HOW TO TURN AROUND AN UNDERPERFORMING ASC

Learn how to recognize the early warning signs and make impactful changes before your facility dips into the red.

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Bacitracin Ophthalmic Ointment USP
STERILE
Rx Only

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

CLINICAL PHARMACOLOGY: 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 AND USAGE: For the treatment of superficial ocular infections involving the conjunctiva and/or cornea caused by Bacitracin susceptible gram 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.

To report SUSPECTED ADVERSE REACTIONS, contact Perrigo at 1-800-634-9120 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DOSAGE AND ADMINISTRATION: The ointment should be applied directly onto 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: NDC 0747-40022-13 3-1 g sterile tamper evident tubes with ophthalmic tip. NDC 0747-40022-35 3.5 g (1/8 oz.) sterile tamper evident tubes with ophthalmic tip. Store at 20°-25°C (68°-77°F) [see USP Controlled Room Temperature].

**Please see adjacent page for full prescribing information.**

References:

The Quintessential Antibiotic

BACITRACIN OPHTHALMIC OINTMENT USP

Proven therapeutic utility in blepharitis, conjunctivitis, and other superficial ocular infections

- Profound bactericidal effect against gram-positive pathogens
- Excellent, continued resistance profile—maintains susceptibility, even against methicillin-resistant Staphylococcus aureus
- Ointment provides long-lasting ocular surface contact time and greater bioavailability
- Anti-infective efficacy in a lubricating base
- Unsurpassed safety profile—low incidence of adverse events
- Convenient dosing—1 to 3 times daily
- Tier 1 pharmacy benefit status—on most insurance plans

Bacitracin Ophthalmic Ointment is indicated for the treatment of superficial ocular infections involving the conjunctiva and/or cornea caused by Bacitracin susceptible organisms.

Important Safety Information

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References:
Can you recognize the signs that your ASC is headed for a downturn? And if your surgery center IS underperforming, do you know how to remedy the situation? We asked two business consultants for guidance on these issues. First and foremost, they say it’s crucial to take your ASC’s vital signs regularly.

Key Performance Indicators

“The one metric that never lies is your financial statement,” says Louis I. Sheffler, co-founder and COO of American SurgiSite Centers, based in Somerset, N.J. “Having a good set of financial records is a powerful tool that will enable you to look at all of the metrics related to whether or not you’re making money,” he says. “The better your financial picture is, the easier it is to spot a problem and direct your attention to it. As with any business, if you start to see red ink, you know it’s time to do something.”

Bruce Maller, president and CEO of BSM Consulting Group (bsmconsulting.com), concurs. “To assess the overall health of an ASC, I examine key performance indicators over time,” he says. “In addition to getting a snapshot of the business at the present time, I want some perspective on whether performance is improving or relatively stable, or if the margins are eroding.”

One key performance indicator is case volume. “Specifically, you want to know how many cataract surgeries were performed in your ASC this year compared with last year, as well as how many premium lens implants, YAG and SLT procedures and so on,” Sheffler says. “This should tell you if case volume has decreased in a specific category.”

When examining case volume by procedure, you can differentiate economy-driven factors, such as a decrease in elective procedures during an economic downturn, versus factors specific to your facility. “For example, a non-owner surgeon may have left to become a partner in a new ASC in the area, or one surgeon may have left a group practice that uses your ASC,” Sheffler says. “Both situations mean patients may follow the surgeon to a different center.”

You should also examine the current roster of participating surgeons. “It’s important to step back and slow things down, so you can examine the situation forensically.”

When you realize your center is underperforming, your first instinct may be to act immediately. Our consultants say, don’t be too hasty. You have some time. Get analytical and get help, if necessary. Healthcare practitioners are trained to react quickly,” Sheffler says. “When it comes to business or administration, it’s important to step back and slow things down, so you can examine the situation forensically.”

Maller agrees. “If you react and dive right in, you’re probably going to take the wrong course of action,” he says. “It’s important to diagnose the situation and evaluate your options before taking action.”
EXAMINE YOUR PAYER MIX AND CONTRACTS

Another important area to scrutinize is the profile of your payer mix, specifically the case mix from Medicare, Medicaid and commercial payers, according to Maller. “Everything else may be great at your center, except for the fact that Blue Cross decided to terminate its contract with you,” he says. “That may be what’s hurting the center.”

What about your remaining contracts? “If you conclude that a particular contract isn’t working for you — maybe a payer has reduced its reimbursements — it may be time to renegotiate that contract,” Maller says. “Be aware, however, that those negotiations can take a year or more to conclude.”

Know trends in terms of each surgeon’s volume and mix of cases to detect any subtle or not-so-subtle changes that might be impacting the center’s financial performance,” Maller says. “I would also look at the payer mix, because an ASC might have a high concentration of cases from a particular payer and that payer may have revised its fee schedule to the detriment of your bottom line.”

All of these data will help shed light on why your ASC may be missing the mark, so you can institute corrective measures. Be prepared to put the business under a microscope, because as Maller notes, “in a turnaround situation, my general feeling is, all bets are off, and everything is on the table.”

Strategy #1: Increase Volume

“With surgery centers, there are really only two things you can do to improve profitability,” Sheffler says. “One, you can raise topline revenue by bringing in more cases, or two, you can lower overhead. I really believe in the topline revenue approach.”

Consider the following revenue boosters:

➢ Recruit more surgeons. “Physician/owners of ASGs may be reluctant to approach others whom they view as competitors in the community,” says Sheffler. “However, we encourage our clients to change their philosophy and open up their doors. By bringing in as many doctors as possible, you’ll keep your center as busy as possible, 5 days a week. Add a robust, well-trained staff and the best equipment, and you’ll have a successful model.”

➢ Expand your surgical offerings. Another way to increase volume is to offer additional types of eye surgery, such as ocular-plastic and retina procedures. “If you have open slots in your OR schedule, consider expanding the breadth of work performed in your facility,” Sheffler says. “For example, in the last couple of years, many of our centers have expanded into retina surgery. While reimbursement for cataract surgery has declined, reimbursement for retina procedures has increased, and the latest equipment enables retina specialists to complete their cases more quickly than in the past.”

Strategy #2: Lower Costs

Next, you’ll want to take a hard look at spending on administration, personnel, equipment and supplies. Although savings realized in some categories may not be dramatic, the overall impact will contribute to a healthier bottom line. Consider the following:

➢ Examine your personnel needs. “Staffing probably accounts for half of an ASC’s overhead costs,” Maller says. “If you factor in benefits and taxes, every full-time equivalent staff member represents between $50,000 and $70,000 per year. So, you have to ask: Are there opportunities for us to get by with fewer staff members? Even though we’ve become accustomed to having all of these people at our disposal, do we really need them?” If you’re considering reducing staff, however, you must consider how doing so will affect the quality and integrity of the care you’re providing.

Another method to reduce staffing is to condense your surgery schedule, perhaps from 5 days a week to 2 or 3 days a week. “One of the real strengths of ophthalmic ASCs is that our doctors have learned how to be much more efficient,” Maller says. “Problems may arise, however, when you’re trying to accommodate numerous doctors who want block time. How do you give surgeon number three a half day of surgery time when he’s only doing three cases? You can’t let that tail wag the dog. Certainly, you want to accommodate your surgeons but not to the detriment of the center. If you condense the surgery schedule in a smart and effective way, you may be able to reduce your labor costs by 40%.”

➢ Comparison shop for services. Most of your administrative expenses warrant periodic review. An increase in your insurance premium, for example, should trigger a fresh look at your current policy: first, to confirm that your coverage is appropriate; and second, to determine if a different carrier can offer cost savings.

➢ Revisit supply costs. “In the ASC environment, supplies can be expensive, so it’s important to look at those items periodically to see if less costly alternatives exist,” Sheffler says. “Some physicians may have used a particular item during residency and fellowship and continue to use it because they’re comfortable with it, when, in fact, other companies may make comparable items at a lower cost.”

According to Maller, “By looking at each surgeon’s utilization of supplies, as well as vendor choices, you may find ways to reduce costs per case.”

➢ Control your inventory. “If you’re not paying attention, you could have thousands of dollars’ worth of supplies on your shelves, because staff members are afraid you’ll run out of something during an operation,” Maller says. “In our facilities, we have computerized inventory systems. Everything is barcoded, so we know exactly how much inventory we have at any given time. The computer alerts us when inventory is getting low and needs to be reordered.”

➢ Put your EHR system to work. “Not only will an EHR system save personnel time — people don’t realize how expensive it is to open mail, photocopy, collate and change toner cartridges — but it also tracks which supplies are being used by specific doctors, and it calculates your cost per case, which is another metric you should be watching,” Sheffler says.

Manage Accounts Receivable

Although not strictly a profit-and-loss issue, don’t overlook what’s happening in your back office. “A common problem in many healthcare businesses, not only in ASCs, is poorly managed accounts receivable,” Sheffler says. “When a patient is covered by Medicare, for example, you may collect your Medicare money but leave the 20% co-pay on the table. Very few doctors have enough personnel to follow up and collect that 20% from every patient who owes it. Soon, you have a significant sum of money outstanding.” Sheffler advises collecting co-pay funds before the surgery. “This has become a more common practice because of high-deductible insurance policies,” he says.

Look Beyond the Balance Sheet

If the cause of your malaise is not apparent in your
financial statements, you may need to look at what Maller calls quality-of-life issues. "Surgeons are the engines that drive the economic performance of an ASC," he says. "By and large, they enjoy their days in the OR, and often it’s the support team that makes those days wonderful. If the center loses a key staff member — a nurse administrator who had a great working relationship with some of the surgeons, for example — the environment in the ASC could change and those surgeons may decide not to perform their cases there."

What You Need to Bring to the Table
Among the intangibles that factor into a successful turnaround is the attitude of everyone involved. "To me, the key is making sure everyone is focused on what needs to be done to turn the business around, and what each individual can contribute to that end," Maller says. "Many tough choices will be required, and my job as a consultant is often helping everyone understand the variables and bringing all parties to the table. It requires compromise and being open to ideas that maybe historically you hadn’t thought about. Once you get that attitude, then the options usually abound, and it’s just a matter of choices."

Diagnosis to Treatment to Resolution
If your ASC isn’t performing to historical levels or to expectations, a thorough assessment will help you better understand what's at play and your restorative options. "You need to be thoughtful and deliberate, and you really need to identity to the causal factors," Maller says. "Once you’ve completed that diagnostic assessment and have a good sense of the issues, you’ll need to carefully vet your corrective measures to make sure you do the right thing to turn your center around while protecting its integrity."

Also key to a successful turnaround is educating and building consensus among the stakeholders. Not only will they want to know their options, but they’ll also want to know the associated costs. "By clearly, laying out the options, you make it easier for them to get on board and support whatever needs to be done," Maller says.

According to Sheffler, "A well-run, profitable ASC can be achieved only if clinical, administrative and financial issues are monitored and issues are quickly addressed."

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Microsurgery in 3D

3D viewing systems help surgeons educate residents, staff and patients. They also deliver better presentations, and provide a big-screen view when needed.

Engaging People in the OR

Until recently, only you and one observer or assistanting surgeon viewing through a beam splitter/assistant scope were able to watch the surgery in three dimensions. With a 3D monitor, everyone can be in on the action.

Jacob J. Moore, MD, medical director of Coastal Bend Eye Center and Ambulatory Surgical Center in Corpus Christi, Texas, uses a Sony 3D system. “The 3D system takes true high-definition video through both of the microscope’s optical paths, presenting it in real time in the OR on a medical-grade 3D monitor as well as recording and storing the video. Instead of relying on an observer’s scope for one person, we can let anyone in the room watch on screen,” he explains.

Another Sony user, Richard Mackool, MD, director of the Mackool Eye Institute and Laser Center in Queens, N.Y., and professor of ophthalmology at New York University Medical Center, says his staff appreciates the system. “Nurses and technicians in the OR love the 3D monitor. Instead of standing there and handing me what I need, they can put on 3D glasses and get in the game.” Cataract surgery is a fascinating procedure to watch, and following along keeps them interested and engaged.”

That inclusivity is important to Michael A. Saidel, MD, director of cornea service at the University of Chicago. He has been using the TrueVision 3D system (truevisionsys.com) for more than a year. “Although folks without glasses can still get an idea of what’s going on — the screen image just appears distorted — I like to have my scrub technician wear 3D glasses. Really, anyone who wants to watch in 3D can have a pair, whether it’s the circulating technician or an anesthesiologist,” he says. “Residents benefit, too. The system’s greatest advantage is that it makes an excellent teaching tool for residents, and the 3D monitor allows more residents to watch without crowding around an observer scope.”

Teaching Residents (and Yourself)

Among the advantages of 3D viewing systems, training is paramount. Residents and other medical professionals get a simulator-style experience, rather than merely an observer’s view.

“The new viewing systems have stunning image quality that makes them superb for training physicians or ancillary medical personnel. If that’s a part of your work, this is the way to do it,” says Dr. Mackool. “The 3D view is absolutely better than what they get with current observer scopes, and there’s no limit to the number of people you can watch in or outside the OR with video.”

Dr. Mackool also uses 3D video to enhance his own work.

“I review videos for teaching purposes and edit them to present to colleagues, but I get a clinical advantage in reviewing the videos for my own education,” he explains. “The 3D video really makes me feel like I’m performing the surgery — I even find my hands going through the motions — there’s just no comparison to two-dimensional video. I find myself saying, Why didn’t he just do this? And it’s me! So I’ve actually improved the way I do certain things based on the 3D video. I also watch past videos to brush up on a step in a surgery when I have an extremely rare case on my schedule. The virtual practice is just about as effective as practicing a real procedure. When I go into the OR, I’m very clear on what I need to do and when I need to do it.”

Educating Patients

Understandingly, many patients may not want to see a 3D video of their eye surgery, but surgeons find that the video does have a place in patient education.

“I share video with patients in select circumstances, such as when a patient is especially curious or when a complex case requires extra explanation,” Dr. Moore says. “For example, when I had to sew in a patient’s IOL, the lens wasn’t perfectly centered, causing some glare at the edge. We discussed the possibility of revising the positioning. The 3D video helped the patient see that this would be a technically demanding surgery, which may never have created a perfect outcome. She realized that she had an optimal situation for her eyes and passed on the second surgery.”

Dr. Mackool also finds that the high-resolution video helps him explain visual phenomena to patients in ways that diagnostic imaging devices can’t.

“If a patient has wrinkles in his cornea after LASIK, high-resolution 3D video of the cataract surgery shows that wrinkling — something slit lamp photography doesn’t have the resolution to capture. If that wrinkling impacts the patient’s vision, I can illustrate the situation, and the patient can then easily understand the problem and potential treatment,” he says. Dr. Saidel agrees. “Fortunately, complications are rare events, but if you have a

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complication or some interesting development, video is useful, and 3D video is even more useful.”

Presenting to Colleagues
Your colleagues have sat in countless presentations with slides and videos. Dr. Saidel prefers that when the lights go down, the 3D glasses go on.

“If you want to get your point across, there’s no better way to do it than to use 3D video,” he says. “I taught a course at the last AAO meeting that was loaded with 3D video. It not only makes certain aspects of the surgery more educational, but it also makes the whole presentation more compelling. It requires a 3D projector and plenty of glasses, but the result is well worth it.”

Dr. Moore presents 3D video to colleagues to market his practice more effectively. “The system has practice-building potential for referrals,” he explains. “When I share cases with colleagues in 3D, I get a ‘wow factor’ that doesn’t occur with two-dimensional video. They get all of the depth information, so they can appreciate how little space we have in the lens capsule. It helps them understand our capabilities and ultimately increases the status of our practice.”

Relieving Your Neck
None of the surgeons interviewed for this article use a 3D viewing system for “heads-up” surgery. The consensus is that the 3D monitor complements, rather than replaces, the view through the microscope.

“It’s an interesting part-time heads-up device for certain procedures, especially when I’m using the TrueVision Refractive Cataract Toolset, which has an overlay for IOL placement,” says Dr. Saidel.

Dr. Mackool sees the downside of looking up. “It’s potentially better for surgeons ergonomically, but whatever might happen to a surgeon’s neck and shoulders has already happened to mine!” he says. “I also think that there are some negatives to a heads-up approach. If I look at the screen, it takes my eyes away from the patient, and my peripheral vision is not focused there. I might miss a patient twitch, move or get ready to move, and those things are very important.”

“I don’t do heads-up surgery with the monitor, but it may be possible sometime in the future,” Dr. Moore says. “I have looked up at the monitor during surgery, and I’d say the quality of the image on the monitor is equivalent to what I see through the microscope, without the limitations of the head’s ability to only rotate only a certain number of degrees. If the system is eventually tested and approved for heads-up surgery, I would be interested in trying that for my long-term health.”

Looking Ahead
Are we likely to see 3D video systems in more and more surgery centers? These doctors say yes, pointing to the systems’ strong educational value and ever-improving features.

“I think all video for education and lecturing will be 3D in a few years,” says Dr. Mackool. “Two-dimensional video isn’t even half as good as 3D for teaching. 3D is so lifelike and vivid — you feel like you’re having the experience.”

Dr. Moore also sees 3D video catching on. “I’m excited about the technology, and I think surgeons will see its potential for teaching, lecturing and practice building,” he says. “The systems are more accessible than ever, too. Any microscope that can attach a beam splitter to a v-mount camera can use the Sony, and they’re coming out with a new dedicated beam splitter so it’s easier to install and use. They’re always refining the product.”

“I think in the future, the next step is a high-information display, whether that’s in the microscope oculars or in a heads-up monitor. We’ll be able to look at multiple images simultaneously, along with demographic information and clinical data such as astigmatism, lens power or potential complications. We’ll see OCT overlays projected onto the eye,” Dr. Saidel says. “Current 3D technology is clearly a stepping stone to the next level. Like any technology, what we’re doing now isn’t what we’ll be doing in the future.”

Discover the 3D difference at sony.com/3Dforsurgery.
inducement

1. An advantage or benefit that persuades or influences someone to do something.

Make sure your referral-boosting efforts don’t cross the line.

Macy’s can do it. Applebee’s can do it. Even your local barber can do it. In a free market, providers of goods and services can use numerous marketing devices — from frequent-shopper rewards to friends-and-family discounts — to encourage loyalty and referrals. In health care, however, some business-building tactics can land you in hot water with the government.

Perks for Physicians

Suppose your surgery center is in growth mode, with a goal of increasing case volume by a certain percentage. To that end, you invite a high-volume cataract surgeon in your community to use your facility. The surgeon expresses interest but notes he requires an expensive piece of equipment for his cases. Would the ASC’s purchase of that equipment be considered an inducement? That’s not likely, according to Mr. Crane.

“If the physician has a clinical preference for a piece of equipment, almost always in that kind of situation, that equipment would likely benefit patients and would not be viewed as a financial payment to the physician,” he says. “Every ASC or hospital wants the best surgical suite to attract good medical staff and have the best outcomes for patients. It’s very unlikely, absent other factors, that anyone would put that in the category of an illegal inducement.”

The situation becomes more complicated, however, when the physician has a financial relationship with a manufacturer. "Perhaps a better example would be a physician’s relationship with a device maker, such as an IOL manufacturer," Mr. Crane says. "More questions are raised about the appropriateness of those kinds of arrangements. Even then, most of the time, any legal challenge would be focused on the device maker or the equipment maker as opposed to the ASC. But the ASC could be swept into the investigation, and that would become very messy. It’s something compliance attorneys spend a good deal of time on.”

What can be more problematic, according to Mr. Crane, is when an ASC gives direct payments or things of value — office space, clerical help or billing assistance, for example — to attract or retain a high-volume surgeon. Some of these inducements may not be readily apparent to patients or even to the employees of an ASC or to the physician-partners who aren’t privy to the facility’s business management details.

“Preferred office arrangements based on referral volume are certainly a problem,” Mr. Crane says. “In fact, CMS prohibits ASCs from leasing or providing office space within the four
corners of the regulated ASC premises. Of course, an ASC may have a large facility that includes physicians’ office suites that aren’t part of the ASC, but essentially next door as part of the overall campus, which is permissible as long as the rent paid is fair market value and the opportunity to rent space isn’t offered preferentially to high-volume surgeons.”

Another situation that may raise a red flag involves the ASC’s administrative, clerical and nursing staff. “Having any member of the ASC staff made available without compensation to a high-volume referring physician is unquestionably a problem,” Mr. Crane says. “Such an arrangement is generally permissible when the physician and the ASC have a written agreement with clearly defined duties and fair market value compensation. But problems arise when an ASC quietly makes available secretarial or nursing staff that floats in and out of the ASC premises and the physicians’ offices. How do you know if the arrangement is in writing? How do you know if it’s for the full amount of the time? Many things about such arrangements are difficult to detect, and compliance attorneys are very careful in advising clients about such situations.”

Transparency and written agreements are keys to avoiding even a suggestion of impropriety. Mr. Crane recalls a case where an ASC was providing free billing services to a physician for his private practice as an inducement to refer his patients. “If there’s a written compensation arrangement, there’s a way to square the corners and make that legitimate,” he says, “but it’s also completely possible to do that without any compensation, and that’s where you’ve crossed the line.”

Significant Fraud and Abuse Laws at a Glance

- **The False Claims Act (FCA)** protects the federal government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the federal government. The “knowing” standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim. An example may be a physician who submits claims to Medicare for medical services he knows were not provided. Private party whistle-blowers may initiate claims under the FCA and are eligible to receive a percentage of the government’s recovery.

- **The Anti-Kickback Statute (AKS)** makes it a criminal offense to knowingly and willfully offer, pay, solicit or receive any remuneration to induce or reward referrals of items or services reimbursable by a federal healthcare program. Remuneration encompasses the transfer of anything of value (including gifts, sports tickets, meals or other incidental benefits), directly or indirectly, overtly or covertly, in cash or in kind. If an arrangement satisfies certain regulatory safe harbors, it is not treated as an offense under the statute. Proof of actual knowledge or specific intent to violate the law is not required. Violations of the AKS are also actionable under the FCA.

- **The Physician Self-Referral Law**, also known as the Stark Law, prohibits a physician from referring patients for certain designated health services to an entity in which the physician or an immediate member of his family has an ownership/investment interest, or with which he has a compensation arrangement, unless an exception applies.

- **The Criminal Health Care Fraud Statute** prohibits knowingly and willfully executing, or attempting to execute, a scheme or artifice:
  - to defraud any healthcare benefit program; or
  - to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any healthcare benefit program;

  in connection with the delivery of or payment for health care benefits, items or services. Proof of actual knowledge or specific intent to violate the law is not required. Fraud against private health plans is actionable under this health care fraud statute. Violations of Medicare fraud and abuse laws may result in nonpayment of claims, civil monetary penalties, exclusion from the Medicare program and criminal and civil liability. Government agencies, including the Department of Justice, the Department of Health & Human Services Office of Inspector General and the Centers for Medicare & Medicaid Services, are charged with enforcing these laws.

Free Rides for Patients

The Office of Inspector General (OIG) is responsible for enforcing the Social Security Act, enacted as part of the Health Insurance Portability and Accountability Act of 1996. In broad-stroke terms, the Act prohibits providers from offering Medicare or Medicaid beneficiaries any remuneration that’s likely to influence their selection of a particular provider, practitioner or facility.

CONTINUED ON PAGE 24
Advances in cataract surgery over the past decade have been dramatic, from instruments to surgical techniques to IOLs. Still, neither industry nor surgeons are resting on their laurels. Incisions are getting smaller and smaller, and there are more advanced IOL options than ever before. Phaco machines not only facilitate these changes with smaller incisions, but also raise the bar for safety and efficiency.

Surgeons looking to upgrade their machines can expect phaco tips for predictable microincisions, new handset features and a range of advances in the area of fluidics. In particular, if you’re interested in elliptical phacoemulsification or in gaining greater pressure control throughout surgery, you might look into trying some newer phaco machines. Colleagues who are using these systems praise their ease of use and, most importantly, their low rates of complication.

Centurion Vision System

“Cataract surgery is changing and will continue to change,” says James A. Davison, MD, FACS, of Wolfe Eye Clinic in Marshalltown, Iowa. “IOLs will be getting less bulky, which will enable us to use smaller incisions, and we’ll get to...”
The VERION™ Reference Unit is a preoperative measurement device that captures and utilizes a high-resolution reference image of a patient’s eye in order to determine the corneal and iris curvature of steep and flat axes, limbal position and diameter, pupil position and diameter, and corneal reflex position. In addition, the VERION™ Reference Unit provides preoperative surgical planning functions that utilize the reference image and preoperative measurements to assist with planning cataract surgical procedures, including the number and location of incisions and the appropriate intracorneal lens using existing formulas. The VERION™ Reference Unit also supports the export of the high-resolution reference image, preoperative measurement data, and surgical plans for use with the VERION™ Digital Marker and other compatible devices through the use of a USB memory stick.

The VERION™ Digital Marker links to compatible surgical microscopes to display concurrently the reference and microscope images, allowing the surgeon to account for lateral and rotational eye movements. In addition, the planned incisionless position and radius, IOL positioning, and implantation axis are all recorded as well as a complete list of contraindications, warnings and precautions.

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“I want the safest, most effective phaco technology in my hands, and I think the Stellaris achieves that by giving surgeons the best fluidics.”

— Louis D. “Skip” Nechamin, MD, of the Laurel Eye Clinic.

Dr. Davison uses the Centurion Vision System (Alcon), a recent successor to Alcon’s Infiniti system. “It enables us to do an excellent job with the routine cases that make up 80% of our work, while also doing a faster, better, safer job on the 20% that are the tough cases,” he explains. “Many of those tough cases are hard cataracts, so having a machine that’s really good for hard cataracts is a great thing. The Centurion does a better job on hard cataracts than the Infiniti did. The Centurion’s Intrepid Balanced Tip provides a uniquely efficient tip motion. Because of that, movement at the shaft is relatively reduced by about 50%, so the chance for thermal effect at the incision is consequently reduced as well.”

The fluidics capabilities of the Centurion give Dr. Davison less concern about complications, such as intraoperative floppy iris syndrome (IFIS). “The Centurion also offers excellent fluidics controls, so I can operate on small pupils or patients on tamsulosin hydrochloride (Flomax, Boehringer

Ingelheim Pharmaceuticals) without worry,” he says. “I can treat these more like routine cases. Turbulence is reduced and pupils don’t come down.”

Dr. Davison believes that the advancement of microincision surgery alone makes it an excellent choice. “The system has a cordless foot switch that everybody in the room loves because it means fewer cords and less clutter. Two computer-controlled plates squeeze the BSS bag gently to provide a constant IOP rather than relying on gravity and a hanging bottle. And the vitrector cuts at an unheard-of 4,000 cuts per minute, a speed that’s used all the time for vitrectomy,” he says. “The system helps us now and prepares us for the future. We always have to be optimistic and think long-term — if something is faster, better and safer, it’s worth the investment over time. I think this system will get us through the next 10 years very nicely.”

WHITESTAR Signature System

“Fluidics have become more and more important in cataract surgery for both efficiency and safety. With patients presenting for refractive cataract surgery earlier and with the advent of the femtosecond laser, we’re dealing with softer cataracts than before. With many of my patients requiring less phaco power, the fluidics become the critical component of ophthalmology at the New York Eye and Ear Infirmary.”

Dr. Ravir says that the two pumps in the WHITESTAR Signature System give him exceptional control. “The system has the ability to sequentially use true peristaltic and true Venturi pumps for different steps in the same procedure,” he explains. “The design allows us to utilize the holding power of the peristaltic pump during lens disassembly. After we’ve broken up the cataract by cracking or chopping, we switch over to ventilu fluidics to draw the pieces safely to the phaco tip. With Venturi, there’s no need for the phaco tip to travel to the periphery. We remove the pieces easily and quickly, without full occlusion, while saving fluid in the eye and causing less damage.”

The phaco tip’s elliptical movement makes surgery safer as well. “The WHITESTAR Signature System uses proprietary elliptical phacoemulsification technology. The longitudinal and lateral energies blend into a smooth elliptical movement,” he says. “There’s less repulsion at the tip, so we can use lower fluidic parameters. This allows

“The Centurion also offers excellent fluidics controls, so I can operate on small pupils or patients on tamsulosin hydrochloride (Flomax) without worry. I can treat these more like routine cases. Turbulence is reduced and pupils don’t come down.”

— James A. Davison, MD, FACS, at Wolfe Eye Clinic

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We have the best of both worlds now – low-energy, safe fluidic systems for the softer, younger lenses of refractive cataract surgery, as well as the ability to safely treat dense cataracts with the Ellips FX. The femtosecond laser can be helpful in both scenarios.”

— Tal Raviv, MD, FACS at New York Laser Eye Center

Stellaris Vision Enhancement System

Louis D. “Skip” Nichamin, MD, is medical director of the Laurel Eye Clinic in Brookville, Pa. He uses the Bausch + Lomb Stellaris Vision Enhancement System and was involved in the system’s inception and design.

“I think the Stellaris represents the best technology; picking up where its predecessor, the Millennium, left off,” he says. “I want the safest, most effective phaco technology in my hands, and I think the Stellaris achieves that by giving surgeons the best fluidics.”

Dr. Nichamin’s high praise for the Stellaris’ fluidics stems from its vacuum-based technology. “It’s the new generation of very efficient, high-performance vacuum-based pump technology. The Stellaris has forced infusion pressure, rather than a gravity-based hanging bag, which gives me very precise pressure control. I couldn’t imagine using anything else today,” he says.

According to Dr. Nichamin, fluidic control translates to better safety and fewer complications. “Consistent, controllable fluidics limit the chances of the most common complications, such as rupture of the posterior capsule,” he explains. “The system’s refined fluidic control and management on both the infusion and the aspiration sides — combined with the 1.8 mm microincisions that the system facilitates — leads to improved safety and stability in the eyes.”

With greater control over intraocular milieu, Dr. Nichamin says he’s able to handle complex cases more easily, including intraoperative floppy iris and small or large pupils. “Pump systems perform extremely well for those of us who often deal with complex cases,” he says. “A unique feature of the Stellaris is that if there’s a complication such as a damaged posterior capsule and vitreous loss, the vacuum-based system’s high cutting rate and smooth fluidics give us the ability to perform a very advanced and efficient vitrectomy — something one wouldn’t think of doing with a peristaltic pump.”

In addition to the clinical advantages Dr. Nichamin attributes to the Stellaris system, ease of use is another factor that makes it attractive. “Nothing is less efficient than a complication, so a good system is generally an efficient one,” he says. “But in day-to-day use, ease of use and efficiency become major criteria. The design team went to surgeons and staff to create a better approach to intraoperative efficiency and user friendliness. It’s mobile, with a very small footprint in the OR. It’s very logical and simple to use, and setup time is quick, which is very important in a high-volume setting like mine.”

Ocusystem ART Phacoemulsifier

“We’ve had Surgical Design phaco machines through three generations of the Ocusystem, starting 30 years ago when we opened the first freestanding ophthalmic ASC in Michigan,” says E. Mike Raphtis, MD, Medical Director of Balian Eye Center in Rochester, Mich., and Clinical Associate Professor at Ferris State University in Big Rapids. “We love performing microincision phaco surgery with the Ocusystem because the procedure results in excellent outcomes and minimizes infection and other complications. Safety is so important to us. We’ve had only six unplanned vitrectomies in the past 12 years, and our endophthalmitis rate is less than 1 in 3,000 cases.”

John V. Balian, MD, founder of the Balian Eye Center, chose the Ocusystem for practical, economic reasons, and those reasons remain valid today. “Originally, we chose the first patented phacoemulsification machine. Dr. Raphtis is excited about the new Ocusystem handpiece currently in development. ‘We’ll be able to perform phaco followed by irrigation, and aspiration with a single handpiece instead of switching instruments. The bi-lumen handpiece has a phaco needle for cataract extraction and an adjoining tube for infusion. After phaco, the handpiece function will instantly switch to irrigation and aspiration in this new design,’ he explains. ‘Eliminating that extra step in surgery saves time. It’s one of those revolutionary ideas you can’t believe hasn’t been thought of until now.”

Several Systems, One Consensus

“Phaco is a competitive environment, and there’s an unmitigated desire from both surgeons and industry to see better instruments with advanced software, needle design and fluidics,” says Dr. Nichamin. “His Stellaris system fills his needs, but surgeons have their choice of several systems. In comparing them, we get a complete picture of today’s cutting-edge cataract surgery. Phaco tip design is enabling surgeons to give patients all the benefits of microincision surgery. Elliptical for safer, more effective lens emul- sification and requires fewer lower settings overall. For example, when I’m down to the last quadrant, my Venturi vacuum is set no higher than 100 mm Hg, rather than the high vacuum levels of 500 mm Hg that other systems may use. I remove the last quadrant safely, with fewer risks and complications.”

Dr. Raviv anticipates continued updates to the WHITESTAR Signature System. “Traditionally, phaco systems have been updated with major machine cycles, but there are also more common software upgrades every couple of years to enhance various features. New phaco tips are continually introduced for smaller incisions and new tools to assist with femtosecond laser cataract surgery are in the works,” he says. “We have the best of both worlds now — low-energy, safe fluidic systems for the softer, younger lenses of refractive cataract surgery, as well as the ability to safely treat dense cataracts with the Ellips FX technology. The femtosecond laser can be helpful in both scenarios.”

with the WHITESTAR Signature System, Dr. Raviv’s Venturi vacuum is set no higher than 100 mm Hg when he is down to his last quadrant.
or medical supplier. Remuneration includes waivers of copayment or deductible amounts and transfers of items or services for free or other than fair market value. Since the Act went into effect, OIG has provided additional guidance, describing safe harbor exceptions. For example, providers may offer inexpensive gifts or services that have a retail value of no more than $10 individually or $50 in total annually per patient.

One question that arises regularly is whether or not a provider may offer free transportation for patients. In 2002, OIG solicited public comment on the possibility of a regulatory safe harbor exception for complimentary local transportation to beneficiaries residing in a provider’s primary service area. Issues of particular interest to the OIG included: forms of transportation; the geographic area in which transportation is offered; eligibility for transportation; type of provider offering transportation; destination; and marketing and advertising. To date, OIG has not adopted an exception for complimentary local transportation.

Examine Your Compliance
With closer surveillance by Medicare and increased enforcement of healthcare fraud laws, the importance of compliance cannot be overstated. “This is a time when most of my clients are taking compliance much more seriously. Some of the penalties can become significant, but equally important is the fact that the cost of an investigation alone can be debilitating.”

— Thomas S. Crane, Esq.

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- Dimitri Azar, MD
  - Bioengineering University of Illinois at Chicago, Chicago, IL
- Perry Binder, MD
  - CompuLinkAdvantage, Westlake, CA
- Uday Devgan, MD
  - Devgan Eye Surgery, Los Angeles, CA
- Deepinder Dhaliwal, MD
  - University of Pittsburgh School of Medicine, Pittsburgh, PA
- C. Stephen Foster, MD
  - Massachusetts Eye Research & Surgery Institution, Cambridge, MA
- Stephen Kaufman, MD
  - University of Minnesota, Minneapolis, MN
- Kenneth Kenyon, MD
  - New England Eye Center, Boston, MA
- Terry Kim, MD
  - Duke University Eye Center, Durham, NC
- Mitchell A. Jackson, MD
  - Founder/Director, JacksonEye, Lake Wila, IL
- Stephen Kaufman, MD
  - University of Minnesota, Minneapolis, MN
- Kenneth Kenyon, MD
  - New England Eye Center, Boston, MA
- Peter Laibson, MD
  - Wills Eye Institute, Philadelphia, PA
- Yaron Rabinowitz, MD
  - Cornea Genetic Eye Institute, Cedars-Sinai Medical Center, Beverly Hills, CA
- Christopher Rappano, MD
  - Wills Eye Institute, Philadelphia, PA
- John Sheppard, MD
  - Virginia Eye Consultants, Norfolk, VA
- Scheffer Tseng, MD
  - Ocular Surface Center, Miami, FL

**Target Audience:** The primary target audience for the ACC is general ophthalmologists and cornea specialists practicing in comprehensive and cornea subspecialty work settings.

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**Practical Innovation with Femto Technology**

- How to successfully integrate femto lasers into your practice
- The femto perspective after purchase
- Why you should invest in the technology now
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**Contributing Doctors:**

- Ryan P. Conley, DO
- Joel Corwin, MD
- John Davidson, MD
- Jose de la Cruz, MD
- Jonathan M. Frantz, MD
- Scott LaBorwit, MD
- Ivan Mac, MD
- James P. McCulley, MD

The doctors featured in this supplement received compensation from Alcon for their contributions to the supplement.

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Early and ongoing teamwork figures heavily into patient acceptance of femtosecond laser technology.

“I don’t consider myself an early adopter of femtosecond–laser-assisted cataract surgery,” says John Davidson, MD. As he explains it, he followed the technology from the sidelines for about 2 years before he was convinced it had reached a point in safety and efficacy to be a worthwhile investment for the practice. When he and his practice partner, Joel Corwin, MD, at Miramar Eye Specialists Medical Group in Ventura, Calif., came to that conclusion, they accelerated their efforts to learn as much as possible about what it would take to make the technology profitable in practice. According to their research, other practices and surgery centers were finding they needed to use the laser in 20 to 30 cases per month to break even on their expenditures.

Dr. Davidson continued to talk with cataract surgeons about their experiences with femtosecond lasers. He visited several practices to observe procedures, attended laser user meetings and set up appointments during industry meetings to ‘test drive’ lasers and talk with engineers about their products’ specifications, capabilities and outcomes. “Once we decided to purchase a laser, I made a pact with myself to read something about femtosecond cataract surgery every day, whether it was a user manual, articles in journals, trade publications or online,” he says. “All of that prompted me to ask questions.”

Early Steps Toward Integration
Several years earlier, Dr. Davidson had already asked and answered one key question: How could he change his practice so it would perform optimally in the era of refractive cataract surgery? “In 2005, when CMS approved billing for presbyopia-correcting IOLs, I was seeing 100 patients some days,” he says. “I wanted to personally speak with each cataract patient about the new lens options, but it was very disruptive to the daily flow. Because of that, I made the decision to give up the half of my practice that involved general ophthalmology patients in order to focus on surgery. This allowed me to spend time with patients and build a surgical referral-only practice.”

With laser-assisted cataract surgery taking off, one of the first steps he took was to hire a refractive cataract surgery counselor to help ensure patients were adequately educated about their options. Also, the surgery center built out what had been a staff break room to house the laser.

In addition, Dr. Davidson collaborated with the entire staff to plan how to talk to patients about the advanced technology. “We concentrated on developing phraseology based upon what we were hearing and reading that was already working in other practices,” he says. “As with advanced technology IOLs (ATIOLs), our goal when talking to patients is to emphasize how the technology benefits them, not necessarily the technology specifications.”

Choosing a Laser Platform
After doing their research, Drs. Davidson and Corwin decided to purchase the Alcon LenSx® Laser. Several attributes of the LenSx Laser platform stood out:

- The laser doesn’t have a fixed patient bed. “This is important for patient safety, comfort and flow,” Dr. Davidson says. “We administer IV sedation while patients are on a gurney in the LenSx Laser room, and then move the gurney to the OR.”
- The laser’s variable numerical aperture is designed to optimize precise cutting of the cornea and the lens. “Some femtosecond lasers typically have only one numerical aperture, which is optimal for either the cornea or the lens but not both, whereas the LenSx Laser is designed to address both,” Dr. Davidson explains.
- The user interface sequentially presents the necessary steps for planning incisions. “I felt that certain other user interfaces displayed numerous parameters without an obvious sequence, so it was difficult to know if I was finished focusing on what I needed to do before moving to the next step and before depressing the foot pedal,” Dr. Davidson says.

- With the curved SoftFit® Patient Interface, the natural curvature of the cornea can conform to a soft contact lens insert. “The SoftFit Patient Interface reduces corneal distortion and striae,” Dr. Davidson notes. “Patients are more comfortable, less energy can be used, the rate of free-floating capsulotomies is increased and procedure time is reduced.”

Dr. Davidson is also looking forward to the new matrix phacofragmentation patterns for the LenSx Laser, which are expected in the near future. “Currently we can perform up to three chops, which divide the lens into six segments, and zero to eight concentric cylinders that divide the lens into microfragments. I’m expecting the new fragmentation patterns to exceed these bounds, further reducing phaco time and collateral tissue inflammation.”

Beyond the technical aspects of the LenSx Laser, Dr. Davidson also felt comfortable partnering with Alcon. “During my 20-year career, the company has demonstrated that its commitment to innovation and making sure it has the best technology available,” he says. “The LenSx Laser is designed with extensibility, so I was confident Alcon would keep up with and surpass whatever other companies were doing. Making such a large investment, you really have to consider future viability.” The development of the company’s SoftFit Patient Interface is just one example of Alcon’s dedication to innovation and continued improvement, he says.

On Target with Case Volume
Richard A. Lewis, MD, and his partners in Capital City Surgery Center in Sacramento, Calif., began using their LenSx Laser at the end of last year. “We have a good setup for this because we have a third OR where we were able to place the laser,” he says. They chose Alcon’s LenSx Laser platform because of their long standing positive relationship with the company. “Also, the laser was the first to be FDA cleared for use in cataract surgery and had broad applications,” he says. “Many centers were recommending it, and there was a great deal of momentum behind it.”

The partners’ goal was to use the laser in 20% of the cataract surgeries performed in the center. “I have a slightly different patient base because of my dual focus on glaucoma care, but I’ve been using the laser in 10-20% of my cataract cases,” Dr. Lewis says. “As a center, we’re doing more than that, so we’re right on target.”

Dr. Lewis cited staff education and patient education, which both require focused teamwork, and anticipating and managing the surgeon learning curve as crucial for meeting the case volume target. “First, everyone in the office and ASC — including technicians, front desk personnel and surgical coordinators — has to be comfortable with the concept of femtosecond laser-assisted cataract surgery and what it involves because all of them will be talking to patients about it. Next, you have to create an OR environment in which everyone, including the pre-op nurses and anesthesia team, is working together to incorporate the laser.

“The surgeon needs to recognize that he’ll be working through a learning curve as well,” concludes Dr. Lewis.

From Planning to Execution
With the LenSx Laser installed in early May of this year, it was time for Dr. Davidson to begin navigating the technology learning curve and see how effective the team-wide preparations would be. “The technique of laser-assisted cataract surgery requires a comprehensive and systematic approach to gain mastery and confidence with its application,” says Dr. Davidson. He took his time in the LenSx Laser room and in the OR with his first cases to adjust to the nuances that make laser-assisted surgery different from the traditional approach, such as visualization with bubbles in the anterior chamber and lens, fine-tuning laser energy settings to promote easy opening of incisions, disassembly of nuclei in pre-chopped lenses and cortical cleanup without “handles.”

“Initially, the laser portion added 10 minutes to each case in the LenSx Laser room and an extra 8 to 20 minutes in the OR,” he says. “We were simultaneously integrating the ORA System® (WaveIic Vision) for intraoperative wavefront aberrometry, so that figured into the added OR time.” Dr. Davidson says he was very comfortable with all of the steps in the laser room and OR by the time he had performed 100 cases. After that point,
**Table 1**

<table>
<thead>
<tr>
<th>MONTH</th>
<th>NO. OF LENSX LASER CASES</th>
<th>LENSX LASER ADOPTION RATE</th>
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<td>May</td>
<td>26</td>
<td>20%</td>
</tr>
<tr>
<td>June</td>
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<td>July</td>
<td>56</td>
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<td>August</td>
<td>56 (in 3 weeks)</td>
<td>39%</td>
</tr>
<tr>
<td>September</td>
<td>79</td>
<td>54%</td>
</tr>
</tbody>
</table>

*The numbers indicate the adoption rate for the LenSx Laser in various months.*

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**Tips for Integrating the LenSx Laser Into Your Practice**

Learn how these new users quickly got up to speed.

It’s one thing to hear early adopters tout the benefits of new technology from the podium, but quite another to decide it’s time to integrate it into your practice. Promises of outstanding outcomes notwithstanding, practical concerns and questions arise. We spoke with two surgeons who believe the femtosecond laser will figure prominently in the future of cataract surgery. They researched their choices, crunched the numbers and decided the LenSx Laser (Alcon Laboratories, Inc.) would meet their needs now and in the future. In this article, they discuss why they chose the LenSx Laser, how they successfully incorporated this technology into their practices and tips for a smooth transition to laser cataract surgery.

### Why the LenSx Laser?

Advanced technology with multiple FDA clearances, along with a supportive, forward-thinking manufacturer made the LenSx Laser the front-runner for the surgeons we interviewed. “When we started looking at femtosecond lasers, we recognized that the LenSx Laser had the most FDA clearances. It’s cleared for anterior capsulotomies, corneal incisions and phacoemulsification,” says Ryan P. Conley, DO, a partner at Triad Eye Medical Clinic and Cataract Institute, Tulsa, Okla. “In addition, having used Alcon pharmaceutical and surgical products, we knew the company provided excellent products and support.” According to Dr. Conley, the company installed the laser promptly and efficiently and provided in-depth education, not only certification training for the surgeons but also important information for technicians, counselors and office staff.

“Alcon’s commitment to the femtosecond laser market and its willingness to deploy resources to support this platform were key factors that influenced my decision to buy the LenSx Laser,” says Ivan Mac, MD, MBA, founder of Metrolinea Eye Associates, Monroe, N.C. “An engineer is always available to us, and the company’s marketing staff has been extremely helpful. I also benefit from the company’s quarterly LenSx Laser user meetings, where I can network and share ideas with other surgeons.”

Both surgeons believe the LenSx Laser platform will form the basis for future advancements in femtosecond technology. Dr. Mac notes, “Alcon has developed an image-guided surgery system called VERION ™ image system which takes a picture and measurements of the eye in an undilated state, and populates the image and data into an advanced planning software program that allows the surgeon to plan each detailed step of their procedure at a single source. This case file may then be transferred via USB stick to the LenSx Laser to auto-align our pre-determined plan for that patient’s incision and arcuate. It automates all of our preoperative steps. The company doesn’t just say, ‘Here’s a femtosecond laser, and look what it can do.’ It shows us what the future will look like with new components that will help us continue to enhance our outcomes.”

### Up and Running Efficiently

Patient flow is key for efficiency in the OR. In just 3 months, Dr. Mac and his team have integrated the LenSx Laser into their surgical routine and patient flow has become “seamless.” Because of limited space, they’ve placed the unit in their OR.

“One of the benefits of the LenSx Laser system is that it doesn’t have a fixed bed,” Dr. Mac says. “Patients are wheeled into the OR on an existing bed and positioned under the laser for that part of the surgery. Then, the bed is swiveled around, and the patient is prepared for phacoemulsification and lens implantation. It’s a patient-friendly set-up because patients

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*Sponsors of this program were key factors that influenced my decision to buy the LenSx Laser.**
Every surgeon has to develop his own techniques to science, so we’re adding only 3 to 4 minutes per case. You don’t have to move to different beds. This is a big advantage from a flow standpoint.”

Space is also at a premium at Dr. Conley’s surgery center. In the 16 months he’s been using the laser, he experimented with different routines before finding the best way to maximize efficiency. He also has the laser in one of his OR suites and after performing the laser procedure, repositions the patient under the microscope to complete the procedure. “We found it’s the most efficient routine. In total, the laser adds 2 to 3 minutes to the operating time. Now that we’ve experimented with different routines before finding the best outcomes for their patients. I believe our referrals have increased as a result.”

Natural Fit with ATIOLs

Both surgeons have been using advanced technology intraocular lenses (ATIOLs) in their practices, and the femtosecond laser is a natural fit for them. “Although my practice isn’t located in a wealthy area, our conversion rate to premium IOls was averaging from 25% to 40%,” Dr. Mac says. “So I viewed femto-phaco as the next logical step in the evolution of my practice.”

In Dr. Mac’s practice, anyone who chooses an ATIOL will undergo laser cataract surgery. The fees for the ATIOL and the laser are bundled. “We increased our fee for premium ATIOLs to include the use of the laser,” Dr. Mac explains.

Dr. Mac has been surprised by the number of patients who are choosing to upgrade. “We’re seeing about a 60% to 70% conversion to either the femtosecond laser or the femtosecond laser with a premium lens,” he says. “In Dr. Conley’s practice, 75% of patients who choose ATIOLs in his practice have laser cataract surgery. “Unless the laser is contraindicated — in patients with corneal scarring, trabeculotomy or some other glaucoma filtration device, for example — we offer it to all patients who would benefit from cataract surgery with ATIOLs,” he says. “Many individuals simply like the idea of a laser creating their incision as opposed to a blade.”

Dr. Conley also has seen an uptick in the use of ATIOLs in his practice. “I think word of mouth is partly responsible,” he states, “but I also believe our referring doctors are more confident in our ability to offer a more precise procedure. Because of the LenSx Laser technology, I’m delivering better results. I’m getting to the intended refractive target more often.”

The laser time and laser energy have trended downward with parameter modifications and transitioning to the Soro® Patient Interface. Consequently, we’re seeing more calm and quiet eyes on post-op day 1.”

Top-down Education

Both surgeons emphasize the importance of educating everyone in the practice about laser cataract surgery, and they credited Alcon for providing a comprehensive educational program. “They included our clinical technicians, our front desk staff, our checkout staff and even our opticians,” Dr. Mac says. “Since then, to reinforce that education, we’ve rotated two or three staff members each week into the OR, to observe cataract surgery with and without the laser, so they can understand the differences.”

Dr. Conley agrees that staff plays a key role when integrating new technology. “After seeing how the technology works and understanding the benefits, our staff members are comfortable discussing laser cataract surgery with our patients,” he says.

To enhance their patient education, both surgeons have incorporated video clips supplied by Alcon into their own cataract videos. As for one-on-one counseling, Dr. Mac does most of the counseling himself. “After a patient views the video, I meet again with him, look at the dilated examination and review the studies,” he explains. “Then, I describe both manual and laser cataract surgery in detail and the differences between them. I spend more time with patients, but it’s definitely higher yield when I have that discussion versus when a counselor has it.”

Dr. Mac uses a program on his iPad that shows patients how presbyopia and astigmatism affect their vision and how ATIOLs address those conditions. “I show them side-by-side comparisons of blurred vision versus clear vision with the ATIOLs,” he says. “I think seeing what the technology can do for their vision really hits home. Then I always tell patients, ‘These are your options. I want you to pick the option that will work best for your visual needs and for your financial situation.’ Patients will upgrade. It’s just amazing.”

Breakeven Realities

With the purchase of any new technology, particularly a big-ticket item such as a laser, concerns about costs, time to break-even and return on investment are always part of the discussion. “Alcon has a business model to help you anticipate what sort of revenue you’ll generate and the number of cases you need to perform to break even,” Dr. Conley explains. “The company also offers financing. All of the details were laid out in advance for us. In our practice, with two surgeons and a modest increase in conversion, we reached the breakeven point in just 3 months.”

Dr. Mac’s practice also reached the break-even point rapidly. “We thought it would take at least 15 cases a month to break even and that we would run at break even for the first year or so,” he said. “Right now, we’re consistently performing 45 to 50 cases a month. We’ve far surpassed expectations. This is the fastest adoption of anything I’ve ever seen before.”

Growth Through Innovation

Both Dr. Conley and Dr. Mac believe femtosecond technology takes cataract surgery to the next level, which in turn has taken their practices to a new level. “It’s giving us accuracy and precision that we could never achieve before,” Dr. Mac says. “My enhancement rate for ATIOLs is extremely low now, because I’m able to make very precise and reproducible arcuate incisions with this laser. My post-op day 1 patients see better than when I perform the surgery manually. Patients have a faster visual recovery, and they’re happier.”

According to Dr. Conley, offering laser cataract surgery has revitalized his practice. “Our practice has always been known for innovation in the local community,” he says. “So when I joined the practice, I wanted to continue the same trend and add new technology when it became available. Since we began offering cataract surgery with the LenSx Laser, our practice has experienced significant growth.”

Dr. Mac offers one additional pearl: “To any surgeon who is concerned about being successful with femtosecond technology, I would say, ‘Don’t sell it.’ Just explain the differences between manual and laser cataract surgery. Patients understand.”

“I wanted to continue the same trend and add new technology when it became available. Since we began offering cataract surgery with the LenSx Laser, our practice has experienced significant growth.”
As surgeons consider whether they should invest in femtosecond laser-assisted cataract surgery, three questions invariably come up. Can the technology improve my procedure? Will enough of my patients choose this option to allow me to at least break even on my investment? In terms of patient flow and awareness, is it logistically possible to succeed? For two surgeons who have been using the Alcon LenSx Laser for 17 months, the answers are yes, yes and yes. Jonathan M. Frantz, MD, FACS, of Frantz EyeCare and Suncoast Surgery Center in Florida, and Scott LaBorwit, MD, of Select Eye Care in Maryland, recently answered some more detailed questions about their experiences with integrating the LenSx Laser.

Q: Why Did You Decide to Adopt Femtosecond Laser Cataract Surgery?

Dr. Frantz: In my opinion, there’s no question the LenSx Laser substantially improves the accuracy and precision of cataract surgery compared to manual procedures. If I program it to create an incision with 20° of arc at 80% of the corneal depth, I know that’s what I will get. Removing variability is invaluable for analyzing results, fine-tuning nomograms and improving visual outcomes.

Dr. LaBorwit: The first time I saw the precision of the LenSx Laser in action, I couldn’t believe it. Like most surgeons, I thought my capsulotomies were great and my lens sculpting techniques were ideal. Now I know the laser can make my 5-mm circular capsulotomy and place it exactly where I want it every time. I have no doubt that studies will show what a difference femtosecond technology can make for the lens position. With OCT imaging for measuring each eye’s distinct size and shape, incisions can be made at specific tissue points, which isn’t possible manually. The incisions seal and heal so well that I’ve reduced my patients’ bending/lifting restriction time. The system precisely measures the cataract, too, so the laser can break it up while leaving a cushion at the bottom. In my LenSx Laser cases, I use 50% less ultrasound energy on average, see less corneal edema, and I’ve seen a reduced need for post-op steroids.

My LenSx Laser procedures are more customized, yet more routine. Everything in the OR is more predictable because of the reproducibility of the laser steps. Because of the precision, I can work comfortably with no surprises — even in the toughest situations such as small pupils, long eyes, weak zonules (Fuchs’ dystrophy or pseudoexfoliation.) I haven’t used iris hooks or manually stretched a pupil in any of my more than 1,000 LenSx Laser cases.

Q: In What Percentage of Your Cataract Surgeries Do You Use the LenSx Laser?

Dr. Frantz: 50%. Patient acceptance of the technology hinges on having thoroughly educated staff members who understand and appreciate its benefits for patients, so they can convey that knowledge and enthusiasm to patients.

Dr. LaBorwit: 65%. We hired a marketing person to help us position the new technology in our market. We added videos about laser-assisted surgery to our website and tried some external advertising, but we’ve found it’s most effective to focus our efforts on our referring doctors and patients who have already decided to come to us. Robert Stutman, OD, MBA, FAAO, our practice administrator, director of optometric services and my partner in the practice, manages our referral network communications. Internally,

Two surgeons discuss outcomes, procedure volume and efficiency after 17 months using the LenSx Laser.
Dr. Stutman made sure everyone had the opportunity to visit the OR and learn what the LenSx Laser was all about.

Also, I make a video of each patient’s laser-assisted procedure and explain each step as I go along. About a week after their surgeries, we ask patients if they’d like to watch it. About 80% opt to do so. We give it to them on a USB drive in the hopes it will help them understand what makes laser surgery different than standard surgery, so they will share what they know with friends and family.

We expect the percentage of cases in which I use the laser to continue to grow, which is why we purchased a second LenSx Laser 6 months ago.

**Q:** What Impact Has the LenSx Laser Had on Your Efficiency?

**Dr. Frantz:** At 17 months after our first case, we’re as efficient as we were previously. We perform very close to the same number of surgeries in the same amount of time, but because we offer upgraded services for which patients pay out of pocket, we’re more efficient from a dollars per hour perspective.

**Dr. LaBorwit:** For predictable patient flow, Dr. Stutman and I schedule all cataract evaluation visits in full-day or morning blocks. All of the necessary tests are performed, and I spend 15 minutes talking with each patient about their procedure and IOL options. Adding the LenSx Laser to the discussion required about one additional minute. After their talk with me, patients meet with the surgical coordinator. She talks with them further about their options, including costs.

On surgery days, I work out of one OR. The LenSx Laser is in a separate room, and we use what had been extra space as a separate LenSx Laser pre-op area. The OR runs the same as it always has, I essentially created a LenSx Laser “loop.” Patients remain on the same wheeled stretcher the entire time. The nurse assesses patients while they’re in the LenSx Laser pre-op area. From there, we move them to the LenSx Laser room, out of the LenSx Laser room to the OR pre-op area (where we start IV sedation) and then to the OR. At the beginning of each day, I perform two LenSx Laser sessions in a row. Each one takes approximately 4 minutes. I then alternate between the OR and the LenSx Laser room. I start at 7:30 a.m. and perform 18 LenSx Laser surgeries with phaco by 1 p.m. followed by 5-7 standard procedures. I talk to each patient before docking the LenSx Laser interface, and I talk to each patient and their family member(s) when they are out of the OR. They appreciate hearing directly from me that everything went well.

**Q:** What’s Next for Laser-Assisted Surgery?

**Dr. Frantz:** The imaging, patient interface, incision software and lens fragmentation components of the LenSx Laser have undergone several upgrades since we purchased the system. Each has delivered measurable improvements in efficiency, flexibility and/or capabilities.

The introduction of the VERION™ Image Guided Laser-Assisted Surgery, the VERION™ Image Guided System is designed to enable us to work with precision and efficiency. The VERION™ Reference Unit (Figure 1) is designed to enhance surgical planning. It integrates with the VERION™ Digital Marker (Figure 2) and the OR microscope to display patient information and images from the Reference Unit and with the LenSx Laser and the CENTURION® Vision System (Alcon’s newest phacoemulsification machine) to guide optimal incision and IOL placement. With this type of communication and registration between the various tools we use, we are one step closer to removing any remaining guesswork out of refractive cataract surgery and replacing it with reproducible accuracy.

Building Confidence in a New Generation of Eye Surgeons

Ophthalmology residents and fellows gain experience with cutting-edge cataract surgery technology.

Keeping up with advances in technology is a challenge faced by every educational institution, but nowhere is it more critical than in medical schools preparing the next generation of eye surgeons. Cataract surgeons in particular are posed on the cusp of a new era of technologically advanced procedures that inevitably will raise the expectations for refractive outcomes among patients and surgeons alike.

“The femtosecond laser will change the way we approach cataract surgery,” says Jose de la Cruz, MD, assistant professor of ophthalmology at the University of Illinois at Chicago (UIC) College of Medicine and director of Millennium Park Eye Center. “At our institution, we want to be at the cutting edge of technology, not only to provide our patients with the most advanced treatments, but also as educators, to prepare our residents to be at the forefront of ophthalmology.”

James P. McCulley, MD, professor and chair of the department of ophthalmology at the University of Texas (UT) Southwestern Medical Center in Dallas, is also eager to have his residents learn to use the new technology. “If our residents aren’t prepared to perform image-guided laser-assisted cataract surgery when they graduate, then we’ve put them at a disadvantage in the job market,” he says.

Both of these educators have integrated LenSx® Lasers (Alcon Laboratories, Inc.) into their residency and fellowship programs. In this article, they share their observations about the laser’s utility in the educational setting and in practice.

**Precise and Predictable**

Since 2009, the LenSx Laser has gained several FDA clearances in quick succession. It’s now cleared for anterior capsulotomies, corneal incisions, phacofragmentation and flaps (future capability). “The LenSx Laser today, compared with the LenSx Laser when it was first rolled out in clinical trials for FDA consideration, is substantially improved,” Dr. McCulley says. “The laser is much more precise than a blade or a needle in a surgeon’s hand. The recent addition of the SoftFit™ Patient Interface is a major advancement (Figure 1). It minimizes corneal distortion, enabling the surgeon to reliably create complete 360-degree capsulorhexes. In addition, the OCT imaging is clearer than the previous LenSx Laser OCT imaging.” Dr. de la Cruz also appreciates these improvements. “The...
Residents Compare Manual Versus Femtosecond Cataract Surgery

Ophthalmology residents and fellows at the University of Illinois at Chicago performed a retrospective study comparing their experiences performing cataract surgery with and without the femtosecond laser. The 6-month results were reported at the 2013 meeting of the Association for Research in Vision and Ophthalmology.

Residents and fellows, with attending supervision, performed cataract surgery on 123 eyes; 32 eyes were treated with the LenSx femtosecond laser, and 91 eyes were treated with standard cataract extraction techniques without the use of the laser. The LenSx Laser was used to create corneal incisions in 31 of 32 laser cases, and anterior capsulotomy and lens fragmentation in all 32 laser cases. In the non-laser group, these steps were performed manually along with standard phacoemulsification. The remaining steps of the cataract surgery were performed in the same fashion in each group.

Cataract extraction in the laser group required fewer seconds of phacoemulsification and torsional movement, less cumulative dissipated energy and less irrigation fluid. There was a trend toward a greater degree of subconjunctival hemorrhage in the laser group, which was likely a result of the suction required during use of the laser. This resolved within 24 hours. No posterior capsular tears or wound burns were detected in the laser group, compared with three cases of posterior capsular tear and one case of wound burn in the non-laser group.

The researchers concluded that resident surgeons on the initial learning curve for cataract surgery are capable of safely learning standard phacoemulsification techniques along with use of the LenSx Laser system. In addition, the LenSx Laser system appears to allow cataract extraction with less energy, which may result in improved long-term outcomes.

High-tech Surgical Training

Dr. de la Cruz has been using the LenSx Laser in his training program at UIC for about 2 years; the SoftFit® Patient Interface was introduced in the spring of 2013. This technology is integral to his approach to teaching cataract surgery. “The laser has the capability to complete certain steps of the surgery, so if a resident is having difficulty manually performing any of these steps, such as constructing the wound, creating the capsulorhexis or fragmenting the lens, I have the laser do it for him,” he says. “The resident will continue to practice the manual technique in the wet lab to perfect it, but by having the laser do that part of the surgery, we don’t put a patient at risk of complications. Nor do we decrease the number of surgeries we’re doing, and we don’t delay the process of learning other parts of surgery. We’re not changing the way our residents do surgery, we’re just giving them another option.”

A survey of cataract surgeons training in Europe several years ago found the most difficult steps in the surgical procedure were capsulorhexis and nuclear division. Dr. McCulley says he would add a third difficult step: creating consistent, self-sealing, watertight corneal incisions. “The LenSx Laser accomplishes all of these steps in a more predictable manner than manual surgery.”

The faculty is using the laser at UT, and Dr. McCulley expects to begin training residents shortly. “My intention with our training program is to have residents begin learning phacoemulsification cataract surgery and IOL implantation by using the LenSx Laser,” he says. “Once they’re proficient with the laser, I’ll have them perform the entire procedure manually. That way, when they finish their training, they’ll be proficient with both methods.”

Although their approaches differ, both Dr. McCulley and Dr. de la Cruz want to ensure that surgeons who’ve been through their programs will have the skills necessary to perform cataract surgery, even if they don’t have access to a femtosecond laser or if they have patients who aren’t candidates for the laser.

Minimal Learning Curve

Dr. de la Cruz had some concerns that residents who were just learning to perform cataract surgery would face a steep learning curve when the femtosecond laser was introduced. He was pleasantly surprised. “Imagine you’re learning to perform a surgery and then someone throws in a new technology,” he says. “My initial thought was the residents might be resistant to it and have difficulty, but in fact, it was the opposite. The learning curve was almost nonexistent. The residents were able to adapt to this new technology very well early on, and we didn’t put anyone at risk. Nor was there a greater burden on the residents with regard to their education.”

Not only did residents adapt, but they embraced the new technology. “For the residents, it’s exciting to add a component of technology,” Dr. de la Cruz says. “Of course, with their initial cases, they were cautious, but once they entered fully into it, they enjoyed it. They really appreciate being able to have a perfect capsulotomy. They enjoy being able to place their wounds wherever they want them with exact precision to depth and thickness. They found their outcomes were much more predictable and reliable.”

Confidence Builder

According to Dr. de la Cruz, residents and fellows using the LenSx Laser are implanting toric and multifocal lenses with more confidence. “I’ve noticed a change in how our residents advise patients,” he says. “In the past, they were more likely to offer patients advanced technology IOLs later in the year. Now, they’re comfortable offering them to patients as early as August, which is the beginning of their third year. Seeing that they’re more confident providing this kind of care early in their training, I believe they’ll be more confident offering it to their patients when they go into practice.”

Dr. de la Cruz notes his own confidence has increased. “Now that I have the LenSx Laser system, I feel my outcomes are more predictable, particularly when positioning the lenses,” he says. “I’ve been more comfortable and confident offering advanced technology lenses to my patients. In fact, my practice has become much more focused on refractive cataract surgery, because I can offer extra precision to patients with the laser and the addition of advanced technology IOLs now.”

High Expectations

Cataract surgery is increasingly becoming a refractive procedure, and patients’ expectations reflect that shift. As Dr. McCulley notes, “With monofocal and astigmatism-correcting lenses, patients expect to see well at distance. With presbyopia-correcting lenses, they expect to see well at all distances. What’s more, patients want their cataracts removed with a laser, because they have the perception that lasers are more precise and safer.”

In addition, they were excited to have the surgery partially done with a laser. That’s very attractive to patients.

Reference


Mr. Cortes received honoraria and research support from Alcon, and Mr. McCulley received honoraria and research support from Alcon.
The LenSx® Laser System should only be operated by a physician trained in its use. The LenSx® Laser System is intended for use in patients undergoing cataract surgery for the removal of the crystalline lens. Intended uses in cataract surgery include anterior capsulotomy, fragmentation, and the creation of a plane along the lens equator used for either capsular support or the creation of a vacuum in the capsular bag. Cataract procedures may be performed either individually or consecutively during the same procedure.

PRECAUTIONS:
- Do not use cell phones or pagers of any kind in the same room as the LenSx® Laser.

AES/COMPLICATIONS:
- Damage to intraocular structures
- Infection
- Corneal abrasion or defect
- Incomplete or interrupted capsulotomy, fragmentation, or corneal incision procedure

WARNING:
- Discard used Patient Interfaces as medical waste.
- Patients with a strong history of ocular allergy need to be premedicated with eyelid ointment and aqueous base.
An article in this issue focuses on the dangers of inducement. This article includes an interview with Thomas S. Crane, Esq. and reviews different aspects of inducements and compliance. Some of the issues in this review involve examples of inducement encountered in an ophthalmic ASC; others involve compliance infringements or simple errors. Some are sins of commission; others are sins of omission.

Cosmetic Procedures

Cosmetic procedures are statutorily excluded from coverage in the Medicare program. From an ASC perspective, this means it is the patient’s responsibility to pay the surgeon’s fee, the facility fee and the anesthesia fee for any cosmetic procedure. If the procedure is both cosmetic and functional then the ASC, anesthesiologist, and surgeon may bill Medicare for the functional surgery but must bill the patient for the associated charges for the cosmetic portion. Here are some examples of compliance infringements I’ve found when auditing ASCs; some are simply mistakes but when there is intent, Medicare would consider it fraud.

CLINICAL SITUATION: Patients routinely scheduled for surgery for functional upper eyelid blepharoplasty and ectropion repair of both lower eyelids.

COMPLIANCE ISSUE: Perusal of the operative notes reveals that bilateral lower eyelid blepharoplasties were performed. This would be considered fraud since there is intent.

CLINICAL SITUATION: Patients routinely scheduled for surgery for direct eyelid lesion excision (CPT codes 11440-11446, 11640-11646, 67840).

COMPLIANCE ISSUE: The coding was intentionally upgraded to CPT codes for tissue rearrangement (CPT codes 14060-14061). In this type of upcoding, the repair codes (CPT codes 12011-12018 or 13151-13153) are used.

CLINICAL SITUATION: Use of CPT code 61782 (Stereotactic computer-assisted [navigational] procedure; cranial, extradural) for cases other than those with which the code was designed to be used.

COMPLIANCE ISSUE: Oculoplastic surgeons should use this code only when performing the specific procedure(s) developed for its use. It should not be used in conjunction with dacryocystorhinostomy or silicone intubation of the nasolacrimal system.

CLINICAL SITUATION: A procedure covered under Medicare has to be billed to Medicare for that procedure. The procedure cannot be broken into component parts (i.e., one part billed to Medicare and the others to the patient).

COMPLIANCE ISSUE: Upper eyelid blepharoplasty with the patient billed for removal of...
the medial fat pad and Medicare billed for the upper eyelid blepharoplasty.

**CLINICAL SITUATION:** If two Medicare covered procedures are performed in the same session both should be billed to Medicare.

**COMPLIANCE ISSUE:** An example would be performing a brow lift and upper eyelid blepharoplasty during the same session. Be sure to check your Local Coverage Determination (LCD) and if your Medicare Administrative Contractor (MAC) doesn’t have one use one of the other providers such as from Novitas-Solutions, WPS Medicare or NGS Medicare.

**Hot Coding/Compliance Issues**

In this section, we’ll discuss several top coding dilemmas that have potential compliance infringement implications.

**Complex Cataract Surgery.** There are definite qualifications that a cataract extraction with insertion of an intraocular lens must have defined in CPT and the MAC LCDs, the most important being that complications occurring during a case are not the reason the surgeon is coding the case as complex. ASC personnel do not usually question the physician’s choice of code. Be sure the indications and characteristics of the case that qualify it as complex are described clearly in the operative notes, preferably stated in a brief narrative at the beginning of the procedure description.

When the code was originally developed, it was estimated that approximately 1-2% of a surgeon’s cases would qualify as complex. The utilization, which was 1-2% in the early years, is now 8-10%. The increased utilization was noticed by CMS since cataract surgery is one of their highest volume procedures. However, there are many cases being coded as complex cataract extractions that do not qualify.

**Use of the Unlisted Codes.** Unlisted codes in CPT are those that end in 99, such as “67399 Unlisted procedure, ocular muscle” or “66999 Unlisted procedure, anterior segment of eye.” CPT instructions state the unlisted procedure code should be used if the exact code does not describe what was performed; however, these codes should not be used for facility coding, since Medicare contractors have no mechanism in place to have these claims evaluated and assigned a payment value.

**Category III Codes (Emerging Technology Codes).** Category II codes are temporary codes for emerging technologies, services and procedures. One purpose is to allow the collection of data for services and procedures that can’t be accomplished by using unlisted codes. The codes are five digit alpha-numeric codes with the fifth digit being a letter. The assignment of codes is chronological, based on the date of approval by the CPT Editorial Panel.

Payment of a Category III code, however, is determined by the MAC, not calculated by RVU (Relative Value Units) methodology as Category I codes are. If the code isn’t confirmed for payment by your MAC, or on the ASC list, then Medicare cannot be billed for that procedure.

**Sins of Commission and Sins of Omission**

**Sins of Commission**

- Knowingly billing Medicare for cosmetic procedures
- Billing patients for covered procedures
- Allowing billing of covered procedures when cosmetic procedures were actually performed
- Allowing overutilization of CPT code 66982 (Complex Cataract)

**Sins of Omission**

- Failure of an ASC to bill a facility charge for a cosmetic procedure
- Anesthetist’s failure to bill a patient for the cosmetic part of a procedure
- ASC not billing the proper party for noncovered procedures, including the physician himself
- Failure to provide proper oversight on coding/compliance issues
- Failure to learn the coding guidelines for procedures such as complex cataract extraction, unlisted codes and Category III codes

“I’VE FOUND WHEN AUDITING ASCs; SOME ARE SIMPLY MISTAKES BUT WHEN THERE IS INTENT, MEDICARE WOULD CONSIDER IT FRAUD.”

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Simple user interface
Intuitive operation

**Cost-Savings**
Lower acquisition cost of system and consumables
Easy setup reduces turnover time

**Customizable Pack Configurations**
Now with valved cannula port entry system
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