The Reward
For Getting It Right

• 2003 AAO: first course on Crystalens
• Now 75% of implants are presbyopia-correcting IOLs.
• Patients refer patients who insist on having premium implants!

What This Course Will Teach You
1. Get Organized—Paul Stubenbordt
2. Educate, Don’t Sell—John Hovanesian
3. Give the Patient What He/She Wants—Ralph Chu
4. Questions and Answers

Hovanesian, 2009

Hovanesian, 2009

Hovanesian, 2009

Hovanesian, 2009

1. Believe in the Technology
   • Take the hesitation out of your voice
   • Spend time with every patient discussing premium implants.

2. Understand the Importance of the Discussion to the Patient

Everyone Must Be On Board
• Receptionists
• Technicians
• Counselors/schedulers
• Opticians
• Physicians

Patients Expect More, So Ask Yourself…?

Am I Ready For the Fully Monty?
• Believe in the technology
• Commit to radically new results.

How to Put Your Foot in Your Mouth…?
Mr. Jones, how do you feel about wearing glasses?
3. Let the Doctor Do as Much Educating as Possible

4. Understand the Patient’s Perspective

What they don’t know CAN hurt them!

3 1/2 Patients and what they take for granted...

Myopes: near
Hyperopes: distance
Emmetropes: distance and near

You will need glasses to read
You will probably need glasses for distance
You may need glasses for everything

5. Offer More than One Type of Implant, But Talk About Only the Implant You Recommend

Current
Future

Don’t mention brand names
Don’t overload with information

Patients think, “I want the best for my eyes.” So tell them what’s best.

6. Keep It Simple

- How good are they?
- How long do they last?
- What are the downsides?

Introduce the Subject

Over the past 5 or 6 years cataract surgery has changed to a new standard—using implants that dynamically focus inside the eye. Unlike the old lenses, these correct not just your cataract but your vision as well.

How Good Are They?

- 90% of people can pass a driver’s test without glasses and 90% can read newsprint without glasses, and that’s just amazing.
How Good Are They?

• You might need glasses to read a medicine bottle or the phone book, and that’s ok.

Most people can do most things most of the time without glasses.

Compare to “Old Fashioned” Implant

• When you’re comparing to perfect, you’re going to be disappointed, whether it’s your lens implant, your car, your computer, or your spouse.

• If you compare to an old-fashioned implant the difference is huge.

How Long Do They Last?

• Testing has shown that vision continues to improve for at least seven years.

• If you’re not completely happy at month 1, with more time you may be completely happy.

7. Be Clear and Unapologetic About Limitations

If you tell a patient about a complication before it happens, you’re a genius. If you tell them afterwards, you’re making excuses.

-Dave Bogorad, MD

8. Be Clear and Unapologetic About Price

“Be clear and unapologetic about price.”

Explaining Cost

• The biggest costs are covered by your insurance, including the operating room, anesthesia fees, fees for my surgery, nursing, supplies. All those add up to about $400 per eye, covered by insurance.

• Adding a high-tech implant adds about $1000 per eye that is not covered by any insurance.

• It’s optional. Not everybody can afford this. About 3 out of 4 of our patients do choose these implants, and our staff can tell you about financing options that make it as affordable as a few dollars a day.

9. Tell What You Would Do For Your Sister (assuming that you like your sister)

• I’m perfectly happy to give you whatever implant you’d like.

• It’s a decision that’s going to affect your vision for the rest of your life, so you need all the facts.

• People ask me what lens I would choose for myself, there’s no doubt in my mind...

• If you can afford it, this is something you really should have.
10. Follow-up on the Discussion

Misinformation comes from all directions and can derail what the patient really wants.

Thank you!

John A. Hovanesian, M.D.
hovanesian@harvardeye.com
(949) 981-2020
Modern Cataract Surgery: Secrets for Technical Success & More

David R. Hardten, M.D.
Minneapolis, Minnesota

Have done research, consulting, or speaking for:
Allergan, AMO, Bausch & Lomb, Alcon, AlconVision, CIBA-GEI, ESI, Ocular, Quantel, TCOI, Topcon

Some of the information may represent off-label uses of approved drugs or devices.

D.R. Hardten, M.D.
www.mn-eye.com
Ph: 612-813-3600    Fax: 612-813-3636

Ask Questions

Randomize to consider:

1. I don't care
2. Really want your best effort at Distance
3. Distance w/Astig
4. Distance and Near

D.R. Hardten, M.D.

Think One Step Ahead

Chess game especially with presbyopic IOLs!
- Always try to think/anticipate several moves ahead of the patient
- Perform surgery on dominant or worst eye first
- Allow recovery in less than 1 week
- Maximize speed of recovery (cool phaco, viscoelastic, posterior chamber phaco, NSAID)
- Have a plan for unhappy patients
- Time Enhancements with LVC
- Time PCO management
- Address dry eye

D.R. Hardten, M.D.

Cataract Patient

Understand that even patients you don’t think should have a presbyopic IOL may have similar desires and also deserve a discussion about options.

- Diabetic with past PRP and focal laser treatment
- Wet ARMD in one eye, smoker, soft drusen and RPE changes in other eye
- Otherwise normal healthy eye
- One eyed patient with severe macular scar

D.R. Hardten, M.D.

Custom Cataract Surgery

>70% of patients have > 0.5 D of pre-op astigmatism

Critical to Address
For Good Uncorrected Vision

Hoffmann & Hatz
JCRS 2010;36:1479

D.R. Hardten, M.D.

Astigmatic Keratotomy

Only current option with Presbyopic IOLs

Same Nomogram
Femto-AK
Blade-AK

D.R. Hardten, M.D.
Astigmatic Keratotomy

Only current option with Presbyopic IOLs
Same Nomogram
Femto-AK
Blade-AK

Timing of Secondary Intervention
Astigmatism Correction after IOLs
Enhance large corrections earlier
Small corrections – wait longer
Typically I wait 1-2 months to do IOL Rotation or IOL exchange for large corrections
Typically I wait 3-6 months to do laser vision correction
Capsule considerations – contraction or PCO
Yag first in many patients

Residual Astigmatism after Toric IOL
Questions to Ask
1. Is it Regular or Irregular?
2. Is the Spherical Equivalent where you want?
3. Is it correctable by rotation of the IOL?

- Example: SN6AT5 at 150 degrees
  WSR: -2.69 + 4.05 x 90
  MR: -2.00 + 3.00 x 95 = 20/40-
  HOA: 0.46 µ @ 4.75mm pupil
  Humphrey Astig 4.12 D at 80 degrees
Irregular Astigmatism

SN-4AT5 at 150 degrees
Pentacam Astig 2.3 D at 54 degrees
MR: -2.00 + 3.00 x 95 = 20/40-2
WSR: -2.69 + 4.05 x 90
Humphrey Astig 4.12 D at 80 degrees

Options – Irregular Astigmatism

Toric after RK - Options?
- Rotate Toric based on Refraction
  (to 115° = 0.94 D x 115)
  [www.astigmatismfix.com]
- Rotate Toric based on Wavescan
  (to 106° = 1.45 D x 106)
- Easier to rotate based on change of position
  Change from 150 to 115 is 30 degrees clockwise
  Perform totally based on intraoperative analysis for best accuracy
- Remove toric IOL (baseline astig of eye likely 3.5 to 4 D)
- PRK? (only 4.75 mm capture) – Might be useful for irregular component
- Exchange IOL for higher powered toric?

Occasionally Confusion on Preop Axis

Management of Regular Astigmatism Example

Preop Sleep Axis OD
K's = 101°
Pentacam = 113°
Humphrey Topography = 101°
IOL Calculator suggests
100° based on K and topo
113° based on Pentacam
Placed at 108°
- Postop at 108°
- Residual refraction: -1.75 + 1.75 x 150
- Residual Wavescan: -1.64 + 1.75 x 133

Options – Regular Astigmatism

Residual Astigmatism after Toric - Options?
- Rotate Toric based on Refraction
  (to 100° = 3.6 D x 102)
- Rotate Toric based on Wavescan
  (to 107° = 1.26 D x 116)
- Easier to rotate based on change of position
  Change from 108 to 120 = 12 degrees counterclockwise
  Perform totally based on intraoperative analysis for best accuracy
- Remove toric IOL (baseline astig of eye likely 3.5 to 4 D)
- PRK? (only 4.75 mm capture) – Might be useful for irregular component
- Exchange IOL for higher powered toric?

Toric IOL Rotation Procedure

Moving from Axis 108° to 120°
Rotate
12° Counterclockwise
168° Clockwise
- UCVA = 20/20
-0.50 + 0.50 x 116
Illuminating Surgical Keratoscope
Helpful for axis identification

Residual Sphere and Cylinder
After Toric IOL
PRK or LASIK
Wavefront usually possible

Post-Operative Management
Laser Vision Correction: Off Label
- PRK
  No issues with prior LRI incision
- LASIK
  May be issues with prior LRI
  More rapid recovery

Timing of Secondary Intervention
Multifocal IOLs
- Enhance large corrections earlier (piggyback or IOL exchange if very large)
- Small corrections – wait longer
- Typically I wait 6 months to do laser vision correction
  Capsule considerations – contraction or PCO
  Yag first in many patients
- Typically I wait 1-2 months to do piggyback or IOL exchange for large corrections

Results
All Patients with Presbyopic IOL
402 eyes of 252 patients
Prior CRS
60 eyes of 43 patients
Mean follow-up: 22±14 mo
Enhancement
10 eyes (16.7%)
No Prior CRS
342 eyes of 209 patients
Mean follow-up: 23±17 mo
Enhancement
56 eyes (16.4%)
No Enhancement
286 eyes (83.6%)

Type of Enhancement | # Eyes
--- | ---
LASIK | 46
PRK | 13
EpilASIK | 2
Laser | 1
Refas | 1
Exchange for different IOLs | 1

Post-Operative Management
Laser Vision Correction: Off Label
- PRK
  No issues with prior LRI incision
- LASIK
  May be issues with prior LRI
  More rapid recovery
- IOL rotation in toric IOLs – usually minimal effect if close to correct axis

Results
All Patients with Presbyopic IOL
402 eyes of 252 patients
Prior CRS
60 eyes of 43 patients
Mean follow-up: 22±14 mo
Enhancement
10 eyes (16.7%)
No Prior CRS
342 eyes of 209 patients
Mean follow-up: 23±17 mo
Enhancement
56 eyes (16.4%)
No Enhancement
286 eyes (83.6%)

Type of Enhancement | # Eyes
--- | ---
LASIK | 46
PRK | 13
EpilASIK | 2
Laser | 1
Refas | 1
Exchange for different IOLs | 1
**Results**

Over 25% capsulotomy rates in these very demanding patients

**Continue Understanding Listening Learning Postoperatively**

**Management**
- Decreased BCVA
- YAG
- Treat Cystoid Macular Edema (OCT helpful)
- Treat Dry Eye
- Epiretinal Membrane
- Normal BCVA
- Glare/Halos – Trial in spectacles
- Residual Refractive Error – Trial in spectacles
- Tincture of Time
- Neuro-adaptation
- IOL Exchange

**Pearls for Success**

**Refractive IOL Practice**
- Keep in touch with the patient until you know they are happy
- Fix small issues for satisfaction
- Yag for mild PCO, PRK /LASIK for mild refractive errors
- Schedule follow-up
- Happiness breeds happy referrals
- Make each patient an ambassador for your practice
- Exceed their expectations

**Summary**

Understanding Needs of Refractive IOL Patient
- Learning about people takes true interest in them and time to learn about them
- Accept the fact that these needs/wants are real
- Patients want the discussion
- Understanding a patients needs helps you choose better patients for the trip through correction of presbyopia and astigmatism
- This helps you and your staff be more comfortable with the process of helping the patients achieve their goals
- Continue to assess their needs by listening, asking, understanding it then celebrating success through the process

Don’t be Afraid to Finally Admit Failure

Offer Removal of Presbyopic IOL if Needed
- Your brain may not be adaptable enough to make this work for you

Page 5
Secrets of Highly Successful Refractive Cataract Surgery Practices

Kevin J. Corcoran, COE, CPC, CPMA, FNAO
President, Corcoran Consulting Group

Financial Disclosure
Kevin J. Corcoran is President of Corcoran Consulting Group and acknowledges a financial interest in the subject matter of this presentation.

Key Points
• Define covered and noncovered services
• Adopt pre-testing strategy as a triage tool
• Charges are proportional to products and services
• Document financial responsibility
• Separate physician and facility
• Follow co-management best practices
• Follow ASCRS/AAO, CMS guidance for FS laser
• Provide choices, not a one-size-fits-all solution

Critical Distinction
• How does routine cataract surgery differ from refractive cataract surgery?

Critical Distinction
• Routine Cataract Surgery
  • Refractive Cataract Surgery
    • Also, addresses:
      • Astigmatism
      • Presbyopia

Covered by Insurance?
• Covered
  • Exam or consultation
  • Biometry
  • Surgery and postop
  • Conventional IOL
  • Facility fee
  • Anesthesia
• Not covered
  • Refraction
  • Tests for ammetropia
  • Refractive surgery
  • IOL upgrade
  • Added facility fee
  • Extended postop care
Covered vs. Non-covered

- Covered
- Follow insurance rules
- Not covered
- Patient pay

Refractive Cataract Surgery
Reimbursement Grid

<table>
<thead>
<tr>
<th>Covered</th>
<th>Facility</th>
<th>Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ophthalmology</td>
<td>Refractive科</td>
</tr>
</tbody>
</table>

Non-covered Preoperative Testing

- Refraction
- Corneal topography
- SCODI-A
- SCODI-P
- Wavefront aberrometry
- Contact lens trial
- Pachymetry

Coding and Claim Submission

- 92015-GY: Refractive error
- 92025-GAGY: Regular astigmatism
- 92132-GAGY: Prophylactic screening
- 92134-GAGY: Prophylactic screening
- 92015-22GY: Higher order aberrations
- 92310-GY: Refractive errors
- 76514-GAGY: Normal cornea

Noncovered Preoperative Testing

- Prior to first surgery, OU $564
- Prior to second surgery $0

- Alternately $282 per eye

For illustration purposes only
Advance Beneficiary Notice of Noncoverage (ABN)

- Option 1. I want the _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment...I can appeal to Medicare...
- Option 2. I want the _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal to Medicare...
- Option 3. I don't want the _____ listed above. I understand with this choice I am not responsible for payment...I cannot appeal to Medicare...

Notice of Exclusion from Health Plan Benefits (NEHB)

- Utilize NEHB for non-Medicare beneficiaries
- Beneficiary may not know that certain services are not covered by health insurance
- Item or services excluded from benefits
- May be customized

Medicare Advantage Organizations

- Do not use an ABN
- Notice of denial of coverage issued by MAO (similar to a preauthorization)
- Pre-service organization determination from the MAO
  - Patient requested
  - Provider requested
- Check with MAO plans on process

Modifier - GY

- Item or service statutorily excluded or does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit.
  
  Line 19 “Seeking denial for secondary payer”
  Line 19 “Cosmetic surgery exclusion”

66999-GY 367.21 Regular astigmatism

Medicare’s Policy
Presbyopia-Correcting IOLs

- “the facility and physician may take into account any additional work and resources required for insertion, fitting, vision acuity testing, and monitoring of the presbyopia-correcting IOL that exceeds the work and resources attributable to insertion of a conventional IOL”
- “the beneficiary requests this service”
- “The physician and the facility may not require the beneficiary to request a presbyopia-correcting IOL as a condition of performing a cataract extraction with IOL insertion”

Source: Transmittal 636

Patient Choices

- Conventional surgery, aspheric IOL
- Monovision
- Surgical correction of corneal astigmatism (SCOCA)
- Astigmatism-correcting IOL
- Presbyopia-correcting IOL
- P-C IOL + SCOCA

**Patient Choices**

- Aspheric IOL
- Monovision
- SCOCA, LRI, PRK, etc.
- Astigmatism-correcting IOL
- Presbyopia-correcting IOL
- P-C IOL + SCOCA
- Patient pay $0, NTIOL
- Small $ for noncovered tests
- Moderate $$
- Moderate $$ + Toric IOL
- Moderate $$ + P-C IOL
- Highest $$$$ + P-C IOL

**Deluxe IOL**

- Price of deluxe IOL $950.00
- Shipping, taxes, restocking + $50.00
- Payment for standard IOL* - $150.00
- Deluxe IOL charge $850.00

* Value of IOL imputed by contract with payer

---

**Surgeon’s Claim**

<table>
<thead>
<tr>
<th>21</th>
<th>366.16 Cataract</th>
<th>367.4 Presbyopia</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. 367.2 Astigmatism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24.a</td>
<td>24.b</td>
<td>24.c</td>
</tr>
<tr>
<td>MM/DD/YYYY</td>
<td>66984 RT</td>
<td>Cataract extraction with IOL</td>
</tr>
<tr>
<td>MM/DD/YYYY</td>
<td>66999 GY</td>
<td>Astigmatic correction</td>
</tr>
<tr>
<td>MM/DD/YYYY</td>
<td>V2788 GY</td>
<td>Presbyopia-correcting IOL</td>
</tr>
</tbody>
</table>

**Facility’s Claim**

<table>
<thead>
<tr>
<th>21</th>
<th>366.16 Cataract</th>
<th>367.4 Presbyopia</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. 367.2 Astigmatism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24.a</td>
<td>24.b</td>
<td>24.c</td>
</tr>
<tr>
<td>MM/DD/YYYY</td>
<td>66984 RT</td>
<td>Cataract extraction with IOL</td>
</tr>
<tr>
<td>MM/DD/YYYY</td>
<td>66999 GY</td>
<td>Astigmatic correction</td>
</tr>
<tr>
<td>MM/DD/YYYY</td>
<td>V2788 GY</td>
<td>Presbyopia-correcting IOL</td>
</tr>
</tbody>
</table>

**FS Laser Guidance**

- January 2012 ASCRS/AAO joint guidance
- Providers may not “balance bill” a Medicare patient or his or her secondary insurer for any additional fees to perform covered components of cataract surgery with an FS laser.
- The patient must be informed about, and consent to, the additional out-of-pocket-costs in advance.
- A refractive lens exchange is not medically necessary and therefore is not covered

* Source: ASCRS/AAO Guidance
FS Laser Guidance

• Patient-shared pricing with one cost for a premium IOL, and a higher cost for the additional use of the FS laser to perform the cataract surgical steps, should not be offered.
• Medicare patients may be charged a fee for performing astigmatic keratotomy, assuming that they were informed about, and consented to, the non-covered charges in advance.

FS Laser Guidance

• Because astigmatic keratotomy for refractive indications is a non-covered service, a higher fee can be charged for performing it using the FS laser, instead of with a metal or diamond blade.
• While most astigmatism treatment is not covered, Medicare does cover the treatment of large degrees of astigmatism that were the result of previous ocular surgery. Local coverage determinations may apply.

FS Laser Guidance

• Advertising: Promotional claims must be consistent with the best available clinical evidence and should not be deceptive or misleading to patients.
• Transparency: Patient-shared pricing should be discussed openly with the patient. Increased charges should be explained and documented.

ASC Buys IOLs

• Best practices entail ASC purchases IOLs from manufacturer
• Avoid giving the appearance of payment for referral between ASC and surgeon
• 2014, Memorial Hospital, Ohio – substantial fine when “an ophthalmologist purchased IOLs and then resold them to Memorial at inflated prices”

OIG Advisory Opinion: Co-management

• OIG publishes opinion on co-management involving non-covered services associated with premium IOLs
• Tightly worded favorable opinion

Co-management Best Practices

• Proper motivation consistent with professionalism
• Surgeon decides suitability for surgery
• Surgeon and patient discuss postop care options
• Co-management depends on what is best for patient
• Document patient’s choice
• Adhere to Medicare instructions
• Follow other third party payers’ policies
• Ensure fair market value for services performed
• Transparent billing so patient knows amount paid to each provider

Source: OIG Advisory Opinion No. 11-14
Co-management Deluxe IOLs

<table>
<thead>
<tr>
<th>Do</th>
<th>Do not</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assign roles and responsibilities</td>
<td>• Extrapolate Medicare’s 80/20 rule to determine value of noncovered services</td>
</tr>
<tr>
<td>• Reduce surgeon’s refractive fee</td>
<td>• Comingle funds</td>
</tr>
<tr>
<td>• Collect separate payment for noncovered refractive services performed</td>
<td>• Factor in the cost of IOL</td>
</tr>
<tr>
<td>• Obtain two financial waivers for noncovered services</td>
<td>• Fail to provide patient with clear description of co-management arrangement</td>
</tr>
</tbody>
</table>

Summary

<table>
<thead>
<tr>
<th>Do’s</th>
<th>Don’ts</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pre-testing</td>
<td>• Use one-size-fits-all</td>
</tr>
<tr>
<td>• Clearly explain choices</td>
<td>• Patient pay for cat sx</td>
</tr>
<tr>
<td>• Document selection</td>
<td>• Disguise fees</td>
</tr>
<tr>
<td>• Collect $ before surgery</td>
<td>• Comingle funds</td>
</tr>
<tr>
<td>• Separate MD and ASC</td>
<td>• Co-manage all cases</td>
</tr>
<tr>
<td>• Patient pay for SCOCA</td>
<td>• MD purchase IOL</td>
</tr>
</tbody>
</table>

Additional Assistance

(800) 399-6565
Website: www.CorcoranCCG.com
Mobile application: Corcoran 24/7