 minutes in which they also establish a relationship and identify the patient's vision needs. Next, they hand the patient over for the clinical examination, and then reunite afterward to transition to the optical area.

By guiding the patient through the entire visit,

Dr. Noreika has found that the opticians significantly enhance the capture rate. At a time of decreasing reimbursement for clinical services, it's an enormous benefit to grow the dispensary's economic contribution in this way. Patients benefit as well because the opticians better understand their individual needs. For example, one optician is dedicated to refracting all post-operative cataract patients, walking them through the process, from determining their optical needs, performing the EPIC refraction, selecting frames and lenses and finally to dispensing a product.

"The role of our opticians has become a key piece of the practice's efficiency," states Noreika. "I'm surprised I didn't implement this sooner, but I couldn't have cross-trained opticians to do this with a manual phoropter. The EPIC creates this valuable opportunity while reducing the dependence on hard-to-find, highly

"The ease of training and use of the EPIC has allowed me to take cross training to a new, more profitable level," says Dr. Noreika.

compensated technicians and optometrists who had performed our refractions in the past."

Another advantage of this model is an increase in the opticians' job satisfaction. According to Noreika, other personnel who are cross-trained on the EPIC like their jobs better, too. "One of my most important staffers who had more than 20 years vested in our practice needed a change from her administrative role. She is now our best refractionist. Her work has been revitalized, and rather than losing her, I gained an asset."

Premium Expectations

Another challenge facing ophthalmologists in all areas of practice is the entwined nature of technology and expectations. For example, cataract patients have far more choices today than they did even 10 years ago. Standard, toric and multifocal IOLs and limbal relaxing incisions have the potential to deliver unprecedented vision after surgery. Therefore, patients expect to be wowed by their vision after surgery, and they don't want to encounter unforeseen issues. The high out-of-pocket price tag for premium IOLs cements those expectations. There is little margin for error.

Dr. Noreika has found that the EPIC is critical for patients who choose premium IOLs because the pre-operative workup leaves little room for error. An accurate refraction, corneal topography and wavefront analysis, combined with accurate A-scan axial length ultrasonography and OCT help him achieve the best outcomes.

To balance the clinical advantages of technology against its cost, the practice prequalifies patients for premium IOLs. "When we identify the need for surgery, we give patients a thumb drive that explains their premium lens options, the processes involved, and the cost. Our senior citizens have become digitally adept; they review the information at home and share it with family," says Dr. Noreika. "Once a patient's interest in a premium lens solution is determined, their decision guides the next step in the process."

At the cataract surgery workup visit, patients with an interest in premium lenses follow one protocol while patients who want standard lenses follow another. For example, premium lens patients get an OPD scan and more time for face-to-face discussion with the doctor.

The high standards for outcomes change the post-operative model as well. In Dr. Noreika's practice, opticians perform the post-op refraction, directing both premium and standard lens implant patients through the EPIC and the OPD, and then meeting up to assist the patient in the optical dispensary after the clinical exam.

Dr. Noreika says that this post-op visit is a key juncture in ensuring patient satisfaction. "The last thing I want is to perform successful surgery and then have the patient experience issues with their eyeglasses," he says. "If eyeglasses are required after cataract surgery, our office will supply them, which means the limiting variables are the quality of the refraction, the selection of frames, the lenses and their fitting. The EPIC and the opticians remove these question marks. And I avoid the expensive proposition of spending 20 minutes listening to a patient who has eyeglass problems."

Positioned for the Future

In addition to its significant clinical and financial benefits today, the EPIC is a keystone of Excellence in Eyecare's strategic plan for future profitability. Dr. Noreika says that the Affordable Care Act means that vision care providers will have to accommodate many more patients, while the newly insured patients will be younger and healthier because older patients already have health insurance through Medicare.

"The EPIC is an excellent fit for this situation. Not only does it help us see more patients efficiently, but the refraction is quickly performed on those younger patients. At the same time, this patient cohort embraces technology and has high expectations. The EPIC excels here as well," he says. "All in all, I know that the EPIC has meaningful clinical and financial advantages today. I'm confident that it will be increasingly useful in a changing and unpredictable healthcare environment."



Cover Costs Using an ABN

Collect a fee for the OPD-Scan III test, boost conversion rates, and create positive word-of-mouth referrals

BY CYNTHIA MATOSSIAN, MD, FACS

When I purchased the OPD-Scan III (Marco), I realized from the start that I wanted to use this technology on every patient scheduled for cataract surgery. I knew that without the data it provided, I couldn't accurately and consistently match the IOL to each patient.

However, Medicare and other insurance carriers don't cover the OPD III test, so I needed a way to generate compensation from my patients to cover the cost of the equipment and the cost of my technicians performing the test. I worked with the folks at Marco, who suggested charging a fee that was determined by combining cost and patient volume. From day one, I had no problem getting patients to accept this fee, and I've always had them sign an Advance Beneficiary Notice of Noncoverage (ABN) form to ensure that I can bill them for payment.

The result: An indispensable clinical device that pays for itself.

Getting the ABN Signed

The key to getting virtually all of my patients to accept my fee for the OPD III, \$90.00, is in getting them to understand the importance of the test and how it will benefit them. To do this, I stick to a very simple process with every single candidate for cataract surgery.

At the time of the cataract consult, if there is a visually significant cataract and if the patient and I agree that cataract surgery would be beneficial, I explain that he will need to return for biometry and a variety of additional tests, one of which is the OPD III. These tests are scheduled several weeks later, giving me time to optimize the patient's ocular surface.

Moreover, I explain to the patient that the OPD III is not covered by insurance; the test has a \$90.00 out-of-pocket cost for both eyes. (I emphasize that the cost is not \$90.00 per eye). In addition, I hand the patient an information sheet on the OPD III. I review how the

data are essential in helping me customize the IOL to each of the patient's eyes in order to obtain the best possible visual outcome. I also stress that without the data, I can't select the best IOL.

I explain that patients don't need to pay this fee until their next appointment. I then ask the patient to sign the ABN. Because the ABN gets signed at the cataract consult visit, my staff and I don't need to reopen that discussion at the biometry appointment.

This whole interaction takes less than 1 minute. It's very successful; in a year, about two patients decline the test. Because my patients understand the importance of the OPD III for their visual outcome and they have lead-time to get their payment ready, they don't object to the \$90.00 fee.

Reinforcing the Test's Value

When I have all the information from the OPD III, I display it on a large-screen monitor in the exam room to show my patients and their families. Not only is there a huge "wow factor," but the display also allows me to demonstrate to patients the value of their out-of-pocket payment. I always say, "This is the \$90 test," as I point to the information from the OPD III. This reaffirms that although the test costs some money, it's an integral part of their surgical planning.

Because I give patients this visual explanation, pointing to the various displays that help me choose a toric or multifocal lens, my conversion rate is very high. We're not talking about abstract concepts; we're looking at tangible images and reports that prove premium lenses will deliver better outcomes. For example, I can get many more patients to understand astigmatism by showing them the "bowtie" in a graphic display than I ever could by explaining this difficult concept verbally. My patients visualize their astigmatism and agree to a toric lens.

Patients verify for themselves that they're candidates for premium IOLs such as torics, multifocals or accommodative lenses, or a procedure like a limbal

relaxing incision. This makes them more confident in following my recommendation. The higher conversion rate to out-of-pocket procedures is another way that the OPD III creates additional revenue.

Implementing the ABN

Offering advanced technology such as the OPD creates added revenue opportunity. If the test isn't covered by insurance, the only way to charge is out of pocket. And the only way to charge Medicare patients out of pocket is to have them sign an ABN in advance, accepting responsibility for payment.

I follow my plan religiously with every patient, explaining the importance of the test, the fact that there is a fee and the Medicare requirement that they must sign an ABN form for any out-of-pocket fee. As I'm having the discussion, a technician hands me the form. I initial it, and the patient signs as well. The whole process adds less than a minute to my cataract consultation. When patients return, the form is already in their chart, and we proceed with the test and charge the fee.

Unlike some of my colleagues, I don't selectively use the OPD-Scan III; I use it for every cataract surgery patient. When I present this model for using an ABN to colleagues, I think that some are hesitant because they aren't familiar with the form. It's very simple when you make it a scripted part of your cataract consultation. It's also an absolute requirement of Medicare. With this model, we have very satisfied patients with outstanding surgical outcomes who become our goodwill ambassadors.

How the OPD III Pays for Itself

Fee: I charge patients a fee for the test. Virtually no patient objects to the fee; I have them sign an ABN during the consult to be sure that I can bill for it after the exam.

Conversion rate: The OPD III has increased my conversion rate for premium IOLs. I use it to help patients visualize conditions such as astigmatism and show them the information I'm using to select the best IOL for them. This boosts their confidence in my choice, and as such, more of them go with the recommended IOL.

Word of mouth: Because I use the OPD III, I'm able to customize the best IOLs for my patients. I also use the information to ensure that patients with pre-existing conditions don't mistake these problems as results of surgery. Consequently, patient satisfaction is very high, and patients tell their friends and families.

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