Uncharted Waters: Navigating the Ins and Outs of ACOs

Examining how Accountable Care Organizations will affect ophthalmology

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Proven therapeutic utility in a variety of superficial ocular infections—including blepharitis, conjunctivitis, and others

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Important Safety Information

Bacitracin ophthalmic ointment should not be used in deep-seated ocular infections or in those that are likely to become systemic.

This product should not be used in patients with a history of hypersensitivity to Bacitracin.

Proof positive for more eyes

References:

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DESCRIPTION: Each gram of ointment contains 500 units of Bacitracin in a low melting special base containing White Petrolatum and Mineral Oil.

ACTION: The antibiotic, Bacitracin, exerts a profound action against many gram-positive pathogens, including the common Streptococci and Staphylococci. It is also destructive for certain gram-negative organisms. It is ineffective against fungi.

INDICATIONS: For the treatment of superficial ocular infections involving the conjunctiva and/or cornea caused by Bacitracin susceptible organisms.

CONTRAINDICATIONS: This product should not be used in patients with a history of hypersensitivity to Bacitracin.

PRECAUTIONS: Bacitracin ophthalmic ointment should not be used in deep-seated ocular infections or in those that are likely to become systemic. The prolonged use of antibiotic containing preparations may result in overgrowth of nonsusceptible organisms particularly fungi. If new infections develop during treatment appropriate antibiotic or chemotherapy should be instituted.

ADVERSE REACTIONS: Bacitracin has such a low incidence of allergenicity that for all practical purposes side reactions are practically non-existent. However, if such reaction should occur, therapy should be discontinued.

DOSAGE AND ADMINISTRATION: The ointment should be applied directly into the conjunctival sac 1 to 3 times daily. In blepharitis all scales and crusts should be carefully removed and the ointment then spread uniformly over the lid margins. Patients should be instructed to take appropriate measures to avoid gross contamination of the ointment when applying the ointment directly to the infected eye.

HOW SUPPLIED: 3.5 g (1/8 Oz) sterile tamper proof tubes, NDC 48102-007-35.
Examining how Accountable Care Organizations will affect ophthalmology.

If you listen in on any conversation regarding healthcare and financial risk lately, you're sure to hear “ACO” mentioned several times. As part of the Patient Protection and Affordable Care Act, an Accountable Care Organization (ACO) must be “financially accountable for the health care needs of a population, manage the care of that population and bear that responsibility at an organizational level.”

By designation, the Centers for Medicaid & Medicare Services (CMS) contract with ACOs to provide integrated healthcare services. In March of 2011, CMS proposed regulations to implement its Medicare Shared Savings Programs, which granted ACOs the responsibility for all aspects of healthcare (quality, costs and overall care) for at least 5,000 Medicare beneficiaries. These shared savings programs went into effect Jan. 1, 2012. Incentives are part of a capitated risk-based model, defined as “a method of prospective reimbursement whereby a health plan or independent practice association) that has accepted risk for medical services pays a provider on a per-member-per-month basis for all members of the plan that are assigned to that provider.”

CONTINUED ON PAGE 6
The moment your can see every last detail with perfect clarity.  
**This is the moment we work for.**

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**Voted the #1 surgical microscope by ophthalmic surgeons**

OPMI LUMERA® 700 features ZEISS’ patented SCI™ (Stereo Coaxial Illumination) for a brilliant red reflex, Xenon illumination for better detail recognition during surgery and fully integrated HD video for convenient recording. It redefines what one should expect of an ophthalmic surgical microscope.

No microscope is more advanced. No microscope is a more natural extension of the surgeon for all areas of ophthalmic surgery.

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CMS estimates that more than 5 million beneficiaries could receive care from ACOs at a savings of almost $1 billion over 3 years. ACOs are predominantly hospital-based, but are expanding to include multispecialty practices. By law, an ACO may include group practice arrangements, networks of individual practices of ACO professionals, partnerships or joint venture arrangements between hospitals and ACO professionals, hospital-employed ACO professionals or other Medicare providers/suppliers.

For ophthalmic practices, the challenges of determining how to fit into an ACO, especially for traditional ophthalmic facilities that are essentially extensions of a solo physician or physician group, have only begun to surface. One thing is for certain, in the realm of ophthalmology, no one fully understands what the ACO concept will mean. But experts say it’s likely that only a small portion of ophthalmologists will be employed directly by ACOs. It’s more likely that ophthalmologists will continue to be paid directly by CMS. That said, ophthalmic practices should still be aware of the coming changes.

"Focus on how to market your value proposition to providers who are used to offering these services only in the hospital."

—Michael A. Romansky, JD

Providing Value

Ophthalmology is the third largest expenditure in absolute dollars for CMS, says William L. Rich, III, MD, medical director of health policy for the American Academy of Ophthalmology (AAO), and the highest percentage of an ophthalmologist’s revenue comes from Medicare. Yet the majority of hospitals “don’t look at us as integral to providing coordinating care and they certainly don’t look at us as a revenue stream,” says Rich.

David W. Parke, II, MD, chief executive officer of the AAO, says ACOs aren’t a single structural entity but large, integrated medical systems, where individual hospitals are coming together to form hospital systems and spending tens of millions to buy physician practices — but they typically purchase only those practices that are a good marketing fit and will generate “a great deal of ancillary revenue.”

An ACO is much more likely to be concerned about pulling in hospital and primary care physician members than an ophthalmic ASC. ACOs don’t think ophthalmology makes any money in a hospital-based ACO so they’re not aggressively pursuing bringing ophthalmic ASCs into the fold (or ophthalmologists themselves, for that matter), says Michael A. Romansky, JD, Washington counsel and vice president for corporate development, Outpatient Ophthalmic Surgery Society (OOSS). OOSS is “encouraging our members to be mindful of ACOs and to build relationships with hospitals and insurers as they’re creating the ACOs,” he says. “Focus on how to market your value proposition to providers who are used to offering these services only in the hospital.”

Ophthalmology as a profession “hasn’t been approached because, of all the medical specialties, we generate the least amount of money for a hospital,” Dr. Rich says. That may end up working in ophthalmology’s favor, says Lou Sheffler, chief operating officer and co-founder of American SurgiSite Centers. “Under the current scenario, specialists like ophthalmologists are allowed to join as many ACOs as they wish,” he says.

Ophthalmic surgery is a Medicare-based practice,
and, except in isolated localities, it is unlikely that ACOs will dominate the Medicare marketplace, Mr. Romansky says, “at least not to the extent of traditional fee-for-service losing its position as the norm.”

“There are two types of ACOs, one that is hospital-based and one where the ACO is built around the managed care organizations that survived the 1980s,” says Dr. Rich. “Those organizations are much more aggressive toward the field of ophthalmology,” he says, and may force physicians who want to participate in a particular insurance plan to participate in a particular ACO and/or purchase a specific EHR system.

ASCs and ACOs Working Together?
ACOs shouldn’t be viewed as doom and gloom for ophthalmology. ASCs are competing for a product the hospital doesn’t want to offer — ophthalmic surgery — and that gives ophthalmologists a great deal of leverage.

“We know ophthalmology isn’t profitable for a hospital,” Mr. Sheffler says. They view ophthalmology as tying up valuable time in the operating room that can be used for more profitable surgeries, such as cardiology or orthopedics cases. “The ACOs of today are like revisiting managed care from years ago. It’s a different approach to the same challenge.”

Under the latest round of healthcare reform, hospitals are responsible for providing medical care to Medicare beneficiaries, Dr. Rich says, and “these hospitals have to demonstrate increased quality and savings” to be eligible for bonus payments. Again, hospitals have ignored ophthalmology and “have no intention of buying us” because of the limited revenue ophthalmology generates for a hospital, Dr. Rich says.

“In the end, hospital-based ACOs are going to have to consider us. All services that are covered by Medicare and those affiliated costs are going to be assigned to hospitals and hospital ACOs,” says Dr. Rich. “If physicians aren’t employed by a hospital, but they’re in the hospital ACO network, they’re getting paid directly by Medicare, not by the ACO.”

Meanwhile, each Medicare-certified ASC was required to submit to CMS patient outcomes and quality data beginning Oct. 1, 2012, or face substantial financial penalties, according to OASS. This may also lay the groundwork for ophthalmic ASCs and ACOs to work together.

“There is an opportunity for ophthalmic ASCs to go to a hospital organization that is setting up an ACO and say, ‘Let us be your provider for eye surgery because we can do it for a fixed price, and we can perform it cheaper than you,’ and advise the hospital to outsource the surgery to an ASC,” Mr. Sheffler says.

From the ASC perspective, the value proposition is that ACOs are ostensibly supposed to improve quality and reduce costs, but the ophthalmic ASCs that are contracting with Medicare already cost less than 60% of what the hospital will receive for the same procedures, Mr. Romansky says.

Ophthalmic practices that hope to avoid becoming part of these integrated systems altogether aren’t being realistic, says Dr. Parke. “ACOs are going to be very important for access to care. And in some cases, they’re going to be setting community-at-large standards of care,” he says. A potential scenario will be the ophthalmologist not working directly in the ACO, but interfacing with it on a contractual basis. And bear in mind “we don’t know what they’re going to look like; we’re all just hypothesizing for now. It’s going to place an opportunity and a burden on the ophthalmologist. We need to understand how to best construct and operate that interface,” says Dr. Parke.

Mr. Sheffler sees two viable possibilities for ASCs similar to those Dr. Parke predicts — in some states, hospitals may lease the surgery center, rendering the ASC a part of the hospital system; in others, the ACO would be entirely separate from the hospital where the hospital ACO splits the insurance fees directly with participating physicians.

Physician-driven ACOs won’t be very different from what ophthalmologists are used to with an ASC, Mr. Romansky says. “The dilemma is this: will the hospital-based ACO transform from the mindset of the ASC being the competition into the mindset of appreciating that the savings accrued by having services performed in a partner ASC will flow to the ACO’s bottom line? I think this is the challenge for the ophthalmic ASC, to market the facility to the ACO.”

Ophthalmology is not profitable for hospitals.
—Lou Sheffler
In his opinion, the multispecialty ASC, “the facility that essentially mirrors the hospital’s outpatient surgical department, may be in the most advantageous contracting position, if for no other reason than that they may have 10, 20, 30 or more surgeons on their medical staffs from various specialties with patient referral bases of their own, Mr. Romansky says.

**Competitive Edge**

Dr. Rich adamantly advises against ophthalmologists (and ophthalmic practices) signing an exclusive agreement with a particular ACO. “We have no idea if that hospital ACO is going to be successful and an exclusive contract will preclude you from participating in other ACOs,” he explains. That’s where Dr. Rich believes ophthalmic ASCs have a significant competitive edge. Hospitals don’t want to get involved with cataract surgery or intravitreal injections. “Plus, they need that operating space for their staff physicians. That, in turn, means self-contained ophthalmology practices are especially inviting. They don’t want to exclusively contract with me, but they want my facility for surgery,” says Dr. Rich. In that scenario, solo practices are no more or less attractive than multiphysician ASCs, he says.

*Practices with an EMR system in place will be more attractive than those without one.*

—David W. Parke, II, MD

Be prepared for the lawyers, Mr. Sheffler adds. A “whole boutique industry of healthcare lawyers” will see this situation as an opportunity to market their services to medical specialty businesses, like ASCs. This will illustrate the benefits of the businesses banding together when being approached by the larger organizations.

Dr. Parke predicts that predicts that a practice with an EMR/EHR system in place will be a more advantageous match with an ACO than on that doesn’t. And if ophthalmologists are going to care for patients within the auspices of an ACO, ensuring that the two EMR systems talk to one another is imperative. Some of the leading EMR systems aren’t user-friendly in ophthalmic settings, which can make the task of cross-sharing data more difficult.

The ACO and the ophthalmic community are going to have to agree to various service standards, says Dr. Parke. The AAO has created “EHR Central” for its administrator and physician members to serve as an information resource on the various vendors, system functionality, educational seminars and even compliance checklists. Likewise, both O OSS and the American Society for Cataract and Refractive Surgery (ASCRS) have guidance documents for their members and administrators on implementing these systems.

The primary goal of these systems and government regulations is cost reduction, Dr. Parke says. “A second goal is improved quality of care.” Both sides of that are equally important as AAO looks to refine and enhance the value of ophthalmology as a profession to the hospital ACOs, he says. “If we can demonstrate that we’re trying to be methodical in our use of resources, and we’re going to improve quality and safety where we can, the value of what we have to offer increases and we’ll be recognized by our peers, by society, and by our patients,” he explained.

“Anything we can do to put hard data out there to highlight the work that we do is going to increase our value.”

AAO is developing a clinical registry its members can use to evaluate their own components and benchmark them to demonstrate quality and value to ACOs, among others. “It would be a huge mistake for ophthalmologists to turn our backs on ACOs,” Dr. Parke warns. “It’s just that we need to do things in a different way than a hospital-employed cardiologist would.”
Bottom Line or Bottom Dollar?

ACOs aren’t the worst thing in the world for ophthalmology and ASCs, nor do they represent the best scenario, Mr. Romansky says. At this point, though, most ACOs aren’t ready to contract with facilities as far down the food chain as ophthalmology, he adds.

As long as ACOs don’t mimic the managed care-type organizations of the 1980s and 1990s, they may succeed, Dr. Rich says, noting the physician hospital organizations of the 1990s all failed. “Right now, the hospitals that are allegedly building their staff of physicians to integrate care under ACOs are dramatically increasing the current cost of care,” he says, and that can’t bode well for a system that was legislated to reduce costs.

“It’s all about the money and where the money’s flowing,” Mr. Sheffler says.

Another reason ophthalmic ASCs and individual practices may not be heavily pursued by ACOs or hospital groups is that “they don’t have the data tracking capabilities that hospitals and other large physician groups do,” Mr. Romansky says, reiterating the need for practices to have an EMR/EHR system.

For hospitals, the incentive to buy practices will continue. Hospitals can pay physicians what they’ve been earning in practice, and be reimbursed at a 44% higher rate. Hospitals may be interested in building integrated teams to provide integrated care under an ACO as well, but the reality of it is that hospitals “had been buying physician practices well before the ACO model,” Dr. Rich notes.

Taking baby steps is the general advice for ophthalmology and the ACO models. “It’s hard to get your arms around a ghost,” Mr. Romansky says. “There isn’t a legislative or regulatory answer for ACOs. It’s going to be dictated by the market and it’s market penetration and impact on physicians and ASCs will be very localized.” OOSSt fields calls from members concerned about ACOs, but the ophthalmic ASC is farther down the ladder than other specialties and that’s not going to change any time soon.

AAO is trying to determine where meaningful relationships with ACOs and ophthalmology exist, and to that end, has requested to see members’ contracts with ACOs to use as examples for other practices.

“We’re also trying to influence in Washington the construct of regulations that pertain to ACOs. We’re reviewing with the American Hospital Association and the American Academy of Family Practice trying to find a way for ophthalmology to have the right kind of access to patients and access to direct procedures in a resource-strained environment,” Dr. Parke says. “We’re trying to put as much information as possible out there, but at the same time, realizing that these things will continue moving forward.”

For now, AAO’s advice for its membership? Don’t sign an exclusive contract and don’t agree to use a specific EHR or EMR system is mandated in order to participate in a particular ACO. “You’re going to get paid fee-for-service anyway,” Dr. Rich says, so there’s little benefit in agreeing to a system that hasn’t been vetted by your administrators and IT personnel.

Dr. Rich continues to doubt any scenario will exist where ophthalmologists are employed by a hospital (exclusive of academic settings). “I think we’ll sign contracts with ACOs,” he says, “and the ACO may dictate that we have to send letters to our patients’ primary care physicians (to keep the lines of communication open) in those contracts. But the ACO can’t control where you refer patients for ophthalmic specialty care — or who gets referred to you. ACOs will not control your flow of money.”

References


The Operating Room Experience with Femtosecond Laser Refractive Cataract Surgery

A major concern with any new surgical procedure is gaining experience with the novel technology and then incorporating it into a practice. Over the past year, we’ve been dealing with this challenge/opportunity at our surgicenter and practice, where 15 surgeons have been trained in the use of the LenSx® femtosecond laser and approximately 600 cases have been performed.

Femtosecond Laser OR Goals

One of the most important considerations of this new technology has been the impact on chair time, but equally important has been the adjustments to patient flow in the operating room (OR) with our initial use of the laser. Femtosecond laser refractive cataract surgery changes the established patient flow and patient experience in the operating room. As we worked to adapt to this technology, we’ve adhered to several basic principles. With any new procedure there are certain goals that must be defined by the OR staff and the surgeon. The overwhelming interest continues to be ensuring patient safety and delivering optimal patient outcomes. After this prerequisite, a second goal is to provide surgeons with appropriate access to the OR so patients can have their operations performed in a timely manner. We also strive to maximize the efficiency of the OR — both in terms of time, staff and materials. Finally, a tertiary goal in the OR is to be cost-effective.

Finding a Place

With these goals in mind, there were four different laser placement options we considered. The first possibility was to place the laser in a different building than the OR. The second option was to place it on a different floor of the same building that contains the OR. We also considered placing the laser outside the OR on the same floor or placing it in the OR. We ultimately decided that our laser should be located in one of our three operating rooms. I discovered very quickly that I was approximately 50% slower in performing femtosecond refractive laser cataract surgery in one room with the increased turnover and procedural time. By using two rooms, I was 35% slower. The additional time taken by positioning the patient under the laser, performing the surgery (which takes approximately 1 minute) was minimal, but moving the patient and clearing the room was a different story.

All operating rooms have challenges in space utilization. After analyzing our experience, I believe the optimal placement for the femtosecond laser is just outside the OR. This allows maximal use of the operating rooms without slowing down patient access. With this scenario, we would be able to ensure quality of care and efficiency with only two rooms. Unfortunately, due to space limitations, this isn’t an option for us.

As such, we now use three rooms. I use the femtosecond laser in one room, and use the other two rooms to perform the remainder of the procedure, which increases my surgical time by 20% as compared to traditional cataract surgery (Figure 1).

A Dedicated Specialist

After performing more than 200 cases and finding a greater demand from my patients to undergo femtosecond laser refractive cataract surgery, I found that having a dedicated laser specialist dramatically increased efficiency, and in fact, makes me more efficient while maintaining superlative outcomes. The specialist who assists me in performing
Laser surgery is either a senior associate ophthalmologist who is dedicated to performing laser surgery or a surgical fellow who has watched me perform several hundred cases.

**Patient Experience**

I greet the patient and tell him during the initial consultation and in the OR that he will have two specialists performing the surgery. The laser specialist performs the laser and I perform the cataract extraction and intraocular lens implantation. This has improved my efficiency by approximately 20%, as the laser performs steps that allow me to perform the cataract surgery more expeditiously, including the incision, capsulorhexis and lens disruption. Most importantly, because of the digital precision of the LenSx® laser, patient outcomes have been more predictable with this system.

With any surgery, we want to offer the patient a premium experience. To that end, we look for minimal patient manipulation, keeping the patient on the same stretcher, if possible. We sedate mildly for laser, as well as for the cataract surgery, and we avoid putting the laser on a different floor.

Patients have overwhelmingly embraced the new premium procedure, including the LenSx® laser. I had expected about 15 to 20% of patients to request femtosecond laser refractive cataract surgery, but it’s actually closer to 60% of eligible patients.

**The Future for Femtosecond Lasers**

I believe femtosecond laser refractive cataract surgery will allow senior ophthalmologists to stay active in cataract surgery longer, while allowing younger associates to perform the manual aspects of the procedure.

The patient flow issues have been addressed nicely (in fact, we’re much more efficient) and we feel that we’re giving our patients a superlative surgical experience and an excellent surgical outcome with the use of femtosecond laser for refractive cataract surgery.
Advancing technology makes it possible to better visualize the anterior and posterior segments of the eye during, and even before, surgery. Newer ophthalmic surgical microscopes, increasingly adaptable to ASCs, provide improved illumination, better ergonomics and more compact footprints. These devices are also more efficient, provide digital recording and often can be easily networked. Below are the latest offerings from six major manufacturers.

Alcon Acquires Endure Medical Systems
With the acquisition of Endure Medical Systems, a pioneer of advanced technology, Alcon (www.alconsurgical.com) has added LuxOR ophthalmic surgical microscopes (Figure 1) to its portfolio of products available for the ASC. These microscopes deliver comprehensive, consistent visualization and user-friendly functionality during cataract surgery in the ASC, according to Alcon.

“The Endure Medical Systems full line of ophthalmic microscopes enhances our cataract surgery portfolio, offering an innovative solution for surgeons to further improve cataract surgery outcomes,” says Stuart Raetzman, head of Global Commercial Strategy, Alcon. “Cataract surgeons will appreciate the depth of perception and detail that these surgical microscopes with unique illumination technology provide.”

Alcon is launching a worldwide phased rollout of the microscopes later this year. The microscopes feature patented ILLUMIN-i technology, which allows for a stable, high-quality red reflex that is six times larger than the red reflex zone created by conventional microscopes. ILLUMIN-i also provides premium visualization and detail recognition and contrast, along with penetrating depth of focus, according to Alcon.

The technology generates collimated, non-focused light, which makes the large red reflex zone possible. A high-quality red reflex is maintained regardless of pupil size, centration, lens tilt or patient eye movement. A proprietary method of positioning the light source below the objective lens provides a long focal length while maintaining working distance, providing useful depth of focus and clear visualization.

The LuxOR Ophthalmic Microscope provides at-a-glance access to unique parameters, such as XY and focus position, via the LIBERO-XY.
Communication System. A full-color touch screen and wireless foot control allow customization of preferred settings for efficient setup. The illumination level, speed of focus, zooming function and XY-centering settings are all easily adjusted. Pupillary distance, initial focus point, magnification level and other settings may be saved for future use. The LIBERO-XY foot control is wireless, rechargeable, programmable and waterproof, as is the touch-screen display.

Once surgeons get established with the LuxOR Microscope, Alcon is hoping they’ll opt for a portfolio of optional upgrades, including Q-VUE 3D Assistant Visualization. This enhancement features 180 degree swivel capability and an independent magnification changer. The Q-VUE 3D provides a true 3-D stereo assistant scope that doesn’t reduce light in the surgeon’s optical pathway.

More Natural Light
The OPMI LUMERA 700 (Figure 2), an ophthalmic surgical microscope from Carl Zeiss Meditec (www.meditec.zeiss.com), provides optimal visualization for anterior and posterior segment surgeries in the ASC, says the company. For the cataract and refractive surgeon, the system’s patented Stereo Coaxial Illumination (SCI) utilizes two, focused beams of light fully coaxial to the observation beam paths to produce a brilliant, homogenous and stable red reflex for optimal anterior segment visualization. Unlike collimated light, the focused coaxial illumination does not compromise visual quality, resulting in unsurpassed detail recognition, contrast and depth-of-field, says Zeiss.

Visualization is further enhanced by the company’s renowned apochromatic optics and Superlux Eye 180W xenon light source — also unique to Zeiss — which offers surgeons a whiter, more natural, higher contrast image of the surgical field than standard halogen illumination.

For retinal surgeons, the company’s proprietary RESIGHT non-contact fundus viewing system integrates seamlessly with the OPMI LUMERA 700, providing detailed visualization of the retina that Zeiss describes as exceptional in both depth-of-field and edge-to-edge clarity.

The OPMI LUMERA 700 can be configured with Invertertube E binoculars, which in addition to providing a more ergonomic sitting position during surgery, integrates motorized inverters and a tiltable binocular tube into a single form factor. When equipped with both the Invertertube E and RESIGHT 700, activation of the RESIGHT automatically results in activation of the inverters and any affiliated user profile settings — light intensity, XY movement speed, focus and zoom start values, for example — to make transitioning from anterior segment to posterior segment viewing startlingly easy. A fully integrated HD video recording system includes a 1080p HD video camera, video recorder and internalized cabling. Maintenance is simplified because no wiring is exposed. All video functionality can be controlled from the central touch-screen user interface, handgrips or wireless foot control panel. This design offers a seamless transition between video capture and other microscope functions.

An integrated assistant’s microscope with independent focusing and motorized zoom can be set for independent use or linked to the zoom of the main observer. A rotatable beam splitter allows accommodation of right-sided or left-sided co-observation with the push of a button. An integrated keratoscope...
enables visualization of corneal astigmatism without interrupting a procedure to attach an accessory. This level of integration can substantially increase workflow efficiency and reduce overall surgery time, according to Zeiss officials.

New Haag-Streit Division
Haag-Streit USA (www.haag-streit-usa.com) has launched a new division: Haag-Streit Surgical. The new unit will market a line of surgical microscopes currently used throughout Europe. Formerly known as Möller-Wedel, the devices are now being offered in the United States under the new Haag-Streit Surgical brand.

“Now American ophthalmologists, neurosurgeons and otolaryngologists will have better access to devices with a proven record of superior optics. This launch offers a new choice for the marketplace — one that will benefit doctors and their patients,” says Ernest Cavin, CEO of Haag-Streit USA.

The surgical microscope line, including the new Hi-R Neo 900 (Figure 3), will be on display at leading conferences throughout the year.

Checking Cell Counts
Changes in endothelial cell morphology and density may indicate corneal distress, but these key indicators are difficult or even impossible to assess with standard biomicroscopy. Insight into these changes is critical for patients who undergo cataract surgery, IOL implantation and other anterior segment procedures, such as refractive surgery, corneal or lamellar transplantations and glaucoma shunt implantation. It’s important that patients with a history of fluctuating and blurry vision, foreign body sensation, photophobia, contact lens intolerance, and halos are identified when entering the ASC. These problems may go unreported or unnoticed, even though they’re associated with substantial underlying issues, such as diabetes, glaucoma, retinal disease, recurrent iritis, long-term medication use or extended contact lens wear.

Product managers at Konan Medical say the CellChek XL clinical specular microscope system (Figure 4) is a critical diagnostic imaging device, routinely used before the patient enters the OR (www.konan-usa.com/products/cellchekxl).

Representing the latest in endothelial cell analytics, CellChek records the cellular image location required for understanding trends over time and critical for reliably evaluating peripheral endothelial function, says Konan. With auto-focus, auto-alignment, auto-capture and auto-cell counting, the instrument easily captures high-quality specular micrographs. Konan also exclusively includes the Center Method of analysis, which they say is regarded as the gold standard for clinical research. CellChek is easily integrated into most EMR systems and ASCs can add DICOM compatibility to simplify workflow to EMR systems at their ASC.

“With continuing changes in delivery and reimbursement, the specular microscope can have a dramatic impact in the ASC,” says Rick Torney, vice president of sales at Konan. “If you’re going to suggest a premium IOL, it’s never been more critical than today to assess the full condition of the cornea prior to surgery.”

“I’ve been surprised by the number of my cataract patients who had substantial endothelial dystrophic changes that weren’t readily visualized through the slit lamp, but were easily detectable with specular biomicroscopy,” says Ming Wang, MD, PhD, Nashville, Tenn. “Konan endothelial analysis is an important part of the work-up for all of my patients who will be undergoing cataract surgery, especially for my premium IOL patients.”

Dr. Wang says it’s important to educate patients about their preexisting endothelial conditions so that they’re fully prepared for surgery and the potential for prolonged postoperative corneal edema and blurriness as a result of corneal endothelial sub-function.

“As one saying goes, ‘If you mentioned a complication before the surgery and it occurs, then you’re a great doctor for predicting it; but if you failed to
mention a complication before the surgery and it occurs, then you’re a bad doctor in having caused it,” says Dr. Wang. “Specular microscopy is now, in my opinion, a requisite contemporary tool for all cataract surgeons who want to provide the state-of-the-art refractive cataract surgery for their patients.”

“If the cell count is very low, beyond good pre-operative counseling, the surgeon may weigh various schemes to further minimize the risk before or during surgery,” Torney notes. “Our customers are constantly commenting that they’re surprised by what they’d been routinely missing with the slit lamp before having a Konan specular microscope,” he concludes.

**New Microscope for Cataract Surgery**

Leica Microsystems (www.leica-microsystems.com/testdrive) has introduced the Leica M822 surgical microscope for cataract surgery (Figure 5), ideally suited to the ASC. Leica says the M822’s coaxial double-beam stereo illumination and OttoFlex II provide brilliant, stable red reflex and 3-D vision, even in the presence of difficult anatomical conditions, such as those associated with small pupils or advanced lens clouding.

The Leica Low Light concept has direct halogen illumination and high-intensity transmission optics, providing an excellent contrast ratio for retinal procedures, according to Leica.

Leica’s surgical microscopes are designed to integrate with commonly used wide-angle observation systems and stereo image inverters to provide an individual ergonomic fit. Depth of field is increased and XY-centering and refocusing are reduced by the double-beam stereo and OttoFlex II illumination. Brightness can be easily adjusted where needed. Leica microscopes are modular in design, meeting the needs of small clinics and operating rooms. The microscopes provide comfortable ergonomics for surgeons and assistants by offering individually adjustable binocular tubes, a wireless foot pedal, a two-in-one display, StepCycle functionality that remembers surgeon preferences and an auto-reset function. Below are highlights of the models applicable in the ASC setting:

- **Leica M822.** This surgical microscope with enhanced Red Reflex meets surgeons’ demands for precise and efficient cataract surgery, minimizing discomfort while optimizing outcomes. It features apochromatic optics and a unique illumination system that combines LED and halogen for brilliant, stable Red Reflex. Floor stands provide a small base, long reach and a choice of mechanical or electromagnetic brakes for a small footprint in ORs with limited space. This microscope suits all of the surgical needs of small and mid-size ASCs and integrates with vitreoretinal accessories. Surgical workflow is optimized by a rotatable beam splitter, a two-beam path solution for a temporal approach to cataract surgery.

- **Leica M844.** APO OptiChrome optics and direct halogen illumination provide exceptional clarity and contrast when using this device, according to
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**Oculus Wide Angle Viewing System**

Oculus Surgical, Inc. (www.oculussurgical.com) is now the sole provider of the SDI/BIOM non-contact wide angle viewing system in the United States. The SDI/BIOM system is used to observe the retina during vitrectomy procedures. Oculus Optikgeraete GmbH (Germany) launched the original BIOM over 25 years ago and forever changed how surgeons view vitreoretinal surgery. Oculus Surgical, Inc. has recently launched the BIOM 5 in the United States.

Made of titanium and stainless steel, the new lightweight BIOM 5c (Figure 6) features surgeon-controlled electronic focusing and provides automatic image inversion of the SDI 4c. A new optimized reduction lens reduces the need to refocus between retina and limbus viewing. The new BIOM can be mounted in a matter of seconds and its slim design facilitates easy cleaning and sterilization. The new OCULUS BIOM HD Disposable Lens ensures a perfect view in every case, increases OR efficiency and lowers costs, according to Oculus. The company states that the BIOM 5, together with the new Oculus BIOM HD Disposable Lens, is ideal for the ASC environment.

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**Figure 6.** Oculus’ new lightweight BIOM 5c features surgeon-controlled electronic focusing and provides automatic image inversion of the SDI 4c.
The routine nature of the ophthalmic ASC operation may lull you into a false sense of complacency when it comes to emergency management. The elective, minimally invasive, short duration procedures we deliver are typically uneventful. And let’s face it, we like it that way. Our predominantly senior patient population often awaits cataract surgery with minimal anxiety. They know what to expect, benefitting from shared experiences of friends and family, discussions with their surgeon and in some cases, their own previous surgical experience.

Yet the need to be ready to effectively manage emergency situations in the ophthalmic ASC is imperative. It’s a regulatory requirement, a risk management strategy and necessary prerequisite for patient safety.

Accrediting bodies and state licensing regulations address emergency management in the ASC. You should refer to your specific standards and regulations and familiarize yourself with the requirements of each to assure compliance. For the purposes of this article, we’ll focus on national standards and regulations.

National Standards and Regulations
The CMS ASC Conditions for Coverage mandate specific requirements for emergency management.

416.44 (a) The ASC must have an effective procedure for the immediate transfer, to a hospital, of patients requiring emergency medical care beyond the capabilities of the ASC.

Governing Body approved policies and procedures should specify the circumstances under which an emergent transfer would occur, the decision-maker, the documentation standards and the procedure for executing the transfer safely and efficiently. Typically, these policies include code blue response, emergency transfer, crash cart, emergency supplies and equipment and incapacitated healthcare professional, at a minimum. Prior to July 2012, the Medicare Conditions for Coverage (CfC) specified required emergency equipment including a mechanical ventilator and tracheostomy set. Many ASCs felt this was overly burdensome given their limited scope of care. This has since been revised and the requirement now states: “ASCs, in conjunction with their governing body and the medical staff, develop policies and procedures which specify the types of emergency equipment that would be appropriate for the facility’s patient population, and make the items immediately available at the ASC to handle intra- or postoperative emergencies. The emergency equipment identified by the ASC should meet the current acceptable standards of practice in the ASC industry.”

Crash Cart Equipment
The crash cart must be fully equipped to handle an emergency anywhere in the facility. For example, a suction machine on the crash cart is necessary to respond to an emergency in the restroom or the waiting room, where wall suction isn’t available. We recommend, at a minimum, the following crash cart equipment:

• An Automated External Defibrillator (AED) or Defibrillator
• Suction Machine, Yankauer, Suction Catheters
• Oxygen Tank
• CPR Back Board
• Sharps Container
• Emergency Medications for Adults and/or Pediatrics (refer to current Advanced Cardiac Life Support [ACLS] Algorithms)
• Airways, Intubation Equipment, Ambu Bag, Oxygen Masks, etc.
• IV Supplies, IV Fluids
• Stethoscope, Blood Pressure Cuff
• Protective Eye Wear/Goggles, Gowns, Gloves
• Stopwatch

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The anesthesia staff should be consulted to determine the drug inventory. The crash cart should be kept locked to preserve the integrity of its contents, unless it is use or open for inspection and inventory. The top of the cart is inspected daily for proper function of the AED or Defibrillator, suction machine and oxygen tank. Monthly, the lock is broken and the entire crash cart is inspected for inventory and outdated materials, equipment or medicine. These inspections, daily and monthly, are documented on the crash cart log and this inspection procedure is included in your crash cart policies and procedures.

Relationships and Responsibilities

The ASC must have a written transfer agreement with a “local” Medicare participating hospital or ensure that all physicians performing surgery in the ASC have admitting privileges at a “local” Medicare participating hospital. A “local” hospital means the ASC is to consider the most appropriate hospital facility to which the ASC will transport its patients in the event of an emergency. It is assumed to be the nearest hospital with appropriate capabilities.

If your facility’s scope of care includes general anesthesia or if your formulary includes any malignant hyperthermia-triggering agents such as succinylcholine, you must be appropriately equipped to handle a malignant hyperthermia (MH) emergency. This includes 36 vials of Dantrolene. The Malignant Hyperthermia Association of the United States (MHAUS, at www.mhaus.org) is an excellent resource for information on the incidence of MH, screening measures, signs and symptoms and treatment protocols including recommended equipment and supplies, posters and training materials.

416.44(d) Personnel trained in the use of emergency equipment and in cardiopulmonary resuscitation must be available whenever there’s a patient in the ASC.

All ASC clinical staff must have current Basic Life Support (BLS) certification. Although only one ACLS-certified RN must be present when a patient is in the facility, it’s considered a best practice to require all RNs working in the facility to be ACLS-certified to provide the highest standard of care and maximize your staffing flexibility. At least one pediatric advanced life support (PALS) certified RN is required whenever a pediatric patient is present. If you routinely care for pediatric patients, the best practice would be to require PALS certification for all RNs.

CMS requires a registered nurse to be available for emergency treatment whenever there’s a patient in the ASC. Per CMS, “available” means on the premises and sufficiently free from other duties that the nurse is able to respond rapidly to emergency situations. The RN(s) designated to provide emergency treatment must be able to use any of the required equipment, so long as such use falls within an RN’s scope of practice. Therefore, if you have one RN handling patient care preop/PACU and one RN circulating in the OR, you need at least one additional RN in your staffing plan to meet this requirement. Remember,
LPNs and technicians are not interchangeable with RNs.

Regular drills or mock codes — at minimum annually — are critical to ensure your facility staff is sufficiently familiar with your emergency policies and procedures, supplies and equipment and prepared for the unexpected. If your facility is equipped for an MH emergency, an MH drill should be held annually as well. (Be sure to save outdated Dantrolene sodium to use in your MH drill.) Your anesthesia staff is a great resource for this training and should be involved in the planning, execution and evaluation of your mock codes. During the mock code, staff roles should be clarified and discussed. For instance, during a code blue situation, an RN must respond with the crash cart. A code blue outside the OR will be initiated by an ACLS-certified RN until a physician is available to direct the code. One RN must be responsible for documentation on the Code Blue Record while another RN should be establishing the IV and administering medications at the direction of the physician. Clarification of roles and responsibilities during mock codes will eliminate confusion during an actual emergency.

Treating Seniors
The ophthalmic ASC patient population is predominantly seniors, most of whom have underlying systemic disease. Appropriate preoperative screening is essential to ensure patients are directed to the most suitable care environment. Medicare requires a comprehensive history and physical (H&P) completed within 30 days prior to surgery. Prior to admission, an ASC RN reviews the H&P and the patient health history questionnaire. This process, when approached diligently, may uncover a “red flag” or cause for concern that should be discussed with the surgeon and/or anesthesia staff prior to admission. In addition, the surgeon reviews the H&P and performs a pre-surgical assessment (CIC 416.52a) and the anesthesia provider will perform a pre-anesthesia evaluation (CIC 416.42a).

In our combined 35 years in ophthalmic ambulatory surgery, we’ve seen acute myocardial infarcts, third-degree heart blocks, acute congestive heart failure, seizures and even sudden death. It’s important to remember that our patient population is often healthy only by the degree to which they’re controlled on medication. Thus, compliance with medication regimens can be a major issue. Additionally, many seniors are reluctant to complain about their problems, not wanting to burden others. Still others are unable to accurately articulate their medical history.

Emergencies DO OCCUR in ophthalmic ASCs.

In our experience, the two components of the ASC operation that are most critical to effective emergency management are 1) clinical competence and 2) staff training and education. The value of strong clinical assessment skills in your nursing staff can not be understated. We’re proponents of hiring RNs with experience in critical care areas such as ICU, L&D and ER for preop and PACU. We’ve seen RNs identify an emerging crisis before it becomes a full-blown crisis on more than one occasion. Additionally, critical care experience usually means they can handle emergencies with calm and competence, which is essential for effective emergency management, particularly in an ASC, where no one expects emergencies.

Appropriate investment in staff training and education is a must. This is challenging for ASCs where the standard staffing model includes many part-time and per diem staff members. We recommend one mandatory annual education day to review disaster preparedness, emergency management, OSHA, and other mandated training, as well as targeted training on clinical topics, customer service, quality assessment and performance improvement (QAPI) or other areas of focus in the organization. This investment of time and talent has reaped great dividends in our organizations as it ensures a consistent standard of knowledge and competency across the entire staff.

While we’re grateful that emergencies in the ophthalmic ASC are the exception rather than the rule, it’s advisable to avoid a false sense of security. If your ASC handles enough cases, you’ll eventually face a serious emergency. Take the time and make the investment to get prepared now to be sure your emergency patient is afforded the best possible care.

Resources

Cristine Benze, RN, BSN and Regina Boore, RN, BSN, MS, CASC are consultants with Progressive Surgical Solutions, LLC, an ASC consulting firm based in Southern California.
Last year was an exciting year for HOYA Surgical Optics. The company announced a new global optimization plan to leverage its strengths and operate more consistently as one worldwide organization. HOYA also became the No. 1 IOL company in Japan.

This year, as it celebrates its 25th anniversary, HOYA Surgical Optics stands on the verge of becoming the company with the No. 3 market share IOL brand in the world. HOYA also opened its new global headquarters in Singapore as well as offices in Spain, Denmark and other markets. In addition, it forged a new path into the highly desirable U.S. market by obtaining FDA approval for two preloaded hydrophobic acrylic aspheric IOLs, the HOYA iSert 231 (yellow) and 230 (clear) Intraocular Lens. The lenses are available in UV-absorbing (clear) or blue light-filtering (yellow) models, making HOYA Surgical Optics the only company in the United States offering both options in foldable cartridge-style and preloaded configurations.

The newly approved IOLs are part of the company’s COMPLETE SOLUTION, a patient-centric approach to visual restoration that combines leading technologies and services to deliver the best outcomes for patients and practices.

According to HOYA Surgical Optics President and CEO Tom Dunlap, the products reflect the company’s core vision of being a “leading global ophthalmic device company with an entrepreneurial spirit and a focus on those things that matter most for realizing both exceptional patient outcomes and better practice results.”

Building on a Rich History: 70 Years in Precision Optics

HOYA Surgical Optics is unique among IOL companies, Dunlap says. “Unlike many of our competitors, we aren’t owned by a big pharmaceutical company or private equity firm,” he explains. “Therefore, our singular focus on ophthalmology and dedication to the industry are not encumbered by any distracting demands.” Dunlap also points to the company’s broad view of the ophthalmic landscape, which led to the move of its global headquarters from Japan.
to Singapore. There it can integrate key functions and enhance operational efficiencies because of the center’s proximity to emerging markets and its state-of-the-art manufacturing facility. The company will maintain already established offices in such places as Germany and Chino Hills, Calif., where they are optimizing interaction with customers on a local level.

The success of the company’s products around the world is deeply rooted in its history in precision optics. HOYA Surgical Optics is a division of HOYA Corporation, a Tokyo-based leading global supplier of high-tech products based on advanced optics technologies. In its three fields of business, Eye Care, Pentax Life Care and Electro-Optics, it provides eyeglasses, retail shops for contact lenses, IOLs, endoscopic systems for diagnostic procedures, mask blanks and photomasks used in the production of semiconductors and LCD panels, and glass disks for hard disk drives. Under this umbrella, HOYA Surgical Optics is focused solely on ophthalmology. "HOYA Corporation has been a model of excellence in optics design, innovation and manufacturing for more than 70 years," Dunlap says. "HOYA Surgical Optics and the HOYA corporate engine that’s behind us are what enable our ophthalmic business to be singularly focused yet globally powered. Our core entrepreneurial culture and management principles of agility, expertise and ingenuity mean we can create value for our customers that other companies can’t. This includes moving technologies forward in clever ways that fulfill unmet needs for the ophthalmologists in our markets."

HOYA Surgical Optics brought its first IOLs to market in Japan in 1987. Technological milestones since then include the 2008 introduction of the iSert, the first hydrophobic preloaded IOL system and the 2009 development of the iMICS1, a preloaded hydrophobic IOL implantable through a 1.8-mm incision with a non-wound-assisted technique. According to Dunlap, the iSert 250/251 series is the company’s fastest-selling IOL globally. Now working their way through clinical trials in the United States, the 250/251 preloaded aspheric lenses can be implanted through a 2.2-mm incision. They’re designed with a pad-polished optic surface and sharp edge for outstanding visual performance. Their hydrophobic acrylic material and PMMA haptic-optic protectors are combined as a monobloc to foster excellent stability and centration in the eye. Additionally, the iSert 351, a toric IOL built on the same platform, is also launching worldwide.

"In the next 12 months or so, we’ll be able to talk more about the very unique products we’ll be rolling out around the world," Dunlap says. "In the meantime," he continues, "U.S. cataract surgeons will be getting familiar with the advantages of the new HOYA Surgical Optics products now available to them and experiencing our relentless focus on customer care." Dunlap cites the HOYA AF-1 Optimized Aspheric Intraocular Lens, the preloaded iSert and the HOYA iTrace Surgical Workstation as examples of HOYA’s ongoing goal to provide a totally integrated system of cataract surgery tools.

“HOYA Corporation has been a model of excellence in optics design, innovation and manufacturing for more than 70 years,”
— HOYA Surgical Optics
President and CEO Tom Dunlap.
to surgeons. This will allow them to achieve not only better, more predictable IOL outcomes but also increased business efficiencies.

HOYA Surgical Optics engineered the HOYA AF-1 Optimized Aspheric™ IOL to provide negative spherical aberration along with a unique central power distribution that maintains image quality with misalignment. In this way, the HOYA® optic design incorporates the best features of neutral spherical aberration designs and the best of spherical aberration designs in a single optic, called Aspheric Balanced Curve™ (ABC) Design. The preloaded iSert option ensures an undamaged IOL is implanted into the eye in a safe, controlled and predictable manner through a true 2.4-mm incision. “From manufacturing facility to implantation, the iSert is a completely closed system, which means it delivers a lens that is untouched by human hands for the ultimate in safety and sterility,” Dunlap explains. The iSert is prepared for the surgeon to use in 15 seconds, and because the inserter is single-use, it eliminates the time and expense of sterilization that’s associated with reusable systems.

The HOYA iTrace Surgical Workstation (at right), co-developed with Tracey Technologies, is a 5-in-1 corneal topography, autorefraction, wavefront analysis, pupillometry and keratometry system. Based on raytracing technology, it streamlines cataract patient work-ups and serves as a surgical planning tool that integrates all of the needed information in one test. It isolates and quantifies corneal versus lenticular aberrations so that surgeons can more accurately predict post-surgery outcomes and select the best IOL for each patient, a must in today’s refractive cataract surgery practices. “World thought leaders are using this technology for teaching purposes, to illustrate why a multifocal IOL shouldn’t have been implanted in an individual eye, for example, because of corneal aberrations that prevented the best possible visual result,” Dunlap says. “In daily practice, the workstation enables the surgeon to have confidence he is choosing the best IOL for each patient, for all lenses — particularly torics and multifocals.” Dunlap notes that the HOYA iTrace Surgical Workstation will evolve into next-generation devices that can be used even more efficiently in the surgery suite.

He also notes how the system specifically matches the company’s vision and mission, which in large part means providing doctors with the innovative tools they need and want. “People comment to us that the workstation is going to help doctors succeed with IOLs from other companies in addition to ours, and we’re fine with that,” Dunlap says. “We want to give doctors choices, which is exactly why we offer our IOLs in clear and blue light blocking options and cartridge-style and preloaded configurations. We don’t get into the debates. Surgeons, not us, should choose what’s best for their patients.”

“A Clear View to the Future
Looking to the future, Dunlap highlights the strides HOYA Surgical Optics has made throughout its past. “In the global markets we’re participating in, we’ve made an impact,” he says. “We’ve been adept at succeeding with a single product line rather than taking the bundled approach to products that some other companies use. Grounded in our precision optics history, our dedication to innovation with specific products and our focus on customer care, we’ve

Avoid 20/Unhappy patients by objectively and clearly setting proper expectations for the patient using advanced ray tracing technology.

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been growing far more rapidly than most of our competitors. We’ve certainly learned a great deal along the way about what it will take to repeat in the United States the success we have had in places such as Japan.”

The company took its first steps into the U.S. market in 2009 when it opened its office in California. Just prior to that, as competition in consumer electronics was becoming more difficult, parent company HOYA Corp. had been ramping up its efforts to build its medical sector into a stronger profit center. Corporation President and CEO Mr. Hiroshi Suzuki made several moves toward that goal, such as acquiring Pentax in 2007. The camera division was subsequently spun off to narrow the focus to the medical field. Mr. Suzuki also shifted key management resources to the medical field and hired executives from outside the company. This included Dunlap, who was hired in 2009 and charged with furthering the globalization of the IOL business, including targeting the U.S. market. Dunlap brought a wealth of experience leading entrepreneurial ventures and global healthcare companies, including ophthalmic device companies.

HOYA Surgical Optics gained momentum in the United States early on but also faced struggles, including miscommunications with the FDA surrounding product approval status that led to the removal of some IOL models from U.S. inventories. “We’ve spent the better part of the past 3 years strengthening our infrastructure, refining commercial strategy and overhauling our sales, marketing and regulatory teams so we can move into a new phase of accelerated growth,” Dunlap says. “Our commitment to the U.S. market is strong, and based on our successes around the world, we’re confident we will succeed. We’ve put together a robust growth plan, but have coupled that with a long-term view of growing the business.”

The company will continue to rely on its rich portfolio and core strengths, but will also evaluate acquisition opportunities that would support portfolio gaps and add products that are synergistic to the IOL offerings, Dunlap says. He sums up his perspective this way: “Our management team is passionate and eager to be part of a success story. We have great internal energy, and surgeons have been quite receptive to us.”

Reference
One of the most common financial reports for any business is the income statement, also known as the profit and loss (P&L) statement. If organized correctly, the P&L statement is an important resource for managers and owners of ophthalmic surgery centers.

The P&L statement is a report of the center’s income (revenues) and expenses for a given period (e.g., 1 year). It shows the amounts spent on various categories and whether there was a profit or loss for the period. Categorizing expenses consistently with national benchmarking standards helps management understand the ratios and relationships between revenues and expenses. This knowledge enables owners and managers to make better business decisions. It also allows a center to put its best foot forward for accreditation surveyors who evaluate both the clinical and business aspects of each organization.

A keen understanding of these financial statements will help managers establish quality improvement programs that can help elevate patient care while streamlining the center’s business operations.

P&L statements are usually set up in a standard format commonly used by accountants and bookkeepers. What most center managers and nurse directors don’t realize is that these documents can be customized. When tweaked to reveal key figures, statements become more meaningful management tools. This article discusses ways to customize a P&L statement by regrouping expenses, so the statement can be used to better monitor the success of an organization’s action plan.

Customizing P&L Statements

To turn a P&L statement into a unique and indispensable management tool, consider the following adjustments and tips (see Figure 1):

**Summarize.** While detail is necessary for identifying opportunities, try to summarize expenses so the P&L statement fits onto two pages or less. This makes it easier for owners and managers to read. Group similar expenses together so they can be more easily summarized. Make sure all major categories being monitored have a group. Common groups for ASCs are medical supplies, staffing expenses, occupancy expenses, office expenses, equipment expenses and other.

**Include Comparative Data.** Actual numbers that stand alone don’t help in decision-making. Ideally, data should be compared to the budget so the following questions can be answered:

- Are we performing as expected?
- Is this an improvement from previous periods?
- Do we need more details about this particular item?
- How does this compare to our goals or benchmarks?

Note: This is the first article in a two-part series designed to help managers better understand the financial statements of their ASCs.
Breathe deeply. The unmatched accuracy of the LENSTAR® Optical Biometer takes the stress out of selecting the correct toric IOL. Along with LENSTAR’s perfect Ks come superior outcomes for you and your patients. Call 888.myLENSTAR for a demo.
If a center doesn’t use a budget, the next best thing is to have a year-over-year comparison of the same time period to help answer these questions.

**Categorize Premium IOLs Separately.** Because Medicare restricts the amount an ASC can collect for presbyopic-correcting and toric IOLs, revenues and expenses for these items should be separated rather than lumped into traditional categories such as “facility fees” for revenues or “surgical supplies” for expenses. These revenues and expenses are unique in that they behave more like retail items than traditional healthcare services. The expense for this supply is nearly equal to the amount a center is able to collect. Because of the low differential between collected amount and expense, this is called a “pass-through” item. If not separated (both in revenues and expenses), it can artificially inflate collections and impact management ratios. The sample P&L statement gives one method for accounting for this item. As the percentage of
premium IOLs increases, it becomes more important to identify the revenues and expenses separately.

**Itemize and Summarize Staff Expenses.** Each staff-expense category should be listed as its own unique line item, but the costs should also be summarized so that “fully burdened” staff expenses (explained later) can be understood. The individual expense categories for staffing typically include:
- Staff wages
- Payroll taxes
- Benefit expenses
- Staff education
- Retirement contributions.

**Include a Column for Management Ratios.** Most management ratios are set up as a percent based on the expense item divided by net collections. Such ratios are commonly used in benchmarking to allow for comparison from center to center.

**A customized P&L statement generates valuable, facility-specific information that can help ASC managers and owners make better management decisions.**

**Maximize the Capabilities of Accounting Software.** The sample statement was created in Excel, however most accounting software packages allow creation of P&L statements that look very similar. Quickbooks is an example of accounting software commonly used for small businesses, such as ophthalmic practices and surgery centers. This program allows for entry of a budget, summarization of categories and creation of management ratios.

**Tracking Results**
Once revenue and expense categories are appropriately set up, it becomes much easier to track results and compare them to national benchmarks. To identify opportunities for quality improvement on the business side of the center, look at national benchmarks to identify key areas. Here are several examples of benchmarks that can be derived from P&L statements:

- **Fully burdened staff expense ratio:** As the name suggests, all of the expenses associated with staffing are included in this ratio. Total staffing costs divided by net collection will provide the ratio. The BSM Consulting Group’s healthy range (25th to the 75th percentiles) for this benchmark for ophthalmology ASCs is 24-32%.

- **Operating expense ratio:** The operating expense ratio (also called the “overhead ratio”) is probably the most commonly quoted benchmark. To determine this management ratio, divide total operating expenses by total revenues. The healthy range for ophthalmology centers is 60-80%. Operating expenses are the total of expenses necessary to operate the center. Periodically, owners may have some unusual expenses in the center, but these should be subtracted prior to the calculation. Managers may also look at one-time expenses and whether or not they should be included in the operating expense ratio calculation. Such items should be footnoted when making comparisons.

- **Net Income ratio:** The converse of the operating expense ratio is the net income ratio. This shows the profitability of the center. Net income divided by net collections results in this ratio. The typical range is 20-40%.

**Make Valuable Information Readily Available**
A customized P&L statement generates valuable, facility-specific information that can help ASC managers and owners make better management decisions. When the P&L statement is customized, it’s easier for managers and owners to understand their center’s financial characteristics and compare their results to national benchmarks.

Maureen Waddle, MBA, is a senior consultant with BSM Consulting, an internationally recognized health care consulting firm.
Ask this regarding your ASC compliance: Are you even close? Most efforts to obtain ASC compliance focus on Conditions for Coverage and the more clinical and technical aspects. Very few ASCs actually focus on ensuring their coding, chart documentation and other compliance-related functions are being accomplished in accordance with Medicare’s rules and regulations.

Medicare audits for correct ASC coding and reports of compliance violations happen less frequently than do physician audits, but they certainly occur. Let’s review some of the basics you need to know to protect your facility.

**Medical Necessity**
The foundation of Medicare compliance and ASC reimbursement is firmly based on medical necessity, as is physician reimbursement.

For example, it’s often difficult to discern from the ASC chart if there’s medical necessity for a given cataract procedure or other surgery. Attorneys caution that procedure codes and other pertinent chart documentation should correlate with the physician’s chart. The ASC chart should be able to stand on its own if audited. In other words, the documentation establishing the medical necessity of a given procedure should be included in the ASC chart as well as the physician’s chart.

It’s probably a good idea to also incorporate the physician’s office notes on the date the surgery is scheduled into the ASC chart. I’ve reviewed many History and Physicals that didn’t address the patient’s Activities of Daily Living (ADL) problems for cataract and YAG surgery, thus no foundation for medical necessity of the procedure was established in the ASC chart.

**Rules of Surgical Coding**
Cosmetic versus Functional Procedures: Patient, Facility Fees and Anesthesia. If the surgery is cosmetic or another noncovered procedure, the patient is obligated to pay the facility fee. The procedures can’t be performed with “no charge.” This applies even when the ASC owner is the surgeon. Cosmetic procedures performed without charge can be considered an inducement for a surgeon to bring other cases to that ASC. If a procedure is partially cosmetic, the portion of the facility fee and anesthesia fee attributable to cosmetics should be charged to the patient.

**Code Selection.** The most frequent error in surgical coding is selecting a code that approximates the surgery performed rather than one that describes it accurately. CPT surgery rules are explicit in stating that if the exact code is not found, you must use an unlisted code. Your worst nightmare in ASC coding is when Medicare doesn’t accept the unlisted codes (the ones ending in 99) and the patient must pay for the procedure, the facility and anesthesia fees.

**Femtosecond-assisted Laser Procedures.** Please refer to the August 2012 issue of *Ophthalmology Management* (pages 24-25) for a complete article on the rules and regulations for femtosecond laser usage. There are strict rules that govern when you can and can’t charge a Medicare patient for its use.

**Premium/Regular IOL Issues.** There are several critical issues facing the ASC when a surgeon arrives with, and uses, an IOL that is given to him and it’s part of a clinical trial or comes from another external source. CMS expects the ASC to reduce its fee accordingly. Medicare prohibits physicians from purchasing IOLs. These issues are best resolved using the advice of a qualified health care attorney.

**Chart Documentation Issues & Tips**
- ADL. Be sure formal documentation (a completed form that’s form signed by the patient) is present for each eye for all cataract and YAG procedures — this is for the ASC chart as well as the physician chart.
- It’s a good idea to maintain a copy of the surgeon’s office notes from the day the surgery was scheduled in the ASC chart.
- Make sure the ASC has its own Advanced Beneficiary Notice or Notice of Exclusion of Medicare Benefits signed and kept on file.
- Surgical encounter forms should be completed and signed by the surgeon. CPT codes as well as modifiers should be selected by the surgeon.
- Codes provided by the physician’s office when the case was scheduled are often erroneous.
- Academic centers must ensure the operative notes...
are in compliance with Teaching Physician Documentation Requirements and that the GC modifier is applied to resident cases.

**Pitfalls in ASC Reimbursement**

Here are some of the most common violations I've found in my ASC auditing:

- Cosmetic procedures being performed without charging the patient for all noncovered procedures including the facility fee (or portion thereof) and the anesthesia fee (or portion thereof).
- Miscoding adventures such as using CPT code 65772 (Corneal relaxing incision for correction of surgically induced astigmatism) when refractive corneal relaxing procedures such as astigmatic keratectomy / limbal relaxing incisions (AK/LRI) are actually performed.
- Upgrading the size of lesions to qualify for reimbursement or coding them using higher paying excision and repair codes.
- Allowing unlisted or cosmetic procedures to be routinely performed without charging the patient in order to accommodate big-time players.
- Not charging the physician fee, but charging the facility fee for surgery relating to complications of a prior procedure in order to avoid “upsetting the patient.”

On the other hand, I have seen significant revenue not being captured by some of the following errors:

- Failure to capture all separately billable drugs on a given case.
- Erroneous use of procedure codes due to lack of understanding of surgical coding.
- Insufficient listing of all procedures performed.

**Pearls in ASC Reimbursement**

- Use a good health care attorney when problems arise.
- External audits by a qualified surgical coding expert can help you avoid costly coding errors and optimize reimbursement as well as provide educational training.
- Learning to code for surgeries in an ASC seems straightforward; however, it is really like learning to drive on the left side of the road. Driving lessons are well advised.

Caution:
United States Federal Law restricts this device to sale and use by or on the order of a physician or licensed eye care practitioner.

**Indication:**
The Lentis® Laser is indicated for use in patients undergoing cataract surgery for removal of the crystalline lens. Intended uses in cataract surgery include anterior capsulotomy, phacoemulsification, and the creation of single plane and multi-plane arc cuts/incisions in the cornea, each of which may be performed either individually or consecutively during the same procedure.

**Restrictions:**
- Patients must be able to fixate and maintain in a supine position.
- Patient must be able to understand and give an informed consent.
- Patients must be able to tolerate local or topical anesthesia.
- Patients with elevated IOP should use topical steroids only under close medical supervision.

**Contraindications:**
- Corneal disease that precludes application of the corneas or transmission of laser light at 1060 nm wavelength.
- Decremented with impending corneal rupture.
- Presence of blood or other material in the anterior chamber.
- Poorly dilating pupil such that the rim is not peripheral to the intended diameter for the capsulotomy.
- Conditions which would cause inadequate clearance between the intended capsulotomy depth and the endothelium (applicable to capsulotomy only).
- Previous corneal incisions that might provide a potential space into which the gas produced by the procedure can escape.
- Corneal thickness requirements that are beyond the range of the system.
- Corneal opacity that would interfere with the laser beam.
- Hypotony, glaucoma, or the presence of a corneal implant.
- Residual, recurrent, active anular or eyelid disease, including any corneal abnormality (for example, recurrent corneal erosion, severe basement membrane disease).
- This device is not intended for use in pediatric surgery.
- A history of lens with annular instability.
- Any contraindication to cataract or keratoplasty surgery.

**Attention:**
Reference the Directions for the Use for a complete listing of indications, warnings and precautions.

**Warnings:**
The Lentis® Laser System should only be operated by a physician trained in its use.

The Lentis® laser delivery system employs one sterile disposable Lentis® Laser Patient Interface consisting of an application lens and suction ring. The Patient Interface is intended for single use only.

The disposable used in conjunction with ALCON instrument products constitutes a complete surgical system. The use of disposable other than those manufactured by Alcon may affect system performance and create potential hazards. The physician should base patient selection on professional experience, published literature, and educational courses. Adult patients should be scheduled to undergo cataract extraction.

**Precautions:**
- Do not use cell phones or pagers of any kind in the same room as the Lentis® Laser.
- Discard used Patient Interfaces as medical waste.

**AEs/Complications:**
- Capsulotomy, phacofragmentation, or cut or incision dehiscence.
- Incomplete or interrupted capsulotomy, fragmentation, or corneal incision procedure.
- Capsular tear.
- Corneal abrasion or defect.
- Pain.
- Infection.
- Bleeding.
- Damage to intraocular structures.
- Anterior chamber fluid leakage, anterior chamber cells/flare.
- Elevated pressure to the eye.
Smarter, Better, Faster.
Advancing Every Femtosecond.

INTRODUCING THE NEW
LenSx® SoftFit® Patient Interface

**SMATER**
- Enhances patient comfort
- Minimizes corneal compression
- Fixates cornea for precise incisions

**BETTER**
- Free-floating capsulotomies in nearly every case
- Pristine capsulotomy edges
- Lower IOP increase—16 mmHg rise over baseline
- 66% reduction in energy

**FASTER**
- 34% reduction in laser time
- Simpler, easier docking process
- Overall reduction in procedure time

1. Multicenter prospective clinical study (n=197 eyes); Alcon data on file.

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