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

2. Understand the Importance of the Discussion to the Patient

   Patients Expect More, So Ask Yourself…

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

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

Secrets to Growing the Use of Multifocal & Accommodative Lens Implants in Your Cataract Practice
John A. Hovanesian, M.D.
David R. Harden, M.D.
Kevin Corcoran

The Reward For Getting It Right
   - 2003 AAO: first course on Crystalens
   - Now 75% of implants are presbyopia-correcting IOLs.
   - Patients refer patients who insist on having premium implants!

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

Patients Expect More, So Ask Yourself…

Am I Ready For the Fully Monty?

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

How to Put Your Foot in Your Mouth…

Mr. Jones, how do you feel about wearing glasses?
3. Let the Doctor Do as Much Educating as Possible

4. Understand the Patient’s Perspective

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

You will need glasses to read

Myopes: near

Hyperopes: distance

Emmetropes: distance and near

You may need glasses for everything

You will probably need glasses for distance

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

6. Keep It Simple

6. Keep It Simple

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

Introduce the Subject

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

How Good Are They?

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

Don’t mention brand names

Don’t overload with information

Patients think, “I want the best for my eyes.” So tell them what’s best.
How Good Are They?

- You might need glasses to read a medicine bottle or the phone book, and that's ok.
- Most people can do most things most of the time without glasses.

Compare to “Old Fashioned” Implant

- When you're comparing to perfect, you're going to be disappointed, whether it's your lens implant, your car, your computer, or your spouse.
- If you compare to an old-fashioned implant the difference is huge.

How Long Do They Last?

- Testing has shown that vision continues to improve for at least seven years.
- If you’re not completely happy at month 1, with more time you may be completely happy.

7. Be Clear and Unapologetic About Limitations

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

-Dave Bogorad, MD

8. Be Clear and Unapologetic About Price

- “This is about all I have in your price range…”

Explaining Cost

- The biggest costs are covered by your insurance, including the operating room, anesthesia fees, fees for my surgery, nursing, supplies. All those add up to about $ per eye, covered by insurance.
- Adding a high-tech implant adds about $ per eye that is not covered by any insurance.
- It’s optional. Not everybody can afford this. About 3 out of 4 of our patients do choose these implants, and our staff can tell you about financing options that make it as affordable as a few dollars a day.

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

- I’m perfectly happy to give you whatever implant you’d like.
- It’s a decision that’s going to affect your vision for the rest of your life, so you need all the facts.
- People ask me which lens I would choose for myself, there’s no doubt in my mind…
- If you can afford it, this is something you really should have.
10. Follow-up on the Discussion

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

Thank you!

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

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

Have done research, consulting, or speaking for:
Allergan, AMO, Bausch & Lomb, Carl Zeiss, Certilux Vision, CXL-USA, ESI, Oculus, Quantel, TLC Vision, Topcon
Some of the information may represent off-label uses of approved drugs or devices

Think One Step Ahead

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

Custom Cataract Surgery

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

Critical to Address For Good Uncorrected Vision

Hoffmann & Hutz
JCRS 2010;36:1479

Ask Questions

Questionnaire
Simple Choices
Identify the Goal
1. I don't care
2. Really want your best effort at Distance
3. Distance w/Astig
4. Distance and Near

Cataract Patient

Understand that even patients you don’t think should have a presbyopic IOL may have similar desires and also deserve a discussion about options.
- Diabetic with past PRP and focal laser treatment
- Wet ARMD in one eye, smoker, soft drusen and RPE changes in other eye
- Otherwise normal healthy eye
- One eyed patient with severe macular scar

Custom Cataract Surgery

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

Critical to Address For Good Uncorrected Vision

Hoffmann & Hutz
JCRS 2010;36:1479

Astigmatic Keratotomy

Only current option with Presbyopic IOLs

Same Nomogram
Femto-AK
Blade-AK

Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/01/2020</td>
<td>10:00 AM</td>
</tr>
</tbody>
</table>

**Note:** The table shows the time for a surgery appointment on Sep 1, 2020.
Astigmatic Keratotomy

Only current option with Presbyopic IOLs

Same Nomogram
Femto-AK
Blade-AK

Astigmatic Keratotomy

Only current option with Presbyopic IOLs

Same Nomogram
Femto-AK
Blade-AK

Timing of Secondary Intervention

Astigmatism Correction after IOLs

- Enhance large corrections earlier
- Small corrections — wait longer
- Typically I wait 1-2 months to do IOL Rotation or IOL exchange for large corrections
- Typically I wait 3-6 months to do laser vision correction

Capsule considerations — contraction or PCO

Yag first in many patients

Toric IOLs

Astigmatism

- Up to 4 D of astigmatism
- Regular Astigmatism

- Typical teaching is to use the K’s
- Often K’s, topo astigmatism, tomo astigmatism don’t match

- Be prepared for enhancement

Residual Astigmatism after Toric IOL

Questions to Ask

1. Is it Regular or Irregular?
2. Is the Spherical Equivalent where you want?
3. Is it correctable by rotation of the IOL?

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

SNRAT at 150 degrees
Pentacam Astig 2.3 D at 54 degrees
WSP: -2.69 + 4.05 x 90
Humphrey Astig 4.12 D at 80 degrees

Options – Irregular Astigmatism

Toric after RK – Options?
- Rotate Toric based on Refraction
  (to 115° = 0.94 D x 115)
- Pentacam Astig 2.3 D at 54 degrees
- Wavescan: -2.69 + 4.05 x 90
- Humphrey Astig 4.12 D at 80 degrees
- Easier to rotate based on change of position
  Change from 150 to 115 is 35 degrees clockwise
  Perform totally based on intraoperative analysis for best accuracy
- PRK? (only 4.75 mm capture) – Might be useful for irregular component
- Exchange IOL for higher powered toric?

Options – Regular Astigmatism

Residual Astigmatism after Toric – Options?
- Rotate Toric based on Refraction
  (to 120° = 0.4 D x 112)
- Pentacam Astig 2.3 D at 54 degrees
- Wavescan: -2.69 + 4.05 x 90
- Humphrey Astig 4.12 D at 80 degrees
- Easier to rotate based on change of position
  Change from 108° to 120° is 12 degrees counterclockwise
  Perform totally based on intraoperative analysis for best accuracy
- Remove toric IOL? (baseline astig of eye likely 3.5 to 4 D)
- PRK? Refraction based results suggests rotation likely to be useful.
- Exchange IOL for higher powered toric? – not available here

Toric IOL Rotation Procedure

Moving from Axis 108° to 120°
- Rotate
  12° Counterclockwise
  168° Clockwise
- UCVA = 20/20
- -0.50 + 0.50 x 116

Occasionally Confusion on Preop Axis

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

Management of Regular Astigmatism Example
Post-Operative Management

Laser Vision Correction: Off Label

PRK
- No issues with prior LRI incision

LASIK
- May be issues with prior LRI
- More rapid recovery

- IOL rotation in toric IOLs – usually minimal effect if close to correct axis

Timing of Secondary Intervention

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

Results

<table>
<thead>
<tr>
<th>IOL Type</th>
<th>Prior CRS (60 eyes)</th>
<th>No Prior CRS (342 eyes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crystalens</td>
<td>70%</td>
<td>33%</td>
</tr>
<tr>
<td>ReZoom</td>
<td>23%</td>
<td>38%</td>
</tr>
<tr>
<td>ReSTOR</td>
<td>5%</td>
<td>15%</td>
</tr>
<tr>
<td>Tecnis-MF</td>
<td>2%</td>
<td>13%</td>
</tr>
<tr>
<td>Array</td>
<td>0%</td>
<td>1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Enhancement</th>
<th>Patient Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>LASIK</td>
<td>46</td>
</tr>
<tr>
<td>PRK</td>
<td>13</td>
</tr>
<tr>
<td>Epi-LASIK</td>
<td>3</td>
</tr>
<tr>
<td>LASIK</td>
<td>1</td>
</tr>
<tr>
<td>Piggyback XL</td>
<td>1</td>
</tr>
<tr>
<td>Exchange for different IOLs</td>
<td>1</td>
</tr>
</tbody>
</table>
**Results**

Over 25% capsulotomy rates in these very demanding patients

<table>
<thead>
<tr>
<th>Days</th>
<th>0</th>
<th>500</th>
<th>1000</th>
<th>1500</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Clear Capsule</td>
<td>0%</td>
<td>50%</td>
<td>100%</td>
<td>150%</td>
<td>200%</td>
</tr>
</tbody>
</table>

**Don’t be Afraid to Finally Admit Failure**

Offer Removal of Presbyopic IOL if Needed

- Your brain may not be adaptable enough to make this work for you

**Summary**

Understanding Needs of Refractive IOL Patient

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

**Continue Understanding Listening Learning Postoperatively**

**Management**

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

**Pearls for Success**

**Refractive IOL Practice**

- Keep in touch with the patient until you know they are happy.
- Fix small issues for satisfaction.
- YAG for mild PCO, PRK/LSIK for mild refractive errors.
- Schedule follow-up.
- Happiness breeds happy referrals.
- Make each patient an ambassador for your practice.
- Exceed their expectations.
Secrets to Growing Use of Multifocal and Accommodative IOLs in Your Cataract Practice

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

Financial Disclosure
The instructor acknowledges a financial interest in the subject matter of this presentation.

Key Points
- Define covered and noncovered services
- Charges are proportional to products and services
- Document financial responsibility
- Separate physician and facility
- Use caution with co-management
- Provide choices, not a one-size-fits-all solution

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

Covered vs. Non-covered
- Covered
  - Follow insurance rules
- Not covered
  - Patient pay

Refractive Cataract Surgery
Reimbursement Grid

<table>
<thead>
<tr>
<th>Covered</th>
<th>Facility</th>
<th>Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered</td>
<td>Cataract surgery</td>
<td>Cataract surgery</td>
</tr>
<tr>
<td>Non-covered</td>
<td>Deluxe IOL, LRI</td>
<td>Refractive Care</td>
</tr>
</tbody>
</table>

Patient shared billing: covered & non-covered services
LRI – Limbal relaxing incisions, refractive keratoplasty
Refractive Cataract Surgery
Reimbursement Grid

<table>
<thead>
<tr>
<th>Covered</th>
<th>Facility</th>
<th>Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-covered</td>
<td>Patient pay</td>
<td>Patient pay</td>
</tr>
</tbody>
</table>

Surgical Correction of Astigmatism

- Several surgical techniques (i.e., LRI, CRI, AK, LASIK)
- Refractive surgery is not part of routine cataract surgery
- Refractive surgery is not required; personal preference
- Value added professional service

Surgical Correction of Astigmatism

- Non-covered professional services
  - Refraction to determine refractive error
  - Corneal topography associated with refractive surgery
  - Contact lens trial fitting to assess refractive error
  - Wavefront aberration testing to assess refractive error
  - Corneal pachymetry associated with refractive surgery
  - Refractive keratoplasty (i.e., LRI, CRI, AK, LASIK)
  - Enhancement

Extended Care Package

<table>
<thead>
<tr>
<th>Service</th>
<th>Charge</th>
<th>Frequency</th>
<th>Wtd Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refraction</td>
<td>$30</td>
<td>100%</td>
<td>$30</td>
</tr>
<tr>
<td>Corneal topography</td>
<td>$75</td>
<td>100%</td>
<td>$75</td>
</tr>
<tr>
<td>Contact lens trial fitting</td>
<td>$125</td>
<td>5%</td>
<td>$6</td>
</tr>
<tr>
<td>Wavefront aberration test</td>
<td>$100</td>
<td>100%</td>
<td>$100</td>
</tr>
<tr>
<td>Routine eye care</td>
<td>$115</td>
<td>100%</td>
<td>$115</td>
</tr>
<tr>
<td>Limbal relaxing incisions</td>
<td>$525</td>
<td>75%</td>
<td>$394</td>
</tr>
<tr>
<td>YAG capsulotomy, early</td>
<td>$500</td>
<td>10%</td>
<td>$50</td>
</tr>
<tr>
<td>Extended postop care, 1 yr</td>
<td>$150</td>
<td>100%</td>
<td>$150</td>
</tr>
<tr>
<td>LASIK enhancement (MD only)</td>
<td>$2,100</td>
<td>5%</td>
<td>$105</td>
</tr>
<tr>
<td>Total Chg</td>
<td></td>
<td></td>
<td>$860</td>
</tr>
</tbody>
</table>

For illustration purposes only

Refractive Cataract Surgery
Nominal Charges

<table>
<thead>
<tr>
<th>Covered</th>
<th>Facility</th>
<th>Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-covered</td>
<td>$850</td>
<td>$1,200</td>
</tr>
</tbody>
</table>

Grand Total $5,550

For illustration purposes only
Refractive Cataract Surgery
Payments for Covered Procedure

<table>
<thead>
<tr>
<th></th>
<th>Facility</th>
<th>Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered</td>
<td>$950</td>
<td>$600</td>
</tr>
<tr>
<td>Non-covered</td>
<td>$850</td>
<td>$1,200</td>
</tr>
</tbody>
</table>

Grand Total $3,600 (after adjustments)

For illustration purposes only

Deluxe IOL

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

* Value of IOL imputed by contract with payer

Surgeon's Claim

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
<th>Date</th>
<th>Description</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>366.16</td>
<td>66984</td>
<td>01/24/2010</td>
<td>Cataract extraction with IOL</td>
<td>1</td>
</tr>
<tr>
<td>367.2</td>
<td>66984</td>
<td>01/24/2010</td>
<td>Astigmatism</td>
<td>1</td>
</tr>
</tbody>
</table>

Facility's Claim

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
<th>Date</th>
<th>Description</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>366.16</td>
<td>66999</td>
<td>01/24/2010</td>
<td>Cataract extraction with IOL</td>
<td>1</td>
</tr>
<tr>
<td>367.4</td>
<td>66999</td>
<td>01/24/2010</td>
<td>Astigmatism</td>
<td>2</td>
</tr>
</tbody>
</table>

Notice of Exclusion from Medicare Benefits (NEMB)

- Beneficiary may not know that certain services are not covered by Medicare
- Item or services excluded from Medicare benefits
- May be customized
- Available on-line (English and Spanish)
- Utilize NEHB for non-Medicare beneficiaries

Source: Medicare Claims Processing Manual Chapter 30, §90 Transmittal 636

Modifier - GY

Item or service statutorily excluded or does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit.

Line19 "Seeking denial for secondary payer"
Line19 "Cosmetic surgery exclusion"

66999-GY 367.21 Regular astigmatism
## Patient Choices

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

## Patient Choices

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

## Hint: ASC Buys IOLs

- Best practices entail ASC purchases IOLs from manufacturer
- Avoid giving the appearance of payment for referral between ASC and surgeon

## Co-management Considerations

- Caution advised
- Similar to co-management of refractive surgery
- Real charges – real services
- Separate services – separate checks
- Patient’s consent in advance of the surgery
- Excludes IOL and facility fee

## Do's and Don'ts

### Do's
- Clearly explain choices
- Document selection
- Collect $ before surgery
- Separate MD and ASC

### Don’ts
- Use one-size-fits-all
- Aggregate charges
- Comingle funds
- Co-manage all cases
- MD purchase IOL

## A Troublesome Thought...

- ABC Insurance called....
- They said they will cover the upgrade on cataract surgery with a P-C or toric IOL
**Yes / No: Refraction**

Following cataract surgery, Medicare pays for a pair of postcataract eyeglasses when medically necessary. The exam and refraction required to prescribe the postcataract eyeglasses are likewise covered.

**Yes / No: Corneal Topography**

A patient has significant regular astigmatism. Prior to cataract surgery, a surgeon orders corneal topography in addition to keratometry. According to Medicare’s national policy for testing prior to cataract surgery, the corneal topography is covered as part of the A-scan or optical coherence biometry.

**Complications**

Unfortunately, complications sometimes occur following surgery. The surgeon has several ways to address complications. Which one is reimbursed?

a) Patient is seen more often and an ICD-9 code for the complication is used on the claim for a billable visit
b) Patient is evaluated by the surgeon's partner
c) Patient is re-operated in the minor treatment room of the office
d) Patient is referred to another surgeon outside the practice
e) All of the above

**Complications**

Dr. Jones performed cataract surgery with P-C IOL on a patient who has some difficulty reading at 1 mo (J2). The surgeon performs a YAG capsulotomy. Who is responsible?

a) The surgeon must cover all of the cost of the YAG due to malpractice
b) Medicare will pay for a YAG in this case
c) The patient must pay for the YAG as a cosmetic refractive procedure
d) The surgeon’s fee for the YAG is zero, but the patient must pay for the facility fee
e) None of the above

**Complications**

Dr. Jones performs cataract surgery on a patient. Subsequently, the patient has some refractive error (1.5D). The patient asks for an IOL exchange. Who is responsible?

a) The surgeon must cover all of the cost of the IOL exchange due to malpractice
b) Medicare will pay for an IOL exchange in this case
c) The patient must pay for the IOL exchange as a cosmetic refractive procedure
d) The surgeon’s fee for the IOL exchange is zero, but the patient must pay for the facility fee
e) None of the above

**Complications**

Dr. Jones performed cataract surgery on a patient. Subsequently, the patient has some refractive error (1.5D). The patient asks for an IOL exchange. Who is responsible?

a) The surgeon must cover all of the cost of the IOL exchange due to malpractice
b) Medicare will pay for an IOL exchange in this case
c) The patient must pay for the IOL exchange as a cosmetic refractive procedure
d) The surgeon’s fee for the IOL exchange is zero, but the patient must pay for the facility fee
e) None of the above

**Yes / No: Cataract Surgery**

A patient had cataract surgery on one eye. The other eye also has cataract. The initial eye exam states: “Plan cataract surgery OD; will re-evaluate OS thereafter”. 10 days after the initial surgery, the patient complains “Vision in the right eye is good. Vision in the left eye is poor. Both eyes don’t work well together. Occasional double vision.” The plan is “Cataract surgery OS”. Does Medicare reimburse the surgeon for this office visit?
A patient has cataracts. BCVA is 20/50 OU. Which statement is true?

a) Medicare will cover cataract surgery for this indication.
b) Medicare requires BCVA worse than 20/50. The surgery would not be covered.
c) Medicare would not cover cataract surgery without a significant patient complaint concerning ADLs and BCVA 20/50 or worse. Occasional exceptions apply for glare.
d) Medicare would cover cataract surgery for any BCVA as long as the patient has significant complaints concerning ADLs.

A patient wants cataract surgery. It’s unclear whether Medicare will cover the surgery or not – the indications for surgery represent a borderline case. If the patient refuses to sign an ABN, and Medicare subsequently declines to pay for the surgery, the surgeon cannot seek payment from the patient.