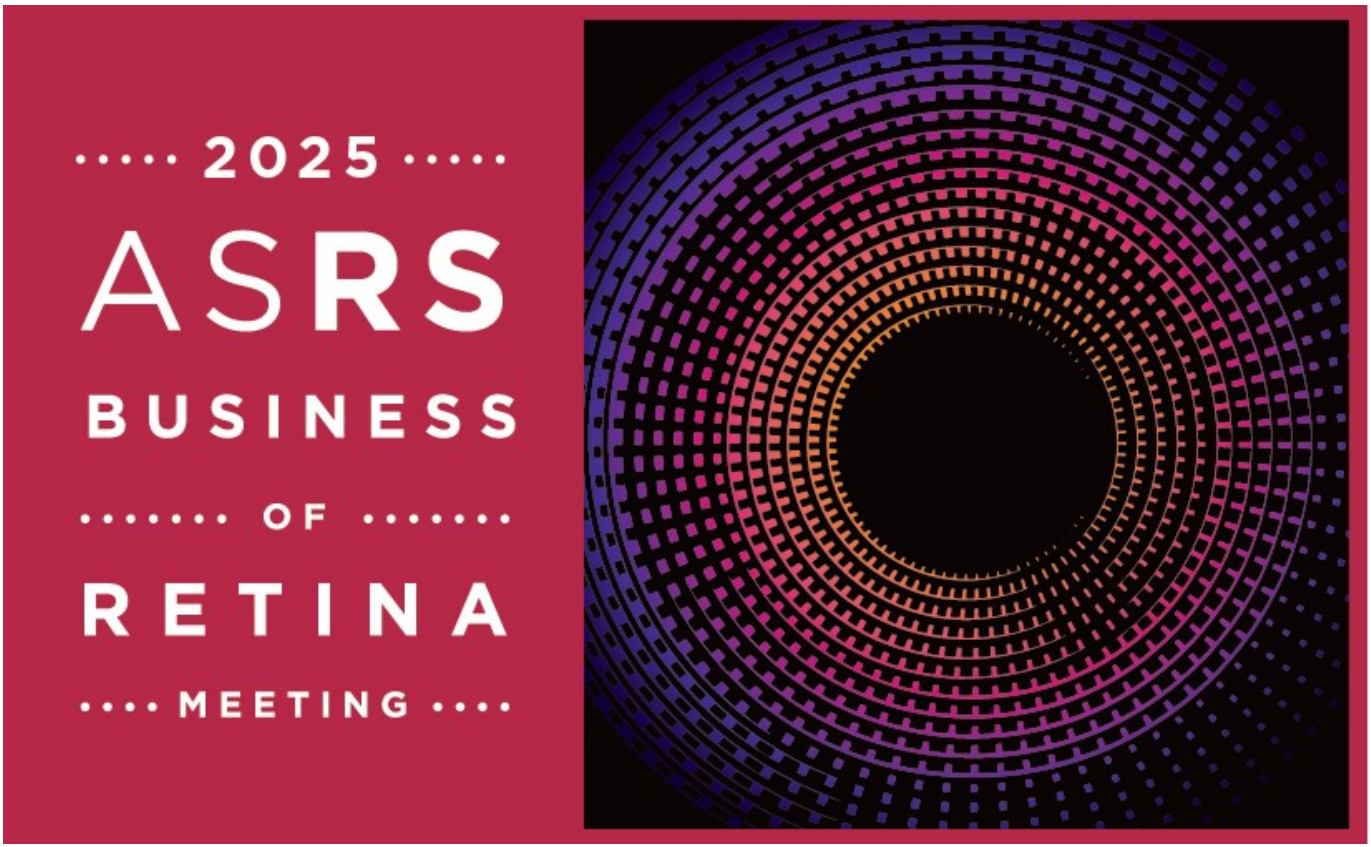


2025 American Society of Retina Specialists

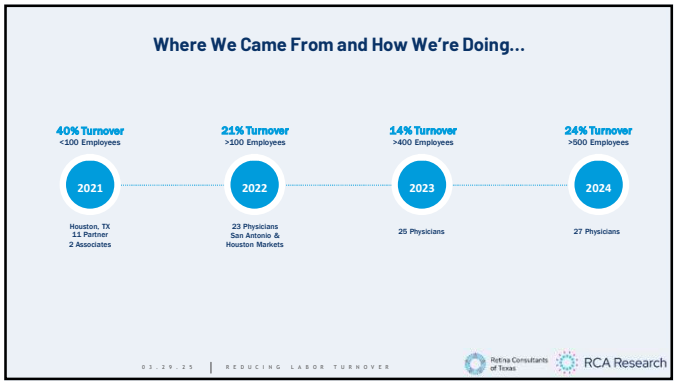
Business of Retina Meeting

Main Program Handout Book

Table of Contents .....


Reducing Labor Turnover
Presented by:
Kurt Defenbaugh
March 29, 2025
Retina Consultants of Texas

1


Where We Came From and How We're Doing...
40% Turnover
<100 Employees
21% Turnover
>100 Employees
14% Turnover
>400 Employees
24% Turnover
>600 Employees
2021
2022
2023
2024
Houston, TX
11 Partner
2 Associates
23 Physicians
San Antonio &
Houston Markets
25 Physicians
27 Physicians
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2


DEFINING A STRONG COMPANY CULTURE AND VISION
Company Culture
• Values and beliefs
• Work environment
• Communication Style
• Employee Engagement
Vision
• Alignment with Purpose
• Goals, clarity in expectations
• Inspiration, motivation, loyalty
• Empowerment through contribution
Stats on Vision and Retention
• 77% of prospective employees would take a company's culture into account before applying
• 37% of employees leave their jobs due to engagement or culture issues (Gallup)
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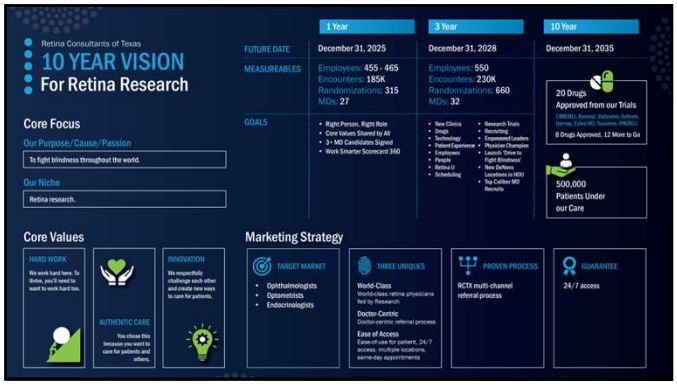
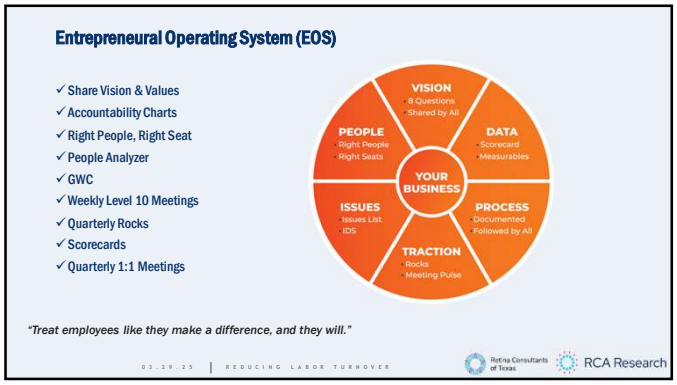
3


Retina Consultants of Texas
10 YEAR VISION
For Retina Research
Core Focus
Our Purpose/Cause/Passion
To fight blindness throughout the world.
Our Niche
Retina research.
1 Year
3 Year
10 Year
FUTURE DATE
December 31, 2025
December 31, 2028
December 31, 2035
MEASUREABLES
Employees: 455 - 465
Encounters: 185K
Randomizations: 315
MDs: 27
Employees: 550
Encounters: 230K
Randomizations: 660
MDs: 32
GOALS
• Right Person, Right Role
• Core Values Shared by All
• 3+ MD Candidates Signed
• Work Smarter Scorecard 360
• New Clinics
• Drugs
• Technology
• Patient Experience
• Employees
• People
• Retina U
• Scheduling
• Research Trials
• Recruiting
• Empowered Leaders
• Physician Champion
• Launch: Drive to Fight Blindness'
• New DeNovo Locations in HOU
• Top Caliber MD Recruits
20 Drugs
Approved from our Trials
8 Drugs Approved, 12 More to Go
500,000
Patients Under
our Care
Core Values
HARD WORK
We work hard here. To thrive, you'll need to want to work hard too.
INNOVATION
We respectfully challenge each other and create new ways to care for patients.
AUTHENTIC CARE
You chose this because you want to care for patients and others.
Marketing Strategy
TARGET MARKET
• Ophthalmologists
• Optometrists
• Endocrinologists
THREE UNIQUES
World-Class
Doctor-Centric
Ease of Access
PROVEN PROCESS
RCTX multi-channel referral process
GUARANTEE
24/7 access

4


Entrepreneural Operating System (EOS)
✓ Share Vision & Values
✓ Accountability Charts
✓ Right People, Right Seat
✓ People Analyzer
✓ GWC
✓ Weekly Level 10 Meetings
✓ Quarterly Rocks
✓ Scorecards
✓ Quarterly 1:1 Meetings
VISION
8 Questions
Shared by All
DATA
Scorecard
Measurables
PROCESS
Documented
Followed by All
TRACTION
Rocks
Meeting Pulse
ISSUES
Issues List
IDS
PEOPLE
Right People
Right Seats
YOUR BUSINESS
"Treat employees like they make a difference, and they will."
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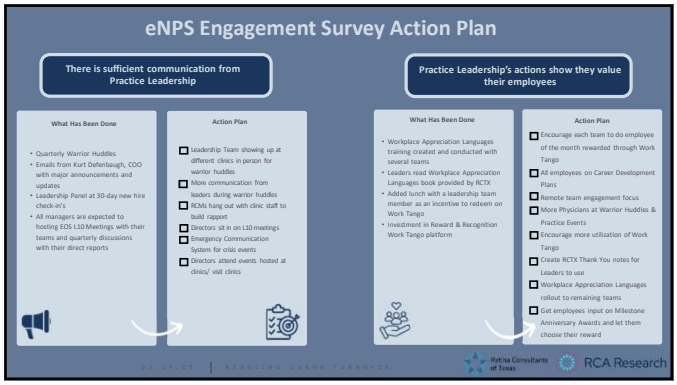
5


2024 RCTX
Annual Employee
Engagement
Survey Results
DID YOU KNOW?
In the healthcare industry, average engagement survey response rates tend to fall within a range of roughly 55% to 75%
Participation
473
450
Overall Favorability
76%
Engaged Employees
63%
Favorability Category

6


eNPS Engagement Survey Action Plan
There is sufficient communication from Practice Leadership
What Has Been Done
• Quarterly Warrior Huddles
• Emails from Kurt Defonbaugh, COO with major announcements and updates
• Leadership Panel at 30-day new hire check-in's
• All managers are expected to hosting EOS L10 Meetings with their teams and quarterly discussions with their direct reports
Action Plan
Leadership Team showing up at different clinics in person for warrior huddles
More communication from leaders during warrior huddles
RCMs hang out with clinic staff to build rapport
Directors sit in on L10 meetings
Emergency Communication System for crisis events
Directors attend events hosted at clinics/ visit clinics
Practice Leadership's actions show they value their employees
What Has Been Done
• Workplace Appreciation Languages training created and conducted with several teams
• Leaders read Workplace Appreciation Languages book provided by RCTX
• Added lunch with a leadership team member as an incentive to redeem on Work Tango
• Investment in Reward & Recognition Work Tango platform
Action Plan
Encourage each team to do employee of the month rewarded through Work Tango
All employees on Career Development Plans
Remote team engagement focus
More Physicians at Warrior Huddles & Practice Events
Encourage more utilization of Work Tango
Create RCTX Thank You notes for Leaders to use
Workplace Appreciation Languages rollout to remaining teams
Get employees input on Milestone Anniversary Awards and let them choose their reward
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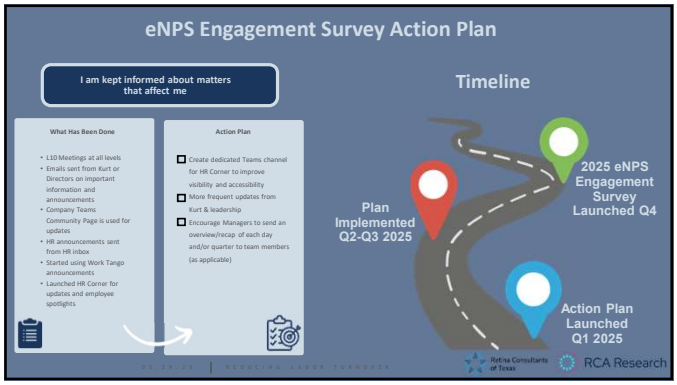
eNPS Engagement Survey Action Plan
I am kept informed about matters that affect me
What Has Been Done
• L10 Meetings at all levels
• Emails sent from Kurt or Directors on important information and announcements
• Company Teams Community Page is used for updates
• HR announcements sent from HR inbox
• Started using Work Tango announcements
• Launched HR Corner for updates and employee spotlights
Action Plan
Create dedicated Teams channel for HR Corner to improve visibility and accessibility
More frequent updates from Kurt & leadership
Encourage Managers to send an overview/recap of each day and/or quarter to team members (as applicable)
Timeline
Plan Implemented Q2-Q3 2025
2025 eNPS Engagement Survey Launched Q4
Action Plan Launched Q1 2025
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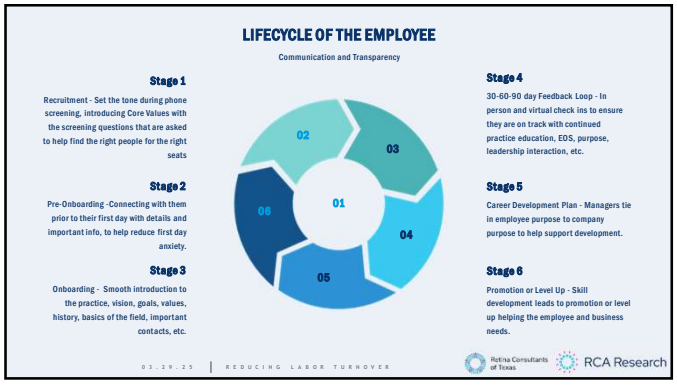
LIFECYCLE OF THE EMPLOYEE
Communication and Transparency
Stage 1
Recruitment - Set the tone during phone screening, introducing Core Values with the screening questions that are asked to help find the right people for the right seats
Stage 2
Pre-Onboarding -Connecting with them prior to their first day with details and important info, to help reduce first day anxiety.
Stage 3
Onboarding - Smooth introduction to the practice, vision, goals, values, history, basics of the field, important contacts, etc.
01
02
03
04
05
06
Stage 4
30-60-90 day Feedback Loop - In person and virtual check ins to ensure they are on track with continued practice education, EOS, purpose, leadership interaction, etc.
Stage 5
Career Development Plan - Managers tie in employee purpose to company purpose to help support development.
Stage 6
Promotion or Level Up - Skill development leads to promotion or level up helping the employee and business needs.
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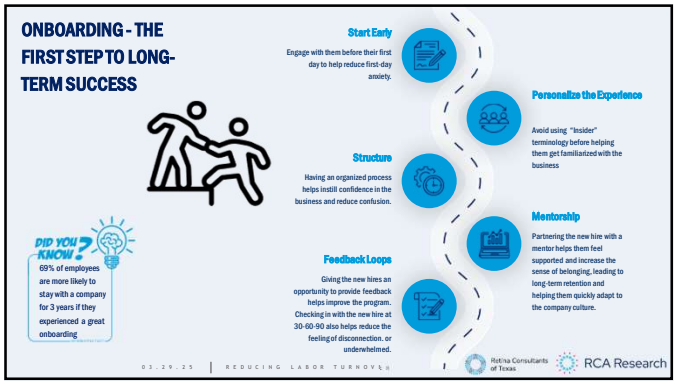
ONBOARDING - THE FIRST STEP TO LONG-TERM SUCCESS
Start Early
Engage with them before their first day to help reduce first-day anxiety.
Personalize the Experience
Avoid using "Insider" terminology before helping them get familiarized with the business
Structure
Having an organized process helps instill confidence in the business and reduce confusion.
Mentorship
Partnering the new hire with a mentor helps them feel supported and increase the sense of belonging, leading to long-term retention and helping them quickly adapt to the company culture.
DID YOU KNOW?
69% of employees are more likely to stay with a company for 3 years if they experienced a great onboarding
Feedback Loops
Giving the new hires an opportunity to provide feedback helps improve the program. Checking in with the new hire at 30-60-90 also helps reduce the feeling of disconnection, or underwhelmed.
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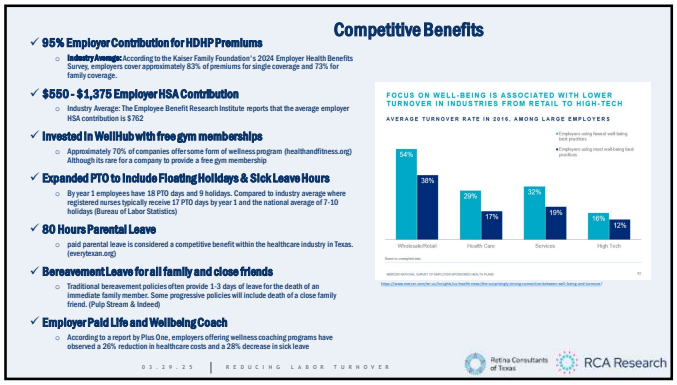
Competitive Benefits
✓ 95% Employer Contribution for HDHP Premiums
Industry Average: According to the Kaiser Family Foundation's 2024 Employer Health Benefits Survey, employers cover approximately 83% of premiums for single coverage and 73% for family coverage.
✓ $550 - $1,375 Employer HSA Contribution
Industry Average: The Employee Benefit Research Institute reports that the average employer HSA contribution is $762
✓ Invested In WellHub with free gym memberships
Approximately 70% of companies offer some form of wellness program (healthandfitness.org) Although its rare for a company to provide a free gym membership
✓ Expanded PTO to Include Floating Holidays & Sick Leave Hours
By year 1 employees have 18 PTO days and 9 holidays. Compared to industry average where registered nurses typically receive 17 PTO days by year 1 and the national average of 7-10 holidays (Bureau of Labor Statistics)
✓ 80 Hours Parental Leave
paid parental leave is considered a competitive benefit within the healthcare industry in Texas. (everytexan.org)
✓ Bereavement Leave for all family and close friends
Traditional bereavement policies often provide 1-3 days of leave for the death of an immediate family member. Some progressive policies will include death of a close family friend. (Pulp Stream & Indeed)
✓ Employer Paid Life and Wellbeing Coach
According to a report by Plus One, employers offering wellness coaching programs have observed a 26% reduction in healthcare costs and a 28% decrease in sick leave
FOCUS ON WELL-BEING IS ASSOCIATED WITH LOWER TURNOVER IN INDUSTRIES FROM RETAIL TO HIGH-TECH
AVERAGE TURNOVER RATE IN 2016, AMONG LARGE EMPLOYERS
54%
38%
29%
17%
32%
19%
16%
12%
Wholesale/Retail
Health Care
Services
High Tech
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Rewards & Recognition Acclaim to Retain!
When employees feel valued, they're not just working for a paycheck… they're working for a purpose!
Rewards
Personalize
Understand what motivates each employee and personalize the reward to their liking.
Growth
Reward employees by offering mentorship and professional development opportunities. Have their success directly linked to their growth.
Milestones
Reward employees for their years of service, project completions, and personal achievements.
Recognition
Timely & Frequent
Acknowledge achievements as soon as possible to reinforce positive behavior. Don't wait for the annual review!
Be Specific
Sure, a generic "good job" or "congrats" is nice. But if you tailor the praise to specific achievements, it will have a much bigger impact.
Encourage
Foster a culture that aligns with company values and implement a system where Employees can recognize each other.
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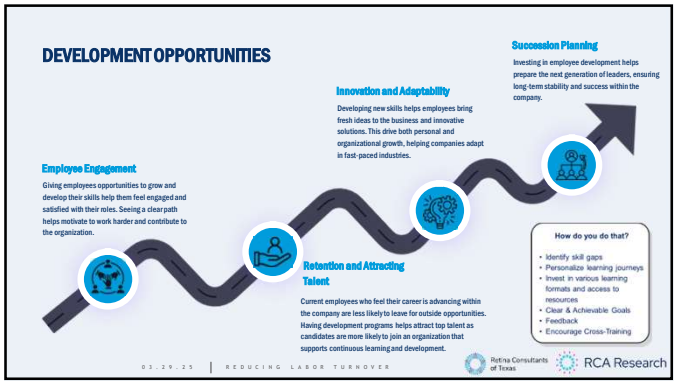

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THANK YOU!

Contact Me:
Kurt.Defenbaugh@retinaconsultantstexas.com
(Scan the QR Code to connect on LinkedIn)

Visit Us Online:
www.retinaconsultantstexas.com

Follow RCTX:
Instagram @retinaconsultantstexas or @drivingtofightblindness
Facebook.com/RetinaConsultantsofTexas

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Bay Area Retina Associates
Diseases and Surgery of the Retina and Vitreous

BOR 2025:
Organizational Structure, KPIs, JDs

Guide Yourself with a Map

Tushar Ranchod, MD

1

Where do KPIs and JDs come from?

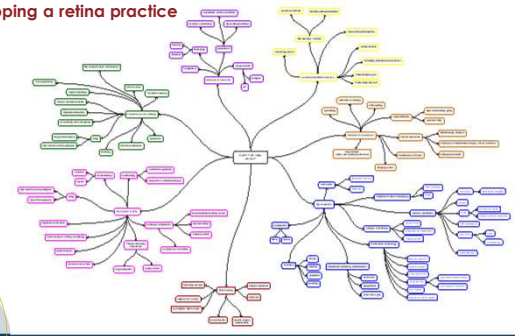
- **Key performance indicators are metrics** that represent performance of a business or its parts
- **Job descriptions are descriptions** of responsibilities and authorities that pertain to a business or its parts

- How well do you know the parts of your business on which these KPIs and JDs are based?
- Is **each part of your business** somebody's responsibility?

2

2

Mapping a retina practice



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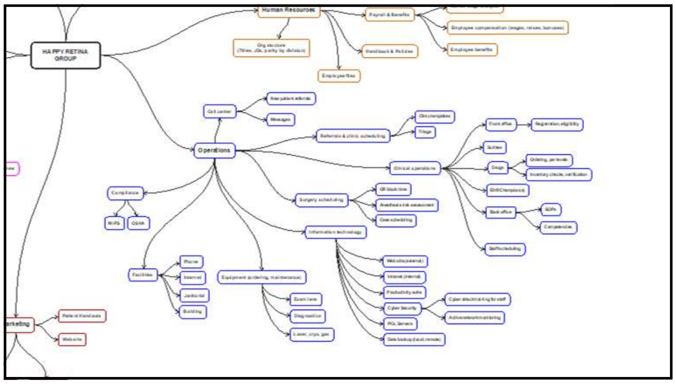
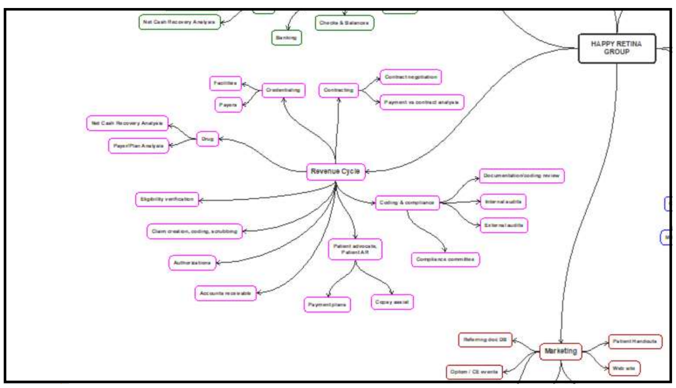
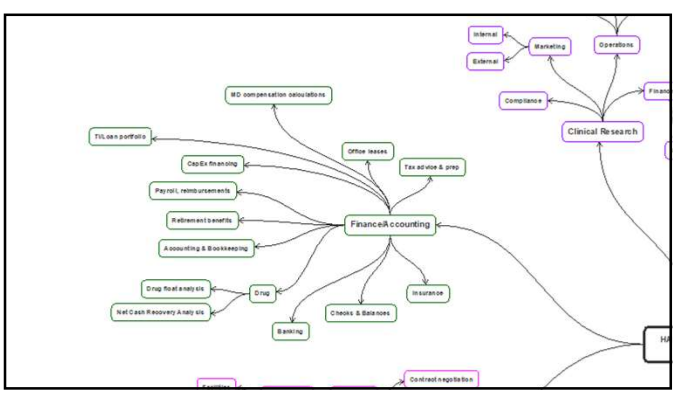

Human Resources
HAPPY RETINA GROUP
Payroll & Benefits
Employee compensation (wages, raises, bonuses)
Employee benefits
Handbook & Policies
Employee files
Operations
Call center
Messages
Referrals & clinic scheduling
Triage
Clinical operations
Front office
Drugs
Back office
Compliance
OSHA
Surgery scheduling
OR block time
Information technology
Facilities
Phone
Internet
Janitorial
Building
Equipment (ordering, maintenance)
Exam lane
Diagnostics
Laser, cryo, gas
Cyber Security
PCs, Servers
Patient Handouts
Website

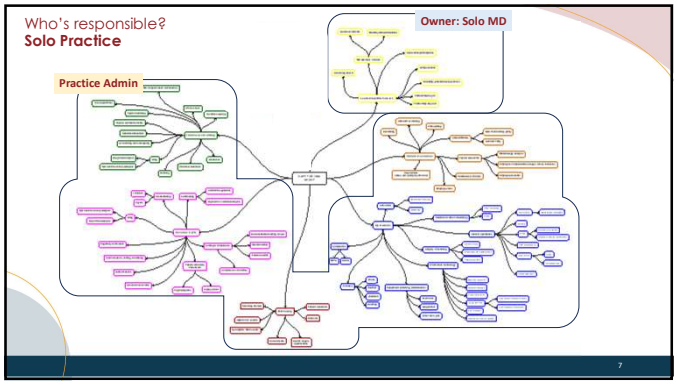
4


Net Cash Recovery Analysis
Checks & Balances
Banking
HAPPY RETINA GROUP
Facilities
Credentialing
Contracting
Contract negotiation
Payors
Payment vs contract analysis
Net Cash Recovery Analysis
Drug
Payer/Plan Analysis
Revenue Cycle
Documentation/coding review
Eligibility verification
Coding & compliance
Internal audits
External audits
Claim creation, coding, scrubbing
Patient advocate, Patient A/R
Compliance committee
Authorizations
Accounts receivable
Payment plans
Copay assist
Referring doc DB
Marketing
Patient Handouts
Option / CE events
Web site

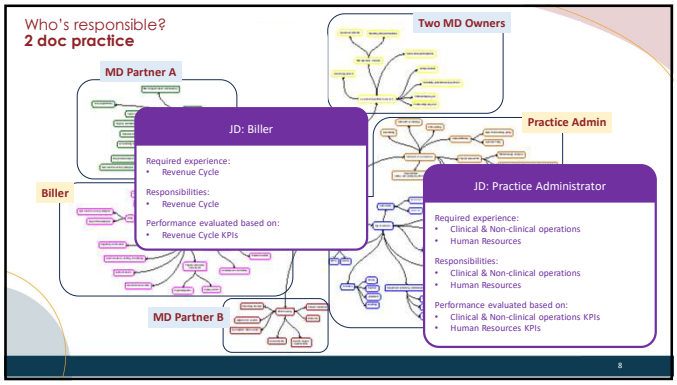
5


Internal
Marketing
Operations
External
MD compensation calculations
Compliance
Clinical Research
TI/Loan portfolio
Office leases
CapEx financing
Tax advice & prep
Payroll, reimbursements
Retirement benefits
Finance/Accounting
Accounting & Bookkeeping
Drug float analysis
Drug
Insurance
Net Cash Recovery Analysis
Checks & Balances
Banking
Contract negotiation

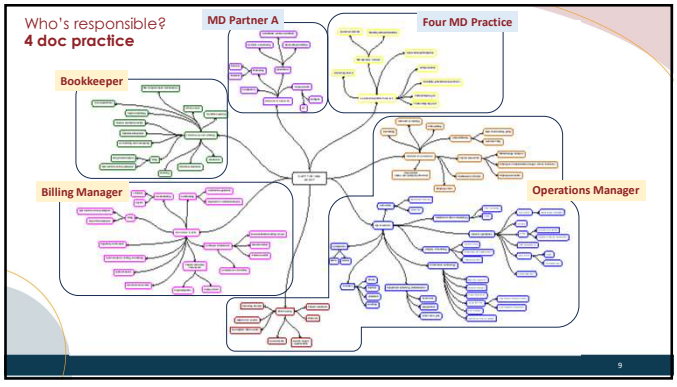
6


Who's responsible?
Solo Practice
Owner: Solo MD
Practice Admin
7

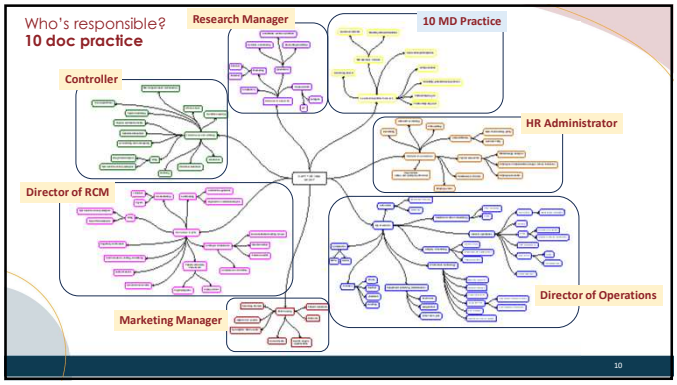
7


Who's responsible?
2 doc practice
Two MD Owners
MD Partner A
JD: Biller
Required experience:
• Revenue Cycle
Responsibilities:
• Revenue Cycle
Performance evaluated based on:
• Revenue Cycle KPIs
Practice Admin
Biller
JD: Practice Administrator
Required experience:
• Clinical & Non-clinical operations
• Human Resources
Responsibilities:
• Clinical & Non-clinical operations
• Human Resources
Performance evaluated based on:
• Clinical & Non-clinical operations KPIs
• Human Resources KPIs
MD Partner B
8

8


Who's responsible?
4 doc practice
MD Partner A
Four MD Practice
Bookkeeper
Billing Manager
Operations Manager
9

9



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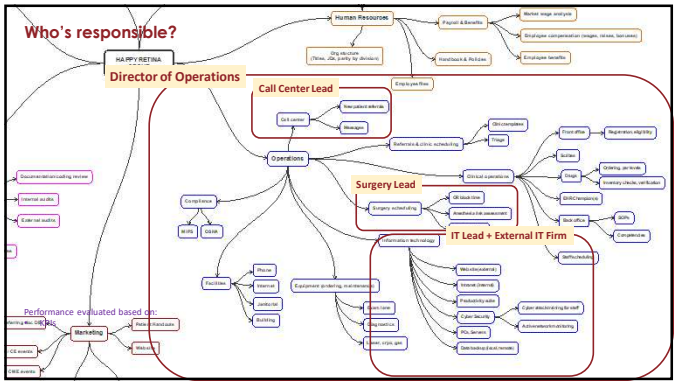


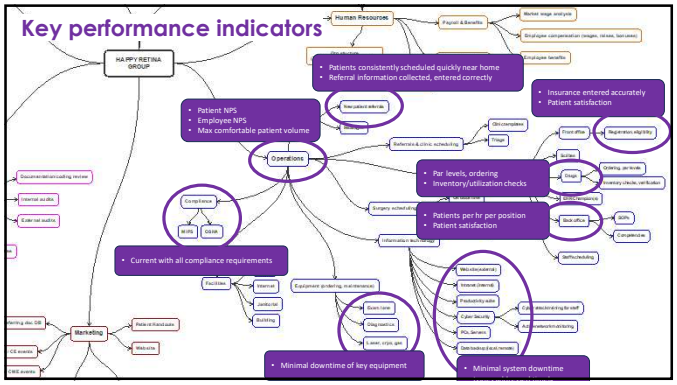
11

What are KPIs based on?

- Almost every part of your organization has KPIs, whether you recognize them or not.
- Things you can measure versus things that actually matter.
- Identify all possible KPIs in a portion of your business, then identify the ones that matter.
- As you go up the organizational hierarchy, select KPIs from the level below and add higher level KPIs if appropriate.

12

12



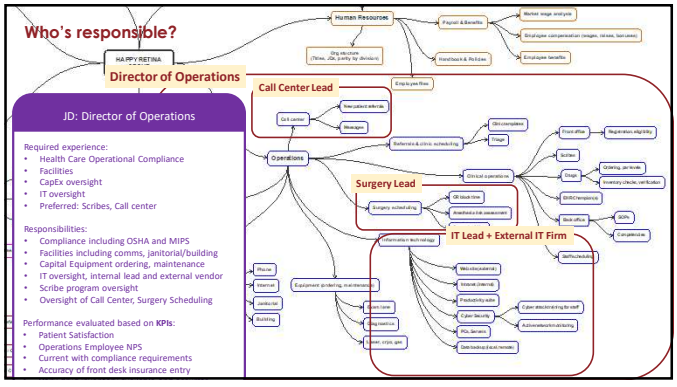
13

What's in the Job Description?

- **Experience** required
  - What type of experience is required? Optional?
  - Educational requirements usually secondary to actual experience
- **Responsibilities**:
  - Tasks or processes to oversee
  - People to manage
- How **performance** will be measured
  - Not always included in the JD but should be well defined internally before posting the job

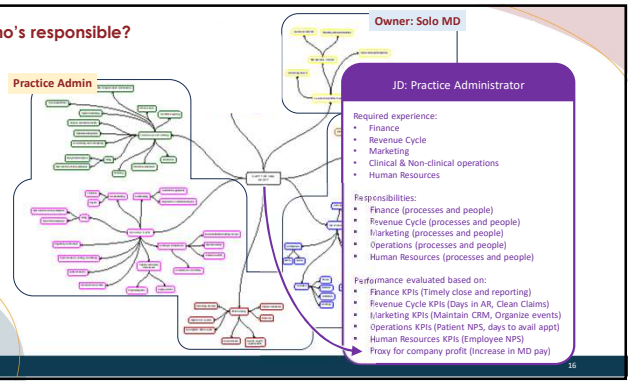
14

14



15

Who's responsible?



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Summary of what we learned

- Any business can be described as a **map**
  - There are many formats/approaches you can use – just pick one!
- The map can be used to identify **KPIs** at any level of the company.
- The map can be used to ensure each **JD** includes the appropriate experience and responsibilities.
- The map can be used to ensure each part of the business is included in somebody's JD
  - No part of the business is unassigned

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17

What can I do when I get home?

- **Make a map** of your practice
- If you find something that's unassigned, assign it to somebody!
- **Update job descriptions** to include all assigned pieces
- **Identify KPIs** for each piece of your map.
- Use those KPIs for accountability at every level

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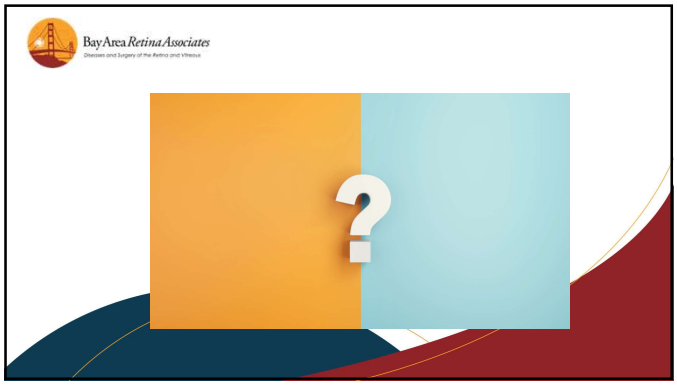
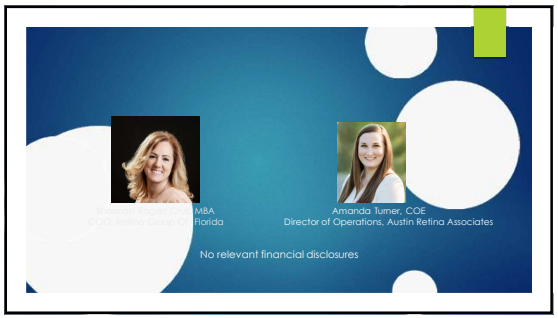
18


Bay Area Retina Associates
Diseases and Surgery of the Retina and Vitreous

19


Cultivating the Future Leader: Talent Recognition and Training
"Key strategies for identifying, developing, and preparing future leaders"

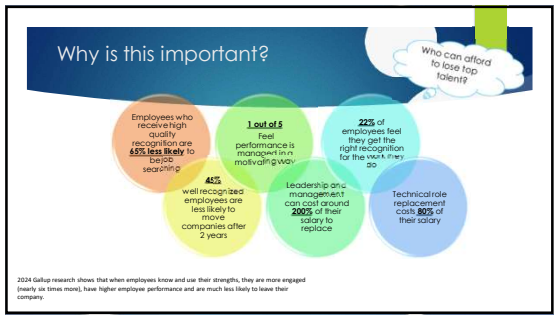
1


MBA
Florida
Amanda Turner, COE
Director of Operations, Austin Retina Associates
No relevant financial disclosures

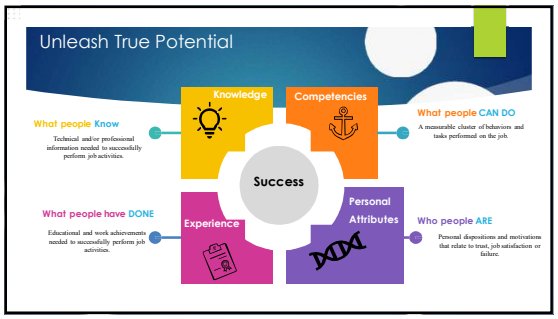
2


Introduction
Identifying and nurturing future leaders is key to long-term organizational success.
Senior leaders play a critical role as mentors and coaches
By modeling desired behaviors and values, senior leaders set an example.
Mentorship and active involvement help nurture emerging leaders
The importance of talent recognition and effective staff training is discussed.

3


Why is this important?
Who can afford to lose top talent?
Employees who receive high quality recognition are 65% less likely to begin searching
1 out of 5
Feel performance is managed in a motivating way
22% of employees feel they get the right recognition for the work they do
45%
well recognized employees are less likely to move companies after 2 years
Leadership and management can cost around 200% of their salary to replace
Technical role replacement costs 80% of their salary
2024 Gallup research shows that when employees know and use their strengths, they are more engaged (nearly six times more), have higher employee performance and are much less likely to leave their company.

4


Unleash True Potential
Knowledge
Competencies
What people Know
Technical and/or professional information needed to successfully perform job activities.
What people CAN DO
A measurable cluster of behaviors and tasks performed on the job.
Success
What people have DONE
Educational and work achievements needed to successfully perform job activities.
Experience
Personal Attributes
Who people ARE
Personal dispositions and motivations that relate to trust, job satisfaction or failure.

5

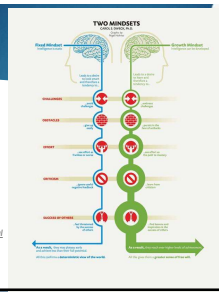

Identifying High Potential Employees
Fear, Anxiety, Stress, Sound familiar?
Use multiple evaluation methods: performance reviews, personality assessments, and peer reviews.
A multi-dimensional approach helps pinpoint employees with leadership potential.
Ask yourself these questions:
Do you measure everything? Just because you can, should you?
Can the employee influence the metric directly with the work they do?
Do any of those measurements focus on the employees' greatest abilities and contributions?
Are they future and growth focused? Do you discuss them on a regular basis?

6

Fixed Mindset

- Avoids challenges
- Gives up easily
- Sees effort as fruitless
- Ignores useful negative feedback
- Feels threatened by the success of others

Achieves less than their potential



Growth Mindset

- Embraces challenges
- Persists in the face of setbacks
- See effort as a path to mastery
- Learns from criticism
- Finds lessons & inspiration from the success of others

Reaches ever higher levels of achievement

7

Talent Recognition and Training

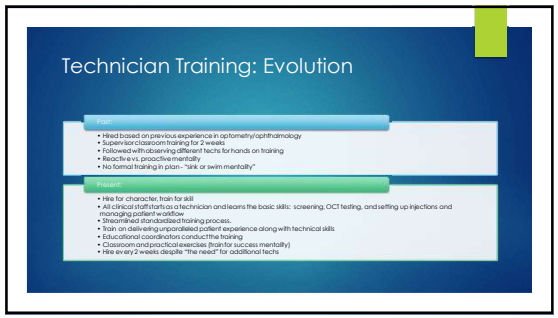
- A supportive environment motivates employees to improve.
- Creating a high development culture is key in retaining top talent.
- Encouraging ongoing training, knowledge sharing, and recognition of achievements is key to a culture of continuous improvement.

Do you have an effective training program? Let's walk through what that looks like.

8

Implementing Effective Training Programs

9


Technician Training: Evolution
Past:
• Hired based on previous experience in optometry/ophthalmology
• Supervisor classroom training for 2 weeks
• Followed with observing different techs for hands on training
• Reactive vs. proactive mentality
• No formal training in plan - "sink or swim mentality"
Present:
• Hire for character, train for skill
• All clinical staff starts as a technician and learns the basic skills: screening, OCT testing, and setting up injections and managing patient workflow
• Streamlined standardized training process.
• Train on delivering unparalleled patient experience along with technical skills
• Educational coordinators conduct the training
• Classroom and practical exercises (train for success mentality)
• Hire every 2 weeks despite "the need" for additional techs

10


Tech Training Program
4 weeks of training
Practical and classroom training
Department observations
Hard skills & soft skills
O3s with supervisors

11


First Week
Onboarding
Practice Introduction, Why? Culture, Mission, Patient Experience Training
Meet the CEO & Managing Physician
Tour of the main office
General information about portals, parking, scrubs, etc.
Logins for all applications used
Safety training
Compliance training
Department Observations
Introduction to Lean
Patient Experience Visit
Meet & greet with their supervisors

12

Training Program-Week 2

MONDAY - DAY 6	TUESDAY - DAY 7	WEDNESDAY - DAY 8	THURSDAY - DAY 9	FRIDAY - DAY 10
8am-10am: Introduction to Retina 10am-11am: Department observation with physician and/or technician 12pm-1pm: Lunch 1pm-3pm: Introduction to Retina 3pm-5pm: Department observation with physician and/or technician	8am-11am: EHR training 11:30am-12pm: Lunch 12pm-4pm: EMR training/practice 4pm-4:30pm: Independent study	8am-10am: Observe a screener in clinic 10am-11:30am: Disease and condition review and/or EHR practice/review 12pm-1:30pm: Lunch 1:30pm-4pm: EHR resources and EHR training/mimic screening 4pm-4:30pm: Independent study	8am-11am: Practical exercises for external exam 11:30am-12pm: Lunch 12pm-3:30pm: Practical exercises for external exam 3:30pm-4pm: Review on external exam 4pm-4:30pm: Independent study	8am-10am: Review 10am-12pm: Practice screening on classmates 12pm-12:30pm: Lunch *Optional:eating lunch or independent study before afternoon clinic* 1:30pm-5pm: Double screen with technician/coordinator in clinic

13

Training Program - Week 3

MONDAY - DAY 11	TUESDAY - DAY 12	WEDNESDAY - DAY 13	THURSDAY - DAY 14	FRIDAY - DAY 15
8am-12pm: Screening in clinic with coordinator/technician 12pm-1pm: Lunch *Optional:independent study before afternoon clinic* 1:30pm-5pm: Screening in clinic with coordinator/technician	8am-10am: Questions and answers followed by review 10am-12pm: Teach different exam encounters and expectations 12pm-1pm: Lunch 1pm-4pm: Practice screening different encounters 4pm-4:40pm: Independent study	8am-12pm: Screen in clinic with coordinator/technician and/or OCT training 12pm-1:30pm: Lunch 1:30pm-5pm: Screen in clinic with coordinator/technician and/or OCT training	8am-10am: Introduce performing manual blood pressure, audits, Google drive resources, and review 10am-12pm: Practice/Review 1:30pm-5pm: Screening in clinic with coordinator/technician and/or OCT practice with photographer	8am-12pm: Additional classroom education/review. If not needed, techs will be screening with another tech and/or practicing OCTs with photographer 12pm-1:30pm: Lunch 1:30pm-5pm: Screening in clinic with coordinator/technician and/or OCT practice with photographer

14

Training Program - Week 4

- Screen with an experienced tech in clinic
- Travel to other locations with coordinator/tech to experience working in other locations
- Practice performing OCT with photographer
- One-on-one training sessions for employees that need additional training

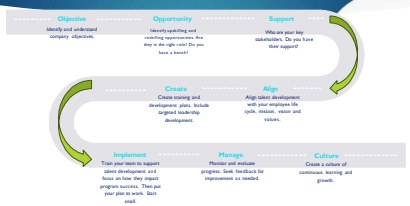
15

Implementation

- Evaluate current training program
- Discuss current struggles with employees and leadership
- Create/modify training program with the input from senior & novice techs
  - Specific skill set requirement
  - Standardize training program
  - Classroom & practical exercises before encountering patients
  - Observe different departments (perspective, understanding, growth)
  - Build redundancies

16

Talent Development RoadMap



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18

1

Agenda

1. | Introductions
2. | Overview
3. | Pros & Cons
4. | Case Studies
5. | Major Highlights

- 2 -

2

Introductions

Disclosure: KY- Regeneron, Genentech, Apellis, Amgen, & EyePoint, AL- Amgen, Amerisource Bergen, Coherus, EyePoint, Genentech, Iveric, Cardinal, & Ophtea, JI- Apellis, Coherus, Genentech, & Eyepoint ,PT- Regeneron, Genentech, & EyePoint, CC- No relevant disclosures

- 3 -

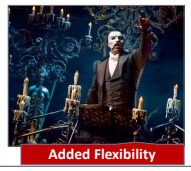
3

Why Cross-Training Matters: A Lesson from Broadway

Swing: A member of the company that understudies several ensemble roles.

Optimize Performance

Continuity of Care



Added Flexibility

Professional Growth

4

Opening Act: Pros & Cons

5

Cross-Training Pros & Cons

Pros

- Increased flexibility & coverage
- Improved efficiency & workflow
- Better patient experience
- Cost Savings
- Employee engagement and job satisfaction
- More effective problem solving

Cons

- Initial training costs and time
- Overreliance on a few key employees
- "Mercenary" behavior
- Overwhelming the "Good Employee"
- Jack of all trades-Master of none
- What happens with the less desirable work?
- Checks and balances/cash controls
- Large vs. Small practice variables

6

7

Case Study #1: Essential Role of Versatile Team Members

Challenge Faced

Intermittent lack of support staff in the clinical, photography and research departments. FTE not needed due to intermittent requirements.

Solution

Identified individuals from the front desk to cross-train in clinic and photography. Identified a technician to complete research certifications and learn how to perform BCVA

Benefit

Added additional support staff to departments intermittently. Gave front desk staff opportunity to grow within the practice. Increased overall clinic flow.

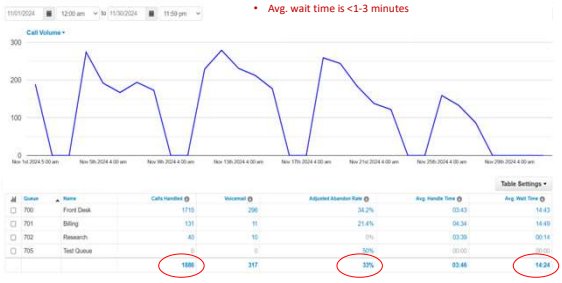
8

Case Study #2: Resolving Call Center Shortages through Cross-Training

Before: November 2024

Industry Benchmarks for healthcare:

- Abandoned call rate ~2-5%
- Avg. wait time is <1-3 minutes



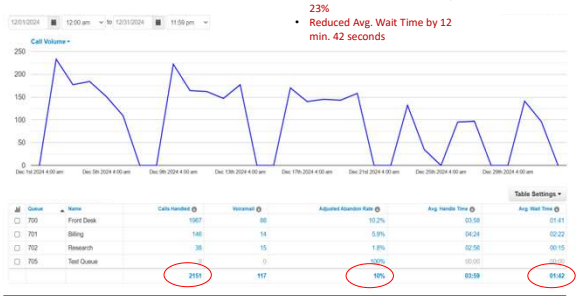
Queue	Name	Calls Handled	Voicemail	Adjusted Abandon Rate	Avg. Handle Time	Avg. Wait Time
700	Front Desk	1715	296	34.2%	03:43	14:43
701	Billing	131	11	21.4%	04:34	14:49
702	Research	40	10	0%	03:39	00:14
705	Test Queue	0	0	50%	00:00	00:00
		1886	317	33%	03:46	14:24

9

Case Study #2: Resolving Call Center Shortages through Cross-Training

In Process: December 2024

Compared to November:
- Handled 14% more calls
- Decreased Abandoned Rate by 23%
- Reduced Avg. Wait Time by 12 min. 42 seconds



Queue	Name	Calls Handled	Voicemail	Adjusted Abandon Rate	Avg. Handle Time	Avg. Wait Time
700	Front Desk	1967	88	10.2%	03:58	01:41
701	Billing	146	14	5.9%	04:24	02:22
702	Research	38	15	1.8%	02:56	00:15
705	Test Queue	0	0	100%	00:00	00:00
		2151	117	10%	03:59	01:42

10

Case Study #2: Resolving Call Center Shortages through Cross-Training

After: January 2025

Compared to November:
- Handled 29% more calls
- Decreased Abandoned Rate by 29.4%
- Reduced Avg. Wait Time by 13 min. 37 seconds

Queue	Name	Calls Handled	Voicemail	Adjusted Abandon Rate	Avg. Handle Time	Avg. Wait Time
700	Front Desk	2274	17	3.4%	04:22	00:28
701	Billing	119	13	8.6%	04:26	00:01
702	Research	41	9	3%	05:07	00:18
705	Test Queue	0	0	100%	00:00	00:00
		2434	39	3.6%	04:23	00:47

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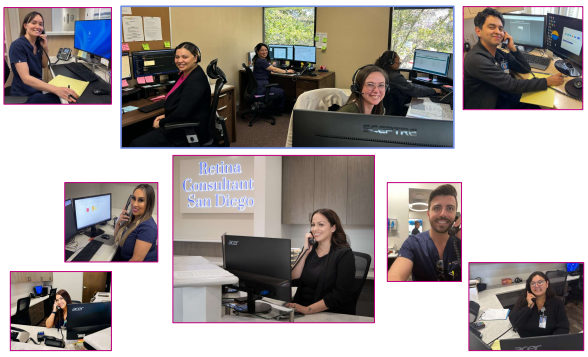
THE TEAM



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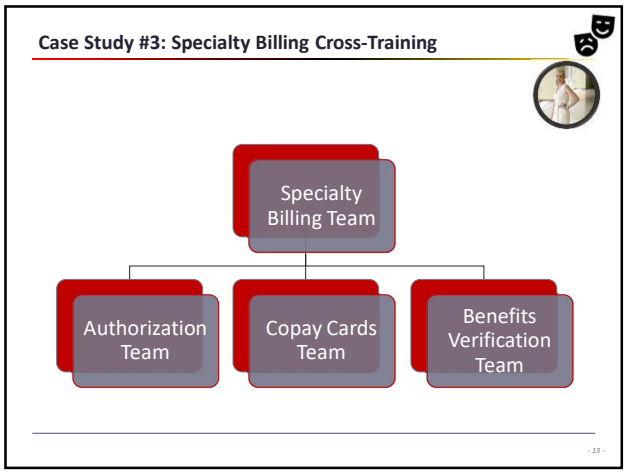
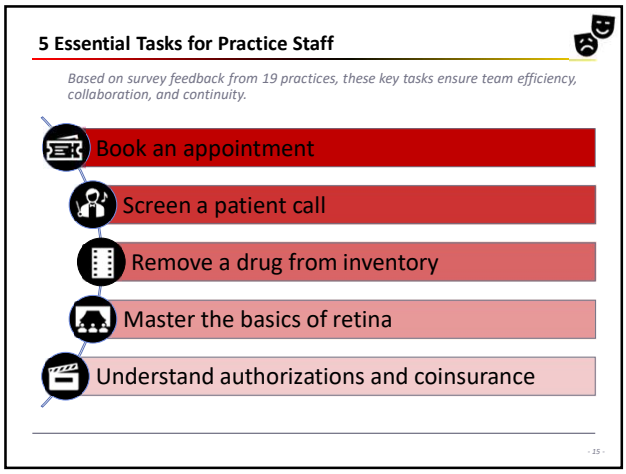

Case Study #3: Specialty Billing Cross-Training
Specialty Billing Team
Authorization Team
Copay Cards Team
Benefits Verification Team

13


Encore

14


5 Essential Tasks for Practice Staff
Based on survey feedback from 19 practices, these key tasks ensure team efficiency, collaboration, and continuity.
Book an appointment
Screen a patient call
Remove a drug from inventory
Master the basics of retina
Understand authorizations and coinsurance

15

16

ASRS Business of Retina Meeting 2025
Atlanta GA

Collaborating with PCPs through Teleretinal Screening for DR

Jose Agustin Martinez, MD
President and Managing Partner, Austin Retina Associates
Clinical Assistant Professor, Department of Ophthalmology
UT Dell Medical School, Austin , Texas

1

Financial Disclosures

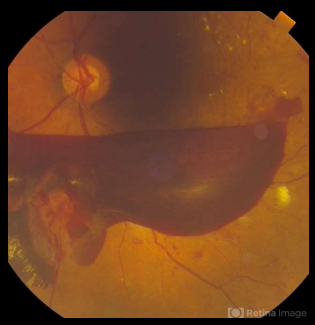
Adverum - Principal or Named Investigator
Aerie Pharmaceuticals, Inc-Principal or Named Investigator
Annexon -Principal or Named Investigator
Aura Biosciences -Principal or Named Investigator
Chengdu Konghong Co. Ltd. -Principal or Named Investigator
EyeBio-Principal or Named Investigator
Eyebiotech -Principal or Named Investigator
EyePoint Pharmaceuticals -Principal or Named Investigator
Genentech -Principal or Named Investigator
Graybug Vision -Principal or Named Investigator
Ionis Pharmaceuticals -Principal or Named Investigator
iRenix- Principal or Named Investigator
Iveric Bio -Principal or Named Investigator
Kodiak Sciences -Principal or Named Investigator
Kyowa Kirin Co. Ltd -Principal or Named Investigator
La Roche Posay/BioMedic -Principal or Named Investigator
Novartis, Alcon Pharmaceuticals -Principal or Named Investigator
Ocular Therapeutix -Principal or Named Investigator
Olleyes stock private. Approved FDA device 2019; VF perimeter
Oculis -Principal or Named Investigator
Ophtec -Principal or Named Investigator
Opthea -Principal or Named Investigator
Privant Theraputics, Inc -Principal or Named Investigator
Regeneron - Speaker Bureau,Principal or Named Investigator
RegenxBio -Principal or Named Investigator
Santen, Inc -Principal or Named Investigator
Theia Therapeutics -Principal or Named Investigator

NONE PERTAIN TO THIS TALK

2

The Problem

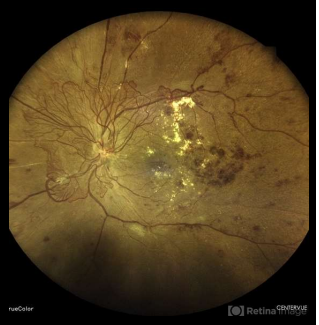
- 1 in 3 develop DR
- 50% receiving screening exams
- OPPORTUNITY
  - PCP on front lines
  - TRS improves access, detection and outcomes.



3

Goals of Collaboration

- Enhance patient outcomes.
- Increase screening rates.
- Reduce referral barriers.
- Increase quality of care.
  - MACRA → MIPS (providers)
  - HEDIS → STAR Ratings (ins)



4

AAO supported

Meta Analyses Establishing Efficacy with good S&S

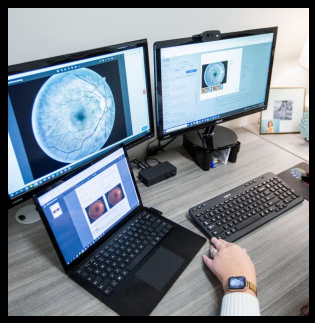
- Telemedicine for detecting diabetic retinopathy: a systematic review and meta-analysis. Lili Shi1,2, Huiqun Wu1, Jiancheng Dong1, Kui Jiang1, Xiting Lu3, Jian Shi. BJO June 2015 volume 99-6.
- Screening for Presence or Absence of Diabetic Retinopathy: A Meta-analysis. Peter Bragge, PhD; Russell L. Gruen, PhD, MBBS, FRACS; Marisa Chau, BBNSc(Hons). Andrew Forbes, PhD; Hugh R. Taylor, M. Arch Ophthalmol. 2011;129(4):435-444.
- Cost-effectiveness and diagnostic accuracy of telemedicine in macular disease and diabetic retinopathy: A systematic review and meta-analysis. Waqas Ullah, Sana Khan Pathan, Ankur Panchal, Swapna Anandan 2019 JDC.Jefferson.edu.
- According to Research GPT, 118 original articles were published from 2015-2020 on the subject.

5

Why Teleretinal Screening?

(TRS)

- ACCESSIBILITY: retinal imaging at PCP office.
- EFFICIENCY: captured and promptly reviewed remotely by MD.
- ACCURACY: high sensitivity and specificity.
- BROADER IMPACT: detects other diseases

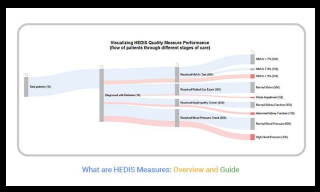


6

HEDIS Scores

The HOOK

- Healthcare Effectiveness Data and Information Set
  - Hgb A1C
  - *RETINAL SCREENING!!!*
  - Nephropathy screening
  - BP control



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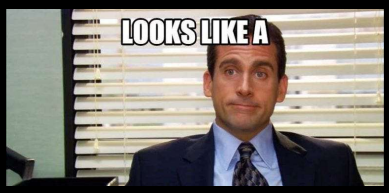
Win-Win-Win-Win

- Patients benefit.
- PCP benefits.
- Retinologist benefits.
- Healthcare system benefits.



WIN-WIN-WIN-WIN SITUATION

8

Why Patients Benefit

- Easy access.
- Fewer appointments.
- Less cost to screen.
- Earlier detection.
- Reduces vision loss.

9

Why Retinologist Benefit

- Builds relationship with PCPs.
- Fewer screening exams in office.
- Managing sight-threatening disease.
- Earlier detection and intervention.
- Preventing vision loss.

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Why Insurers Benefit

- Improve quality measures.
- Improve patient-doctor relationship.
- Reduce cost
  - Reduce # appointments
  - Earlier intervention
  - Cost savings to screen pts

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Why PCPs Benefit

- HEDIS Scores determine care quality thus impact reimbursement.
- Better control of pt compliance with in-office cameras.
- Better coordination of care through third party web based infrastructure and outsourced appointment scheduling.
- Patient - Doctor satisfaction.
- Proven benefits. (2 cam to 24 cameras in 8 years)

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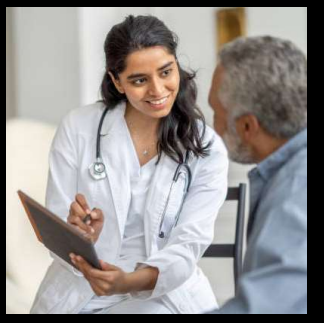
CMO Own Words

15,000 DM pts

- Offering retinal screening builds patient connection to PCP.
- Reduces frustration of chasing outside records.
- PCP showing fundus image improves focus on Hgb A1C.
- MC ACO (and other risk-based contracts) increase pay for DM pts from 12K to 18K if any DR detected.
- Screening rates jumped from 25% to 70%.
- MC Advantage STAR ratings up.
- MC ACO in top quartile.



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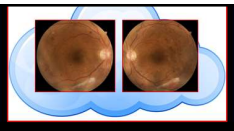
The Details

- Fee for service …break even at best
- Code 92250… MC $74. Commercial Ins… $125
- Third party infrastructure gets around $33/ patient
- Table top camera: $15K ; stability and longevity. Locations >10 PCPs
- Hand held camera: $7K ; 3% less readability. Locations 5-10 PCPs
- As readers paid $5/pt.
- *Speak to CMO, PCP lead physician, Population Health Department. NOT CFO.*

14

How TRS works?


1. Image acquisition @ PCP's lab


2. Upload to platform


3. MD reads


4. Automated report


5. Schedule

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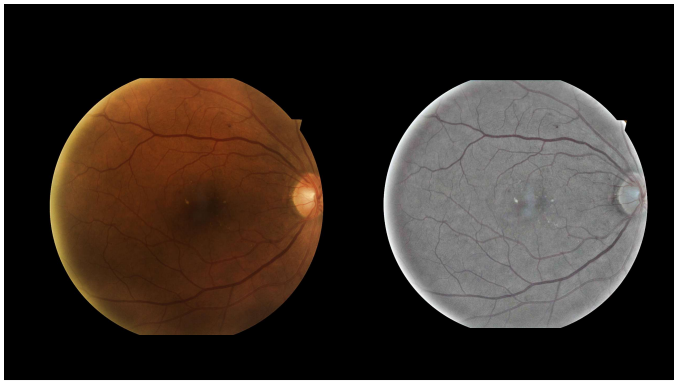

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The Process (TRS)

PCP → FP → Upload

Review → Report → Chart

Schedule → Exam → Letter

17

Cloud-based TRS Platforms

- Retina Labs
- IRIS
- Eyenuk*
- Hillrom's RetinaVue
- AEYE Health*

*AI for DR

18

TRS Platform Considerations

- Image Quality: *table top* v hand held, standard v UWF, FP v *image enhancement.*
- Image Reader: AI as reader, *local retina expert*, centralized Eye MD readers.
- Work Flow: follow up intervals
- Scheduling: who, by when, with whom, no answer protocol…

19

ine for Diabetic Retinopathy Screening in an Urban, Insured Population Using Fundus Cameras in a Primary Care Offic

Jose Agustin Martinez, Shelley Day Ghafoori, C. Armitage Harper, James W. Dooner, Mark Levitan, Peter A. Nixon, Ryan C. Young, Robert W. Wong

Poster 217

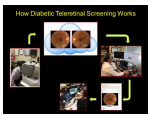
INTRODUCTION

Telemedicine for diabetic retinopathy screening has been established as a viable screening program option.[1-5] This report reviews our two year experience using telemedicine to screen for diabetic retinopathy in an urban, insured population.

METHODS: We report our two year experience from May of 2015 through April of 2017 deploying telemedicine for diabetic retinopathy screening using table-top fundus cameras stationed in primary care offices of a well established regional medical clinic serving commercially-insured patients . Collected data included the number screened, number with diabetic retinopathy, number requiring further evaluation, and number actually evaluated by trained retina specialist (capture rate). A third party company provided the interconnectivity required via a cloud-based platform. Fundus images were reviewed by a local retina reading center. comprised of local retina specialist whose administration assisted in scheduling at-risk patients.

RESULTS:

1. **# patients screened: 5,764**
2. **# patients with ungradable images: 132 (2.3%).**
3. **# patients with gradable images: 5,632 (97.7%)**
4. **# patients with retinal pathology 1,830 (32.5%)**
5. **# with diabetic retinopathy were 1,152 (20.5%).**
6. **# requiring a retina appointment: 668 (11.9%).**
7. **# actually examined by a retina specialist: 547 (9.7%).**
8. **compliance capture rate (examined/ required) 81.9% (547/668).**
9. **# patients treated 82 (1.45%of total and 15% of those examined).**



Study	Present report	Jani 2017 JAMA Ophthal	Keenum 2016 JAMA Ophthal
Pop	urban, insured	rural, underserved	urban, safety net
# screened	5,764	1,681	949
# DR (%)	1,152 (20.5%)	20.3%	NA
# DR needing retinal evaluation (%)	668 (11.9%)	9.3%	UA
Compliance Capture rate 547/668	**81.9%**	60.0%	29.9%

Authors have no pertinent financial interest.
No human research was performed.

CONCLUSION

This report confirms the utility of telemedicine for diabetic retinopathy screening, particularly in an insured, urban population. It also documents a higher than previously reported capture rate (81.9%) of those patients needing further retinal evaluation actually seeing a retina specialist. Because of this, telemedicine for diabetic retinopathy screening is likely to expand in the future.

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1. Nguyen, H.V., et al., *Cost-effectiveness of a National Telemedicine Diabetic Retinopathy Screening Program in Singapore.* Ophthalmology, 2016.
2. Rosses, A.R., et al., *Three-year experience of tele-ophthalmology: An diabetic retinopathy screening in a rural population.* Arch Soc Esp Oftalmol, 2016. **91**(6): p. 600-.
3. Rosses, A.P., et al., *Diagnostic performance of retinal digital photography for diabetic retinopathy screening in primary care.* Fam Pract, 2017.
4. Scanlon, P.H., *The English National Screening Programme for Diabetic Retinal Disease.* Semin Ophthalmol, 2017. **32**(1): p. 23-28.
5. Zhang, W., et al., *Screening for Diabetic Retinopathy Using a Portable, Noncontact, Nonmydriatic Handheld Retinal Camera.* Am J Ophthalmol, 2016.
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7. Jani, P.D., et al., *Evaluation of Diabetic Retinal Screening and Factors Predictive of Ophthalmology Referral in a Telemedicine Network.* JAMA Ophthalmol, 2017. **135**(7): p. 706-714.

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The University of Texas at Austin Dell Medical School

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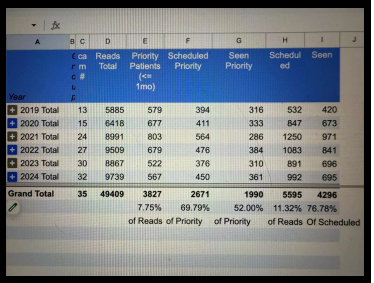
8. **compliance capture rate (examined/ required) 81.9% (547/668).**
9. **# patients treated 82 (1.45%of total and 15% of those examined).**

Study	Present report	Jani 2017 JAMA Ophthal	Keenum 2016 JAMA Ophthal
Population	urban, insured	rural, underserved	urban, safety net
# screened	5,764	1,681	949
# DR (%)	1,152 (20.5%)	20.3%	UA
# DR needing retinal evaluation (%)	668 (11.9%)	9.3%	UA
Compliance Capture rate 547/668	**81.9%**	60%	29.9%

21

Austin Retina Experience

- Started in 2014
- In last 6 years, 49,409 screened
- 11.32% with DR needing exam
- 76.78% actually examined

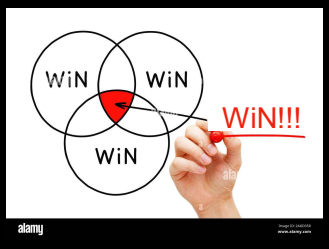


Year	Carrier #	Reads Total	Priority Patients (<= 1mo)	Scheduled Priority	Seen Priority	Scheduled	Seen
2019 Total	13	5885	579	394	316	532	420
2020 Total	15	6418	677	411	333	847	673
2021 Total	24	8991	803	564	286	1250	971
2022 Total	27	9509	679	476	384	1083	841
2023 Total	30	8867	522	376	310	891	696
2024 Total	32	9739	567	450	361	992	695
Grand Total	35	49409	3827	2671	1990	5595	4296
			7.75% of Reads	69.79% of Priority	52.00% of Priority	11.32% of Reads	76.78% Of Scheduled

22

Summary

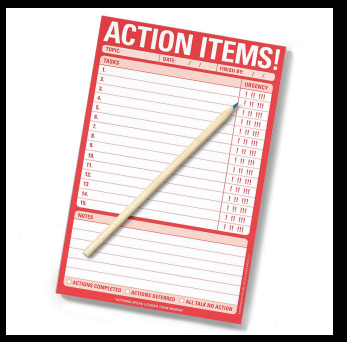
- TRS collaborates with PCPs.
- TRS improves pt access.
- TRS maximizes retinologist time.
- TRS catches disease earlier.
- TRS reduces vision loss.
- TRS saves time and money.
- TRS is a win-win-win-win.



23

Action Items

- Reach out to CMO of large multispecialty groups.
- Propose TRS to improve screening rates for HEDIS scores and ACO risk based DR detection.
- Offer retina scheduling support.
- Signal willingness to leverage technology for better pt outcomes.



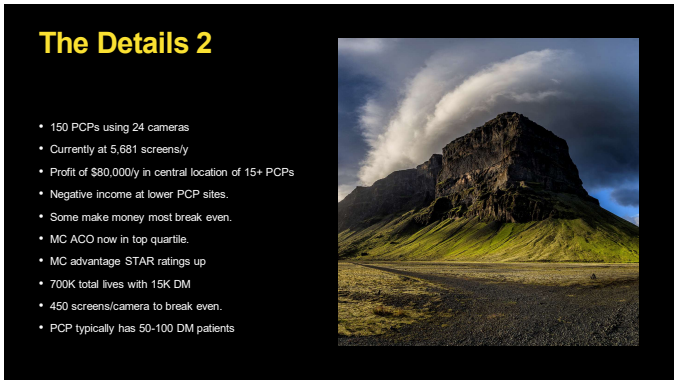
24


ASRS Business of Retina Meeting 2025
Atlanta GA
Thank you!!!
Jose Agustin Martinez, MD
President and Managing Partner, Austin Retina Associates
Clinical Assistant Professor, Department of Ophthalmology
UT Dell Medical School, Austin , Texas

25

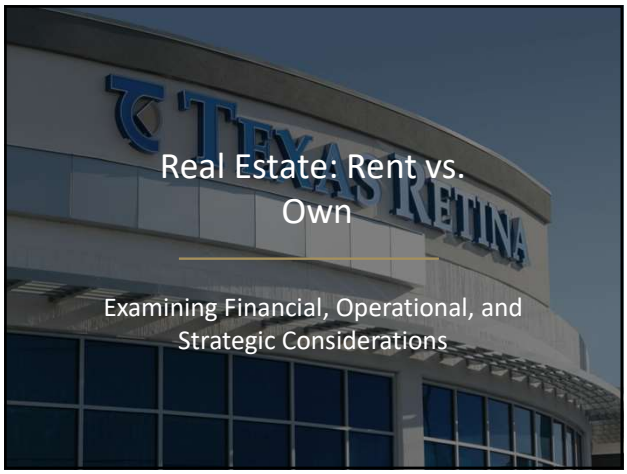

"A good reputation is more valuable than money."
–Publilius Cyrus (100-44 BC)

26


The Details 2
• 150 PCPs using 24 cameras
• Currently at 5,681 screens/y
• Profit of $80,000/y in central location of 15+ PCPs
• Negative income at lower PCP sites.
• Some make money most break even.
• MC ACO now in top quartile.
• MC advantage STAR ratings up
• 700K total lives with 15K DM
• 450 screens/camera to break even.
• PCP typically has 50-100 DM patients

27

28



Real Estate: Rent vs. Own

Examining Financial, Operational, and Strategic Considerations

1

Disclosures

No Related Disclosures

2

Learning Objectives

- Evaluate financial and operational implications of renting vs. owning.
- Apply key decision-making strategies to choose the best option for a practice.

3

Description

Helping physicians align real estate decisions with long-term goals.

Focus on strategic, financial, and operational considerations.

4

Strategic Considerations

Alignment with long-term practice goals.

- Location, Location, Location
- Own for long term strategy and growth
- Referral Relationships
- Leasing is beneficial for entering new markets, short term strategy and "wild" real estate markets

Market conditions and property appreciation.

- Think outside the box while ensuring location aligns with practice operations
- Owning – longer term strategy
- Build, Remodel or Repurpose

Autonomy vs. affiliation.

- Biggest return doing it on your own
- Consultant vs. Developer
- Cast your net wide on resources
- Participation in a JV with a health system or a developer – better than writing rent checks forever.

Exit strategies and resale value.

- Buy and Hold vs. Flip to REIT
- It is real estate – fluctuations happen
- Real estate attorney key to structure buy in, buy out, and final exit planning

5

Financial Considerations

Initial costs and capital investment.

- Ok to start out slow – not too big a bite on your first project
- Allocate the equity as an investment
- Fully understand the financial modeling for both short and long term

Long-term financial impact:

- Pay yourself. One of the best career investments you can make
- Cash flow return and long-term asset appreciation
- Long term lease will be required for financing – location is key.

Tax implications and benefits.

- Consult a tax professional!
- Cash flows - not ordinary income
- Cost Segregation strategies offset taxable income

Financing/Loan options.

- Rule of 3s Apply – banks, terms, and guarantees
- Your corporate bank might not be the best real estate fit
- Align with strategy of flip vs. hold
- Maintain ability to refinance at some point
- Lenders love owner occupied projects

6

Operational Considerations

Professional Resources

- Cast your net wide
- Don't obligate yourself to any one professional
- Rule of 3 – brokers, developers, architects, lenders, contractors.
- Remember – they make money doing these deals every day!

Lease agreements vs. mortgage responsibilities.

- Existing lease agreements key to new real estate deals
- Separate entities for each real estate venture – flexibility
- Practice entity is the tenant
- Multiple ways to structure the ownership entity – flexibility important

Maintenance and facility management.

- Not the responsibility of your practice manager!
- Outsource to a qualified source or consultant.
- Good consistent maintenance and HVAC service agreements make happy tenants

Expansion and scalability.

- Based on your long-term growth strategy and investment goals
- Each investment is a learning tool for the next one

7

Case Study/Repurpose – Dallas, Texas

- 40,000 sf. Former retail space.
- High visibility interstate location.
- Purchased from health system that received the property from a donation

8

Case Study/Ground Up – Frisco, Texas

- 60,000 square foot ground up. 2027 occupancy
- Expanding market and growing patient base
- Ophthalmology ASC and core referral tenants

9

Case Study/Repurpose – Sherman, Texas

- 10,000 square foot Repurpose with tenant.
- Any guesses of prior use of building?
- Expanding market and growing patient base

10

Case Study/Remodel – Fort Worth, Texas

- 20,000 square foot medical building. 3 total tenants
- Purchased from a transitioning Radiology group.
- Complete interior remodel
- Core medical district in Fort Worth, Texas

11

Case Study/Ground Up Single Use – Waco, Texas

- 10,000 square foot single tenant stand alone facility
- Ground up construction
- Built for marketplace growth and future opportunities

12

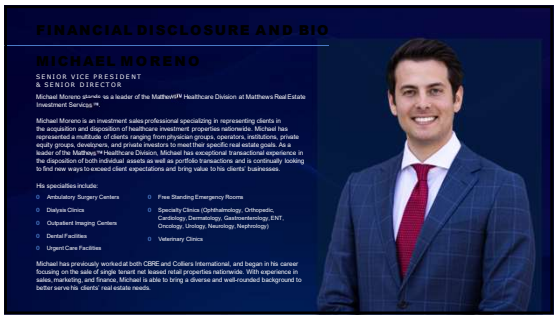
Conclusion

- Recap of key takeaways.
- Encouragement for proactive decision-making.
- Q&A session.

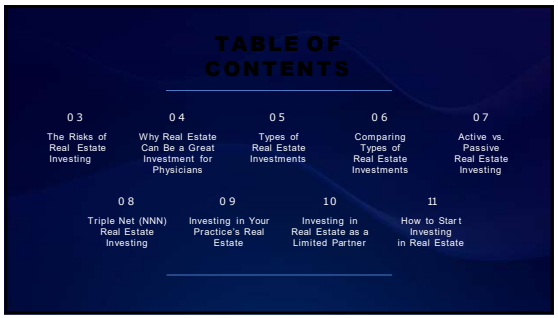
13


MATTHEWS
REAL ESTATE INVESTMENT SERVICES
REAL ESTATE AS AN INVESTMENT
BUILDING WEALTH OUTSIDE THE CLINIC
MICHAEL MORENO

1


FINANCIAL DISCLOSURE AND BIO
MICHAEL MORENO
SENIOR VICE PRESIDENT
& SENIOR DIRECTOR
Michael Moreno leads as a leader of the Matthews™ Healthcare Division at Matthews Real Estate Investment Services™.
Michael Moreno is an investment sales professional specializing in representing clients in the acquisition and disposition of healthcare investment properties nationwide. Michael has represented a multitude of clients ranging from physician groups, operators, institutions, private equity groups, developers, and private investors to meet their specific real estate goals. As a leader of the Matthews™ Healthcare Division, Michael has exceptional transactional experience in the disposition of both individual assets as well as portfolio transactions and is continually looking to find new ways to exceed client expectations and bring value to his clients' businesses.
His specialties include:
Ambulatory Surgery Centers
Dialysis Clinics
Outpatient Imaging Centers
Dental Facilities
Urgent Care Facilities
Free Standing Emergency Rooms
Specialty Clinics (Ophthalmology, Orthopedic, Cardiology, Dermatology, Gastroenterology, ENT, Oncology, Urology, Neurology, Nephrology)
Veterinary Clinics
Michael has previously worked at both CBRE and Colliers International, and began in his career focusing on the sale of single tenant net leased retail properties nationwide. With experience in sales, marketing, and finance, Michael is able to bring a diverse and well-rounded background to better serve his clients' real estate needs.

2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03 The Risks of Real Estate Investing
04 Why Real Estate Can Be a Great Investment for Physicians
05 Types of Real Estate Investments
06 Comparing Types of Real Estate Investments
07 Active vs. Passive Real Estate Investing
08 Triple Net (NNN) Real Estate Investing
09 Investing in Your Practice's Real Estate
10 Investing in Real Estate as a Limited Partner
11 How to Start Investing in Real Estate

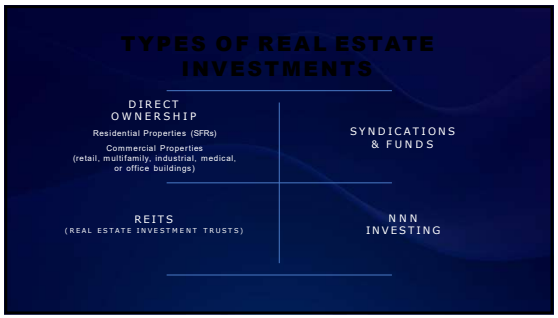
3


THE RISKS OF REAL ESTATE INVESTING
MARKET AND INTEREST RATE RISK
Property values can fluctuate during various market cycles
TENANT RISK
Tenants can vacate leaving the investor to cover mortgage costs until the space is leased
LIQUIDITY RISK
If cash is needed immediately, other investments (e.g., stocks) tend to be more liquid
MANAGEMENT RISK
Poor property management reduces returns
FINANCING RISK
Rising interest rates can affect cash flow

4


WHY REAL ESTATE CAN BE A GREAT INVESTMENT FOR PHYSICIANS
PROVIDES ADDITIONAL INCOME STREAMS FOR PHYSICIANS
REAL ESTATE "GENERALLY" APPRECIATES IN VALUE LONG-TERM
PROVIDES TREMENDOUS TAX BENEFITS FOR INVESTORS
IS A GREAT WAY TO DIVERSIFY STOCK HEAVY PORTFOLIOS
IS A GREAT WEALTH PRESERVATION TOOL
PROVIDES A GREAT HEDGE AGAINST INFLATION

5


TYPES OF REAL ESTATE INVESTMENTS
DIRECT OWNERSHIP
Residential Properties (SFRs)
Commercial Properties (retail, multifamily, industrial, medical, or office buildings)
SYNDICATIONS & FUNDS
REITS
(REAL ESTATE INVESTMENT TRUSTS)
NNN INVESTING

6

COMPARING TYPES OF REAL ESTATE INVESTMENTS

INVESTMENT TYPE	ACTIVE OR PASSIVE	POTENTIAL RETURN	RISK LEVEL	PROS	CONS
DIRECT OWNERSHIP	Active	High	Higher	Control, Tax Benefits	Time Intensive
SYNDICATIONS	Passive	Medium-High	Medium	Passive, Diversified	Less Control
REITs	Passive	Medium	Lower	Highly Liquid	Market Volatility
NNN INVESTING	Semi-Passive	Medium	Low	Stable Income, Hands Off	Slower Appreciation

7

ACTIVE VS. PASSIVE REAL ESTATE INVESTING

ACTIVE INVESTING
(DIRECT OWNERSHIP OR GP)

PROS: Higher potential returns, full control over investment

CONS: Requires significant time, expertise, and management duties

PASSIVE INVESTING
(INDIRECT OWNERSHIP OR LP OR NNN INVESTING)

PROS: Hands off, ideal for busy professionals

CONS: Less control over decisions

WHICH IS RIGHT FOR YOU?

Active for hands on investors seeking higher control and higher potential returns

Passive for physicians with limited time looking for more steady returns

8

TRIPLE NET (NNN) REAL ESTATE INVESTING

- TRIPLE NET OR NNN INVESTING IS TYPICALLY THE PURCHASE OF SINGLE TENANT BUILDINGS LEASED TO NOTEWORTHY TENANTS UNDER LONG-TERM NNN LEASES
- NNN STANDS FOR THE 3 NS OR "NETS" OF THE KEY PROPERTY EXPENSES WHICH THE TENANT PAYS:
  - PROPERTY TAXES
  - INSURANCE
  - MAINTENANCE
- THESE BUILDINGS ARE TYPICALLY FREE-STANDING RETAIL, MEDICAL, OR INDUSTRIAL PROPERTIES
- NNN PROPERTIES ARE GREAT FOR INVESTORS LOOKING FOR PASSIVE LONG-TERM CASH FLOW, BUT TYPICALLY APPRECIATE SLOWER THAN OTHER INVESTMENT PROPERTIES

9


INVESTING IN YOUR PRACTICE'S REAL ESTATE
WHY OWN THE BUILDING WHERE YOUR PRACTICE OPERATES?
Control over lease terms and rent
Potential for appreciation
Tax Benefits
MONETIZATION STRATEGY
SALE LEASEBACK: Selling your building for a price premium and leasing it back from the buyer
POST PRACTICE SALE STRATEGY: Selling your building once a lease is put in place with a practice acquirer

10


INVESTING IN REAL ESTATE AS A LIMITED PARTNER
WHAT IS A LIMITED PARTNER (LP)?
AN INVESTOR THAT PROVIDES CAPITAL TO A DEAL, BUT HAS NO ACTIVE MANAGEMENT RESPONSIBILITIES
LPS TYPICALLY INVEST IN REAL ESTATE SYNDICATIONS OR PRIVATE EQUITY FUNDS
LP INVESTING CAN BE A GREAT WAY FOR PHYSICIANS TO GENERATE RETURNS IN REAL ESTATE WITH SMALLER CAPITAL REQUIREMENTS
THE MOST IMPORTANT PART OF LP INVESTING IS THE VETTING OF THE GENERAL PARTNER OR SPONSOR

11


HOW TO START INVESTING IN REAL ESTATE
ASSESS YOUR FINANCIAL GOALS
INCOME NEEDS
RISK TOLERANCE
TIME AVAILABILIT Y
BUILD YOUR KNOWLEDGE BASE
BOOKS, PODCASTS, MENTORS
SEEK ADVICE OR CONSIDER PARTNERING WITH EXPERIENCED INVESTORS
BUILD YOUR INVESTING TEAM
REAL ESTATE BROKER
REAL ESTATE ATTORNEY
REAL ESTATE ACCOUNTANT
DO YOUR DILIGENCE AND START INVESTING
CONSIDER STARTING WITH 1 OR 2 DEALS, THEN EXPAND FROM THERE

12


QUESTIONS?
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13

The Changing Landscape of Patient Assistance

Strategies for Operations and Patient Counseling

Thomas Stone, MD
Nadeem Vaidya, MD
Stephanie Collins, MBA

ASRS Business of Retina

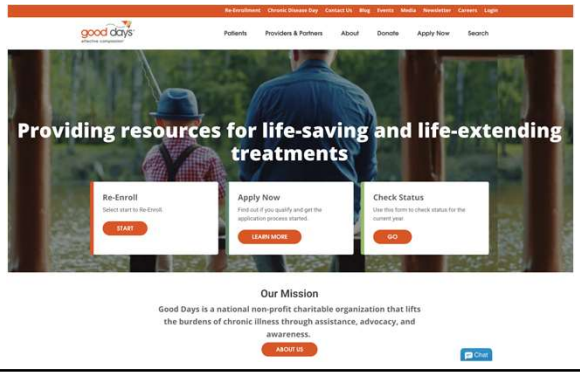
March 29, 2025

1

Anatomy of Payment for Injectable

- Medicare fee for service and Medicare Advantage Patients
  - No CoPay assistance allowed or legal directly from pharmaceutical companies with these federally funded programs
- CoPay Assistance – Good Days
  - Must be through a charitable organization
  - Covers CoPay for medication
  - Payment goes towards patient annual Out of Pocket for their insurance
- Good Days is one of few charitable organizations in this role
  - PANF - currently inactive
  - Healthwell - currently

2



3

There's no way CDF is out of money in January Check with RCM.

Things have changed, but patients will be fine. I need to figure out other options for the patients who really need it.

I can't believe they just abandoned our patients like that. What are they thinking?!

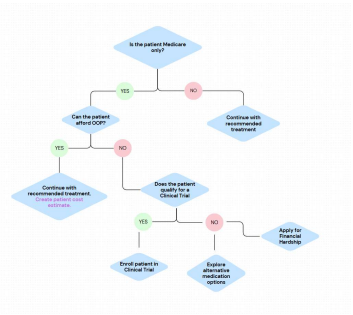
If I can only get funding for the patients that really need it, I can use Avastin for the rest.

None of my patients will ever get funded. They're all going to be blind.

4

Respond to the Challenge

- Identify the patients at risk
  - Report via CPT code vs Good Days
- Implemented operational changes
  - Internal flags
  - Clear workflow of next steps
- Patient notification and counseling
  - Integrate counseling into patient interactions
  - Provide written material for understanding
- Update drug ordering processes
- Enhanced staff communication and training protocols



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Background

- The facts of the matter: We've been lucky. For 20 some odd years, we've had Medicare paying 80% of the cost of high cost drugs AND a cheap, nearly as efficacious, alternative
- Trump DOJ filed suit in 2020 accusing Regeneron of providing kickbacks in the form of payments to GoodDays


THE WALL STREET JOURNAL.

Justice Department Sues Regeneron Over Payments to Copay-Assistance Charity

Lawsuit alleges drugmaker's payments to charity illegally boosted sales of eye drug Eylea

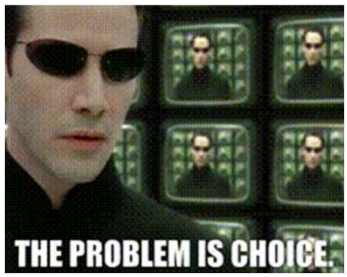
6

Options

Option 1: Move everyone over to Avastin
- Harder to stock Avastin with current shortages

Option 2: Make them pay their Copay if they want the branded drug
- Low likelihood of continued payment
- $9,350 max out of pocket maximum
  - Even with Eylea HD (currently the most expensive drug 20% of ~2500 is $500 x 12 or 24 if bilateral is $6000 or $12000. Unlikely to reach out of pocket max with drug costs alone

Option 3: Move patients to Medicare and a supplement
- Expensive
  - Patients likely chose Medicare Advantage to save money on premiums in the first place



7

Options cont.

Option 4: Use Samples
- Not sustainable long term
- **This will be a long term problem**

Option 5: Use Patient Assistance Programs for patients without a secondary of any sort
- Very few patients fall into this category

Option 6: Use a specialty pharmacy
- Logistically difficult

Option 7: Use a lower priced medication that isn't Avastin
- When you find this magical medication, please let me know
- Biosimilars are all more expensive than their reference counterparts
- Lucentis is an option but is still $100 copayment

8

Don't

- Just inject
  - Know the insurance coverage for each patient
- Rely on retroactive coverage
  - GoodDays is likely not coming back
- Rely on patients to pay
  - Some practices are hundreds of thousands of dollars in the hole in AR

9

David Eichenbaum, MD
Retina Vitreous Associates of Florida
Partner and Director of Research
Collaborative Associate Professor
University of South Florida College of Medicine
Tampa, Florida

Clinial Trials: How to be Profitable

1

Disclosures

S: Speaker, C: Consultant, I: Investigator , E: Equity/Stockholder, F: Founder (Role Over Calendar Years 2024-2025)

- 4DMT I,C,E
- AbbVie C
- Aerie/Alcon I
- Allegenesis I
- Amaros C,E
- ANI/Alimera C
- Annexon I,C
- Apellis C,S
- Astellas I,C,E
- Aviceda I
- Bausch & Lomb C
- Bayer I,C,S
- Boehringer-Ingelheim C
- Boston Image Reading Center E
- Coherus C
- Complement Theapeutics C
- CorEvitas/Vestrum C
- Crinetics C
- EcoR1 C
- EyeBio I
- Eyepoint I,C,E
- Genentech I,C,S
- Gyroscope I
- Harrow C
- Ionis I
- Janssen I,E
- Kodiak I,C
- Kriya C
- Jyowa Kirin I
- Mylan I
- Neurotech C
- Notal Vision C
- Ocular Therapeutix I,C
- Oculus C
- Ocuphire C
- Ocu Tema I
- Ollin C,E
- Opthea I,C
- Orasis C
- ONL I
- Outlook C
- Privant I
- Recens Medical I,C
- Regeneron I,C,S
- Regenxbio I,C
- Revive C,E
- RetinAI I,C
- Roche I,C
- Samsara C
- Stealth I,C
- Tilack C
- Unity I,C

2

The 3 Keys to Success

- Smile and Have a Good Attitude
- Say 'Yes'
- Go to Meetings

"Showing up is 80 percent of life."
– Woody Allen & Marshall Brickman, New York Times August 1977

3

An Engaged MD Principal Investigator (PI) is Required for a Clinical Science Program to Succeed

4

Primary Goals with Early Trials

1. Enroll, Enroll, Enroll
2. Understand and negotiate clinical trial budgets and agreements
3. Monitor clinical trial collections
   - Consider a Clinical Trial Management System

5

You've Already Achieved That… What's Next?

6

You Want to Start Making a Profit

7

Clinical Science is Transactional

8

P&L for your Clinical Trial Program

Revenue Centers
- Subject Recruitment
- Subject Retention

Cost Centers
- Doctors
- Staff
- Rent
- Equipment
- Utilities
- Opportunity for SOC
- Opportunity for Drug Profit

9

Where do you have Leverage?

- Scale – increase recruitment, retention, throughput
- Staff – associate pay to performance
- Equipment – sponsor assistance
- Budget – increase payment per subject

10

Increase Recruitment

- Your Clinic is your source of business
  - Get your Doctors engaged
  - Get your Clinical Trial staff engaged
  - Get your Clinic Staff engaged
  - Get your Referral Community engaged

11

Increase Retention

- Emphasize the high quality care in trials
- Add value to recruit and retain subjects
  - Provide a positive clinical experience
  - Provide snacks and drinks
  - Negotiate transportation
  - Negotiate stipend
- Praise your subjects
  - Emphasize humanitarian nature of clinical science
  - Emphasize providing for the next generation

12

Increase Throughput

13

Scaling Your Clinical Trial Program

- Redundancy
- Reward
- Reinvest
- Ramping-Up Efficiency
- Remain Vigilant

14

Redundancy

- Clinical Science is the most efficient line of business
- Downtime is expensive: Zero Downtime
- MD, Coordination, & Clinical Staff Redundancy Reduces Downtime
  - Recognize and retain your best talent
  - Cross-train your staff
  - Hire when you must

15

Reward

- People respond to incentive
- Incentives must be appropriate and proportionate to role
- MD incentive is most important
- CSC incentive is close second
- Ask your staff "Do you feel appreciated?"
- Put in the time to team-build

16

Reinvest

- Clinical Trial CAPEX may be different from practice CAPEX
- Should be separated and paid by clinical trial revenue
- Engaged MD-PI listens to CSC's, sponsors, monitors in that order
- Not all scientific CAPEX produces more clinical trial revenue
  - Some makes clinical trials easier for CSC's
  - Some makes site more appealing to sponsors
  - Some makes more revenue

17

Ramping-Up Efficiency

- Ongoing process
- Most efficient to run clinical trials in parallel with clinic
- Requires staffing and space

18

Remain Vigilant

- The Engaged PI needs to be situationally aware
- The Research Management and Practice Administrator need to be situationally aware
- The CSC's need to be situationally aware
- Meet regularly with the PI present to ensure CSC and staffing needs are addressed

19

Active Clinical Study Marketing

Incentivize MD's to Recruit

Keep Potential Subject Lists for Upcoming Trials

Re-Examine Clinical Operations

Actionable Growth Strategies that you can Start Today

20

Study Marketing

- Markets both the clinical trial program and the practice
  - Referring MD's/OD's often do not recognize the difference
  - Make study referrals easy
- Funded by the sponsor of the clinical trial
  - Initial budget or budget amendment
- Many options
  - Referral dinners – improve attendance with CE credit when permitted
  - Internal and Community Newsletters

21

Incentivizing MD's to Recruit

- Financial incentive will drive recruitment and participation
  - Must be significant, tangible, and immediate
  - Must be compliant with anti-kickback
- Explain the indirect value of clinical science at MD meetings
  - Ability to care for uninsured/non-par patients
  - Reputation locally
  - Reputation nationally
  - Opportunity for further sponsor engagement

22

Keeping Potential Subject Lists

- Most Clinical Trials study common retinal diseases
- Coordinators should always keep lists of patients with common chronic diseases under study
  - Geographic Atrophy
  - Diabetic Macular Edema
  - Proliferative Diabetic Retinopathy
- Develop a Screening Plan once a disease state trial is active
- MD's and/or clinic staff can help with this – at every office

23

Re-Examining Clinical Operations

- Time – know how long clinical trial visits are
- Space – challenges are where to fit and when to expand
- Staff – use as much existing staff as possible, hire as you grow
- Flexibility – look for what works and make changes

24


Active Clinical Study Marketing
Incentivize MD's to Recruit
Keep Potential Subject Lists for Upcoming Trials
Re-Examine Clinical Operations
Actionable Growth Strategies that you can Start Today

25

1

Objectives

- Learn the basics of biodesign in engineering solutions for clinical medicine
- Understand obstacles in entrepreneurship
- Empower your ideas to become products and know that time is on your side

In this case-based course, we will review one retina specialists journey into medical device from idea creation, engineering and commercialization highlighting the principles of biodesign. The goals of the course are to encourage other retina specialists to consider taking the next step into entrepreneurship.

2

Disclaimer

- This is my story and one that is not even a success story
- The goal is to encourage you to consider executing the idea that you have
- My knowledge is biased into medical device, not pharma or apps
- I am not any different than anyone else in this room, grit is defining characteristic

3

An Idea

- Patients complained all the time about PI and how their eyes were irritated
- Patients asked for a “good rinse” and a “rinse under my lid”
- How do we create a “good rinse”

4

Biodesign

- An **innovation process** that applies:
  - **engineering**
  - **medicine**
  - **and business principles** to develop new medical technologies and healthcare solutions.

It focuses on(1) **identifying unmet clinical needs first, (2) designing solutions, and (3) bringing them to market** efficiently.

5

Unmet Clinical Needs

- We are experts in this area
- We experience every day – patients will tell us to our faces what the unmet needs are
  - Complaints are opportunities
- Issues that we as physicians have may not be shared with other physicians – lean on colleagues to spitball ideas

6

Unmet Clinical Needs: How I did it?

- Go to work every day
- Listen to patients over and over and over
- Ask what worked and what didn't with their rinse
- Ask what a good rinse was and what the effects were

7

Designing Solutions

- Iterative design and prototyping
  - Fail Fast
  - Refine quickly
- Remember to think about Intellectual Property Protection
  - Provisional Patent

8

Designing Solutions-How I did it?

- Printed a preliminary design off of a sketch I had
- 3D Printed next iteration with design engineering team
- Used that for preliminary data collection
- Refined design based on feedback of patients but also other physicians

9

Bringing to Market

- Regulatory Pathway – FDA, CE Mark
- Reimbursement Strategy – OOP, Insurance Coverage, DME
- Market Adoption – Patient Education, Physician Education/Training

10

Bringing to Market – How I did it

- Regulatory Strategy
  - Employed a regulatory consultant
  - FDA Class I – reduced regulatory burden
- Reimbursement Strategy
  - Evaluated similar procedures, trends of reimbursement, current landscape
  - Needs to be feasible for patient, physician and practice
- Market Adoption
  - Commercialization strategy assistance

11

12

Challenges

- Cost/Funding
- Regulatory Hurdles
- Adoption Barriers
- Life

13

Challenges – How I did it

- Cost/Funding
  - Self vs Capital/PE
- Regulatory Hurdles
  - Class I
- Adoption Barriers
- Time
- Life

14

Adoption Barriers – How I did it

- RS in private practice are not custom to charging out of pocket which was model of reimbursement I devised
  - Not the right customer
  - Listened to patient in trial, actually improved Dry Eye Syndrome symptoms
    - Background knowledge in DED/Clinical Trials –Restasis® clinical trial end points
- Shifted to DED/Anterior Segment for most commercial activity
  - RS in Government/VA Systems still a viable option→Federal Contract obtained
  - Shifting into premium IOL market?
- Barriers breakdown when (1) patient has an exceptional experience (2) doctor has positive feedback from patient in medical device.

15

Time

- The runway to commercial product will take 2-3x longer than any time you predict.
- Formula 409 concept (409 iterations to get to magic)

16

Life

- High stress
- No clear path; very different than pathway from college→med school→residency→fellowship→Attending
- 72% of entrepreneurs struggle with Mental Health
  - High Uncertainty
  - Loneliness/Isolation
- No is the most common word you will hear
- Burn Rate by Andy Dunn good resource

17

Pop Quiz

- Name the three people who were in the slides.

18

You have time.

- They all began their entrepreneurship journey at various stages in their life.
- Ina Garten: Worked at White House, at 30 years old bought Barefoot Contessa store, at 51 wrote her first cookbook, at 53 filmed first episode for Food Network.
- Ron Popeil: Grew up in entrepreneurship, in his 30s showcased Veg-O-Matic, at 63 he had the showtime rotisserie
- Martha Stewart: A stockbroker at 26, at 36 began her catering business, 41 her first book, 56 when she started Martha Stewart Omnimedia

19

3 ways artificial intelligence can increase your revenue in 2025

ASRS Business of Retina Meeting 2025

T. Y. Alvin Liu, M.D.

James P. Gills Jr M.D. and Heather Gills Rising Professor of Artificial Intelligence in Ophthalmology

AI Operations Team and Co-chair (Imaging) of the Artificial Intelligence and Data Trust Council, Johns Hopkins Medicine

AAO AI Committee

1

Financial Disclosures

Optain Health
AKASA
FerRx Bio
OMNY Health
Amaros AI

2

Objectives

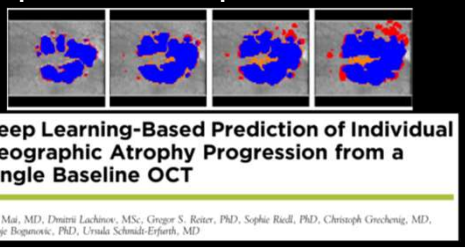
- How deep-learning-based segmentation of OCT images can unlock commercial value of your datasets
- How AI can accelerate your clinical trial recruitment
- LLM for prior authorization

3

#1 Segmentation/quantification

Input: image

Output: quantification of specific biomarkers



Deep Learning-Based Prediction of Individual Geographic Atrophy Progression from a Single Baseline OCT

Julia Mai, MD, Dmitrii Lachinov, MSc, Gregor S. Reiter, PhD, Sophie Riedl, PhD, Christoph Grechenig, MD, Hrvoje Bogunovic, PhD, Ursula Schmidt-Erfurth, MD

4

Current limitations in ophthalmology big data

- Management and prognostication of retinal vascular diseases is heavily reliant on OCT images and associated biomarkers.
- EHR: demographics, VA, treatment regimen, ?CST
- CST only has moderate correlation with VA

5

OCT biomarkers

- Type of fluid, amount of fluid, fluctuation of fluid
- How turbid/ hyper-reflective is the fluid
- Intraretinal hyperreflective foci
- Outer retinal tubulation
- Pigment epithelial detachment morphology, e.g. shape, height, volume
- EZ
- SRHM

6

Why would pharma care/pay?

- Need more fine-grained data, beyond VA, to differentiate themselves from competitors and convince payors to skip step therapy
- Real world data: natural prevalence and progression of biomarkers, change in biomarkers in response to therapies
- Explore novel structural endpoints for therapies for earlier diseases

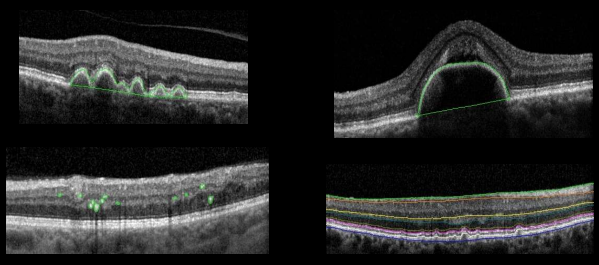
7

Why would pharma care/pay?

- Built in segmentation algorithms are rudimentary and very limited
- Manual segmentation is labor intensive and only feasible in a clinical trial/reading center setting, not for large-scale commercialization of imaging data

8

Why would pharma care/pay?



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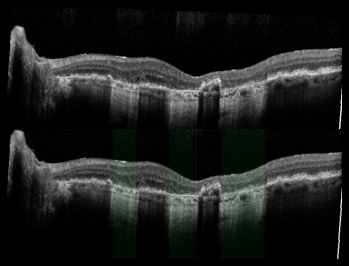
Why would pharma care/pay?



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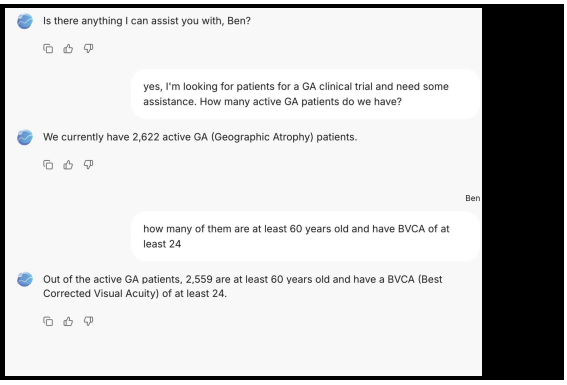
#2 Clinical trial recruitment

- Current limitations: time consuming, labor intensive, not comprehensive; requires manual identification of patients and then additional verification of images
- Needs integration of the EHR and imaging databases (IT infrastructure), automatic AI analysis of the images (real time or *a priori*) and an intuitive user interface (LLM)

11



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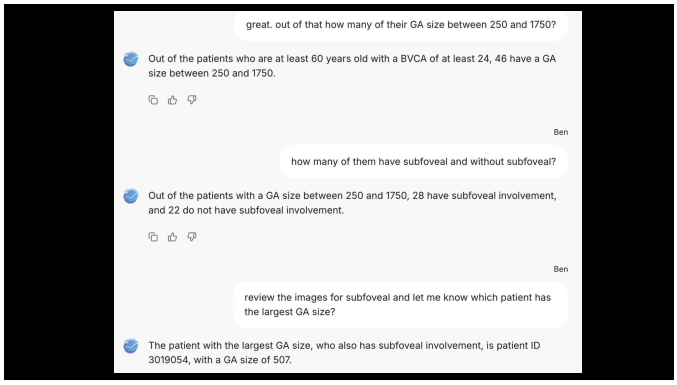

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#3 revenue cycle management (RCM)

- **How providers bill for service and get paid by insurance payers? ~ 92% patients have insurance coverage**
- **RCM = $156 billion market per year**
- **12% claims denied; 65% of denied claims were never resubmitted**
- **Health systems are losing between to 1 to 5% of net revenue due to denied claims; average margin 4% in 2024 Q1**

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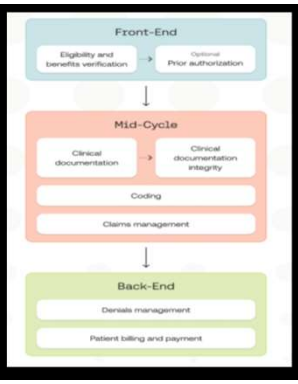

Courtesy of Elion

15

Why does front end of RCM matter?

- Eligibility and prior authorization (PA) issues are top denial reasons.
- PAs are complex, time-consuming, tedious and costly.
- PAs are often required in retina, e.g. intravitreal injections.
- Submission of PAs often require going through a payer portal online (50 to 60%), but each payer portal typically has its own interface and navigation.

16

RPA vs. LLM

About 50% of health systems have adopted some form of automation, mostly via robotic process automation (RPA).

RPA (legacy solution):

- explicit rules/instructions that have to be programmed ahead of time, e.g. a complex decision tree; cannot handle edge cases
- Brittle to payer portal interface change
- Not proficient with unstructured data, e.g. free clinical text

LLM (cutting edge solution):

- Proficient with unstructured data
- Adaptive; can be finetuned with reinforcement learning
- Great in understanding complex set of payer requirements and searching through lots of health records to find the right documents for PA

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Case study:

Pilot implementation of LLM-based process for prior authorizations at Johns Hopkins Medicine

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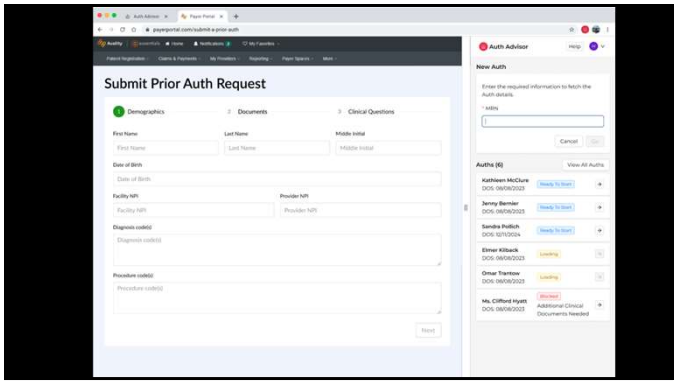
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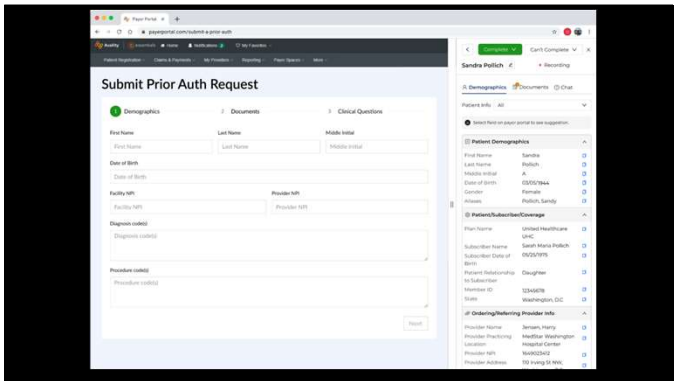
Demographics
Documents
Clinical Questions
Auth Advisor
New Auth

19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Demographics
Documents
Clinical Questions
Sandra Pollich

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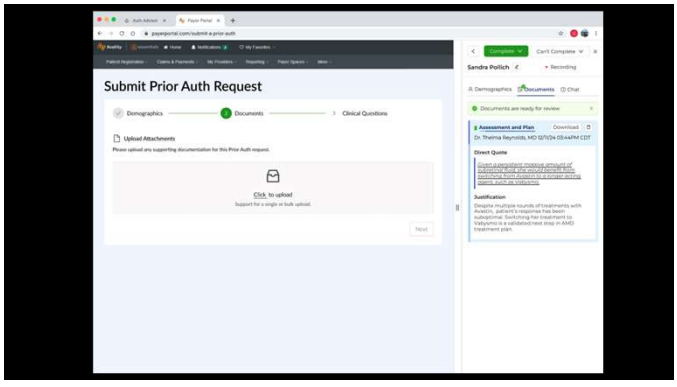
Submit Prior Auth Request
Demographics
Documents
Clinical Questions
Upload Attachments
Click to upload
Sandra Pollich

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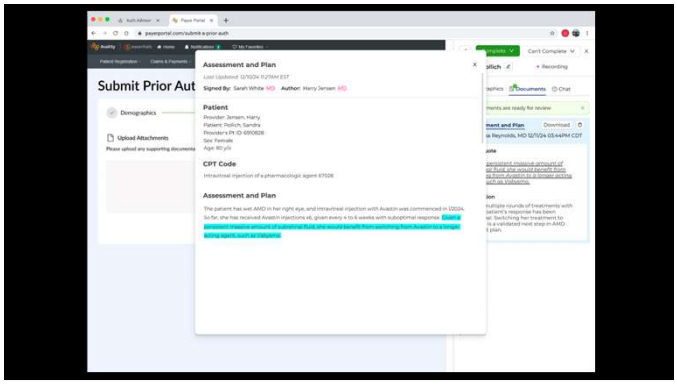

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LLM for prior authorization: lessons learned

Hopkins metrics during pilot:

Improved productivity by 25%

PA with all uploaded documents suggested by LLM: 71%

23

Thank you!

Contact:
tliu25@jhmi.edu
607-280-4609

24

Using AI This Monday

NATHAN RUDOMETKIN MD
LAGUNA RETINA
PACIFIC EYE INSTITUTE
APRIL 29, 2025

1

Transformer Architecture

"Attention is All You Need" by Vaswani et al., in *2017*.

Used in Training and Inference mode (asking a question)

2

3

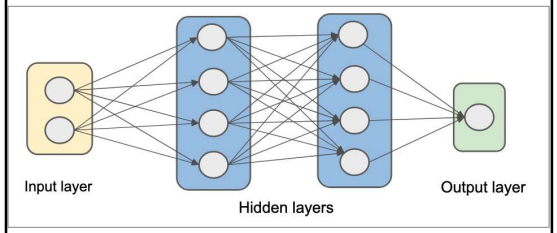
What is AI?

4

…It's just Mathematical Functions

$$y = f(x)$$

5



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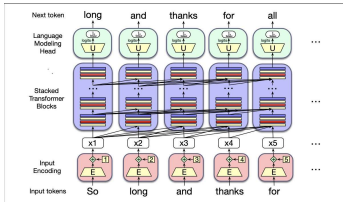

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Blah, Blah, Blah, Blah, Blah

8

How can I use this on Monday?

9

1. Patient Education

2. Clinical Decision Support

10

#1 Use is Patient Education

11

Doximity GPT for Patient Education

Overview of Doximity GPT:

- Personalized patient education materials
- High engagement with text messages
- Efficiency in addressing patient-specific questions
- >90% Response/Engagement with Text Messaging1,2

1. Shimoni, N., Nippita, S. & Castaño, P.M. Best practices for collecting repeated measures data using text messages. *BMC Med Res Methodol* **20**, 2 (2020). https://doi.org/10.1186/s12874-019-0882-6

2. Nelson LA, Spieker A, Greevy RJr,Stourgeon LM, WallstonKA, Mayberry LS User Engagement Among Diverse Adults in a 12-Month Text Message–Delivered Diabetes Support Intervention: Results from a Randomized Controlled Trial JMIR Mhealth Uhealth 2020;8(7):e17534

12

My Numbers over last 12 months:

For the last 12 months we estimate:

625 Sent
459 Opened

73% open rate

Let us know if you have any other questions.
Thank you.

Brian Leslie

Support Specialist
Doximity Technical Support

13

Patient Education

- New GPT
- HIPPA Compliant
- Patient Education
- Patient Instructions

doximity

https://www.doximity.com/

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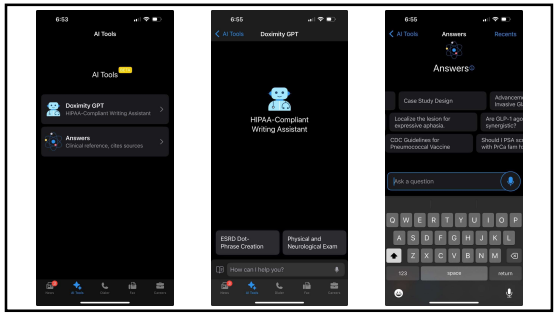

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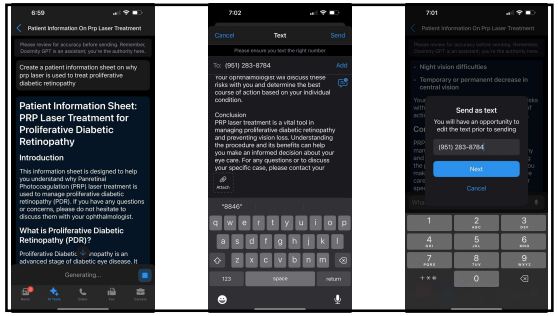

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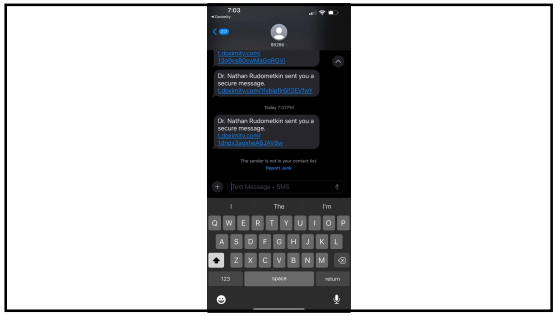

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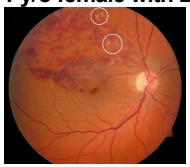
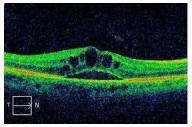
71 y/o female with BRVO





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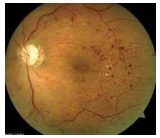
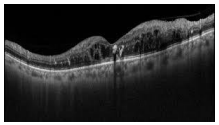
19

65 y/o Male with Diabetic Macular Edema





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21

Creating Differential Diagnosis with ChatGPT

- https://chat.openai.com/?model=gpt-4

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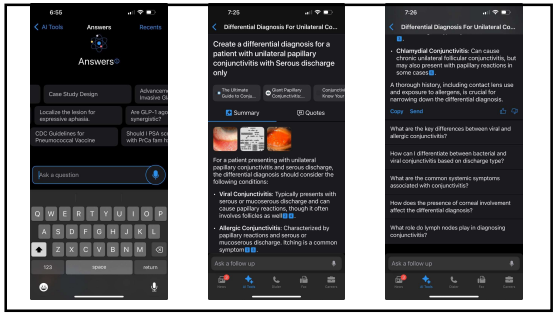

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56 y/o old male with 6 months decreased vision at night. PMH: Cancer MEDS: Xelado, Folfox Cocktail (fluorouracil, leucovorin, and oxaliplatin).

24

Exam:

VA 20/20 OU
Pupils Normal
SLE: wnl
DFE:
- ONH-nl no pallor
- Mac- wnl
- Periphery-no pigment

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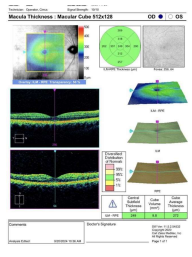
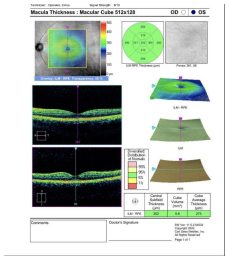

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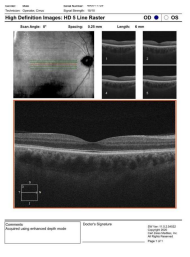
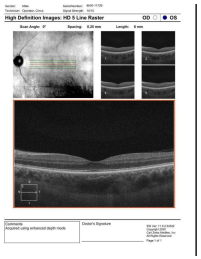

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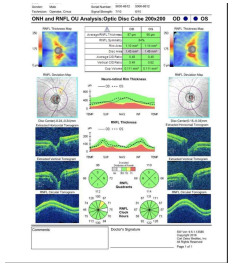

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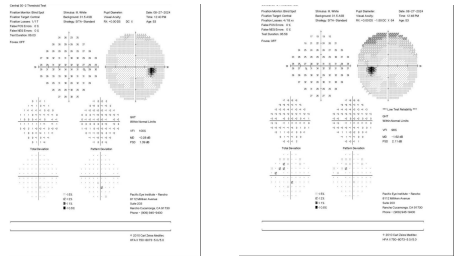

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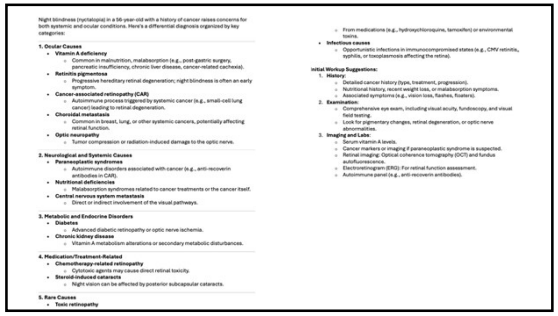
What Else can I do?

Send it to the University's Inherited Disease?

Ask ChatGPT?

30



Night blindness (nyctalopia) in a 56-year-old with a history of cancer raises concerns for both systemic and ocular conditions. Here's a differential diagnosis organized by key categories:

1. Ocular Causes

- **Vitamin A deficiency**
  - Common in malnutrition, malabsorption (e.g., post-gastric surgery, pancreatic insufficiency, chronic liver disease, cancer-related cachexia).
- **Retinitis pigmentosa**
  - Progressive hereditary retinal degeneration; night blindness is often an early symptom.
- **Cancer-associated retinopathy (CAR)**
  - Autoimmune process triggered by systemic cancer (e.g., small-cell lung cancer) leading to retinal degeneration.
- **Choroidal metastasis**
  - Common in breast, lung, or other systemic cancers, potentially affecting retinal function.
- **Optic neuropathy**
  - Tumor compression or radiation-induced damage to the optic nerve.

2. Neurological and Systemic Causes

- **Paraneoplastic syndromes**
  - Autoimmune disorders associated with cancer (e.g., anti-recoverin antibodies in CAR).
- **Nutritional deficiencies**
  - Malabsorption syndromes related to cancer treatments or the cancer itself.
- **Central nervous system metastasis**
  - Direct or indirect involvement of the visual pathways.

3. Metabolic and Endocrine Disorders

- **Diabetes**
  - Advanced diabetic retinopathy or optic nerve ischemia.
- **Chronic kidney disease**
  - Vitamin A metabolism alterations or secondary metabolic disturbances.

4. Medication/Treatment-Related

- **Chemotherapy-related retinopathy**
  - Cytotoxic agents may cause direct retinal toxicity.
- **Steroid-induced cataracts**
  - Night vision can be affected by posterior subcapsular cataracts.

5. Rare Causes

- **Toxic retinopathy**
  - From medications (e.g., hydroxychloroquine, tamoxifen) or environmental toxins.
- **Infectious causes**
  - Opportunistic infections in immunocompromised states (e.g., CMV retinitis, syphilis, or toxoplasmosis affecting the retina).

Initial Workup Suggestions:

1. **History:**
   - Detailed cancer history (type, treatment, progression).
   - Nutritional history, recent weight loss, or malabsorption symptoms.
   - Associated symptoms (e.g., vision loss, flashes, floaters).
2. **Examination:**
   - Comprehensive eye exam, including visual acuity, fundoscopy, and visual field testing.
   - Look for pigmentary changes, retinal degeneration, or optic nerve abnormalities.
3. **Imaging and Labs:**
   - Serum vitamin A levels.
   - Cancer markers or imaging if paraneoplastic syndrome is suspected.
   - Retinal imaging: Optical coherence tomography (OCT) and fundus autofluorescence.
   - Electroretinogram (ERG): For retinal function assessment.
   - Autoimmune panel (e.g., anti-recoverin antibodies).

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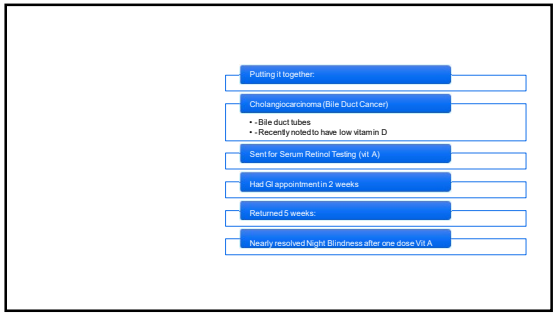

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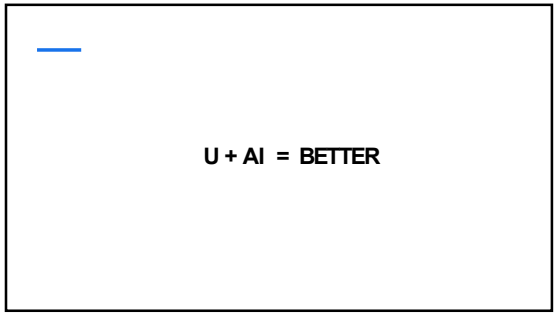

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YOU + AI = BETTER

34

Contact Info:

- Nathan Rudometkin
- nathan@lagunaretina.com
- 951-283-8784

LinkedIn QR

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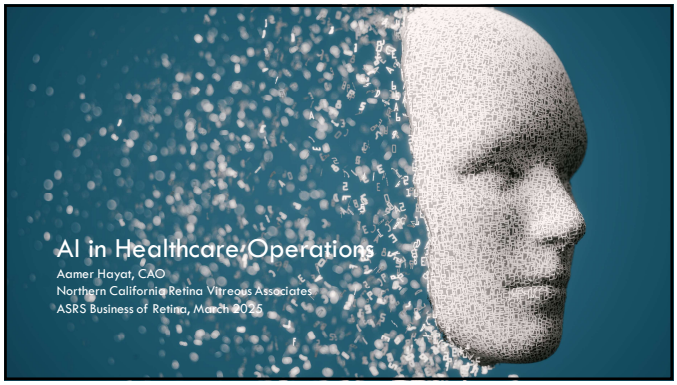


1

DISCLOSURES

I, Aamer Hayat, serve on the Advisory Board for Outlook Therapeutics, Eyepoint, Podis Inventory Management, and Athenahealth RCM.

2

AI in Healthcare Operations

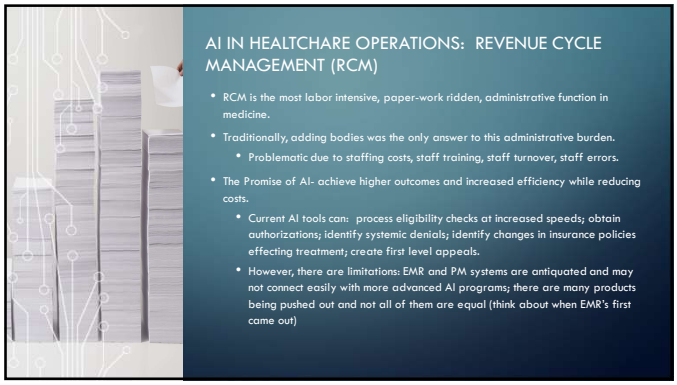
In a 2025 MGMA study, 92% of medical practices saw an increase in operating expenses in 2024 and this trend is expected to continue.

The average medical practice operating expense ratio is between 60-70% (in the early 2000's, it was about 50-55%).

Practices spend on average 34% of their budgets on managing paperwork, phone calls, and outdated systems. Staff often struggle with volume of phone calls, processing referrals, managing documents and handling patient communication.

Recent surveys indicate health care executives are bullish (85%) on AI's abilities to improve efficiencies in RCM over the next five years. That means there will be a lot of options, some good ones, and many not so good ones.

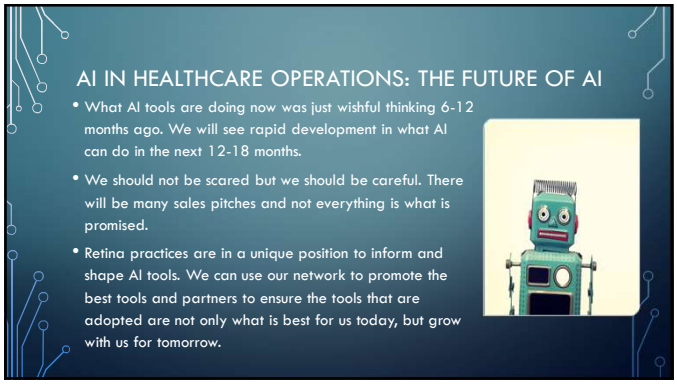
3


AI IN HEALTCHARE OPERATIONS: REVENUE CYCLE MANAGEMENT (RCM)
• RCM is the most labor intensive, paper-work ridden, administrative function in medicine.
• Traditionally, adding bodies was the only answer to this administrative burden.
• Problematic due to staffing costs, staff training, staff turnover, staff errors.
• The Promise of AI- achieve higher outcomes and increased efficiency while reducing costs.
• Current AI tools can: process eligibility checks at increased speeds; obtain authorizations; identify systemic denials; identify changes in insurance policies effecting treatment; create first level appeals.
• However, there are limitations: EMR and PM systems are antiquated and may not connect easily with more advanced AI programs; there are many products being pushed out and not all of them are equal (think about when EMR's first came out)

4


AI IN HEALTHCARE: FRONT DESK/CALL CENTER OPERATIONS
A PATIENT'S OR REFERRING OFFICE'S FIRST IMPRESSION OF YOUR OFFICE IS INCREASINGLY IMPORTANT. BOTH HAVE CHOICE AND IF THEY CAN'T REACH YOU, THEY WILL GO TO THE RETINA SPECIALIST THEY CAN REACH.
HOWEVER, OVERWORKED, UNDERTRAINED, OR JUST NOT HAVING ENOUGH STAFF TO HANDLE THE VOLUME OF INBOUND CALLS, FAXES, AND WEB REFERRALS SENDS THOSE PATIENTS ELSEWHERE.
AI SOLUTIONS FOR VOICE AGENTS (CALL CENTER OPERATORS), EFAX "TRIAGE", AND REFERRAL MANAGEMENT ARE ALREADY SHOWING SIGNIFICANT IMPROVEMENTS IN EFFICACY AND EFFICIENCY. VOICE AGENTS CAN DO SCHEDULE MANAGEMENT AND THUS ADDRESS 50% OR MORE OF YOUR CALLS. EFAX SOLUTIONS CAN "READ" INCOMING FAXES, SORT, ADDRESS/ASSIGN FAXES QUICKER THAN STAFF.

5


AI IN HEALTHCARE OPERATIONS: THE FUTURE OF AI
• What AI tools are doing now was just wishful thinking 6-12 months ago. We will see rapid development in what AI can do in the next 12-18 months.
• We should not be scared but we should be careful. There will be many sales pitches and not everything is what is promised.
• Retina practices are in a unique position to inform and shape AI tools. We can use our network to promote the best tools and partners to ensure the tools that are adopted are not only what is best for us today, but grow with us for tomorrow.

6

Business Considerations for Emerging Treatments

Retina Consultants of Texas

RETINA CONSULTANTS OF AMERICA

Ankoor R. Shah, MD, FASRS

ASRS Business of Retina

March 29, 2025

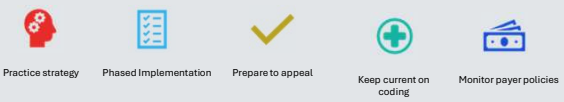
1

Financial Disclosures

- RegenexBio: Consultant/Advisor
- **Notal Vision: Consultant/Advisor**
- Regeneron: Consultant/Advisor
- Ocular Therapeutix: Consultant/Advisor

2

Implementation Strategies



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Outline – Emerging and Evolving Tech

1. PDT Laser
2. Home OCT
3. Photobiomodulation (PBM)

4

Photodynamic Therapy

- Previously Practices Purchased the Equipment
- Newer Lasers Offer Click Fee per use
- Challenges:
  - $854 Click Fee Per Treatment
  - $276 Novitas Reimbursement
- Solution:
  - ~~Charge Patients Click Fee~~

5

Photodynamic Therapy

Business Challenges:

- Awareness of when Advanced Beneficiary Notices (ABN) should be used
- Educate the companies on billing limitations
- Advocacy to reimbursement increases where appropriate

6

Home OCT

- Dosing Regimen: PRN, Fixed, Treat & Extend/Maintain
- Newer Regimen: Treat with Home Monitoring?
- Reimbursement (Category 3):
  - Carrier Priced
  - 0604T – initial device set-up (labor)
  - 0605T – remote surveillance with support (equip)
  - 0606T – professional component for interpretation

7

Home OCT

Implications
- Potentially reduce visits for patients
- Help with any real/perceived retina specialist shortages

Challenges
- As category 3 code – carrier priced (or not covered depending on the carrier)
- With continued use – likely to progress to a category 1 code – increased easy of use

8

Photobiomodulation

- LumiThera – Lightsite IIII Completed
- Other products: Diopsys ERG, Dark adaptation
- FDA – authorization granted November 4, 2024
- Treatment for Dry AMD
- Regimen: 9 treatments repeated every 4 months
- Mean gain of 5.4 letters Treat vs 3.0 letters Untreated
- Vas Sadda Article in JAMA:
  - Differences in Age of Groups, Placebo Effect, Reversion to Mean, Trial Size, Drop Out Rates, etc

9

Photobiomodulation

Reimbursement Issues

- Category 3 Code (0936T)
- Cost of Laser vs Click fee approach
- Inability to use ABN once this is a covered diagnosis

10

Designing Physician Compensation Plans

2025 Business of Retina Meeting

Presented by: Caroline Patterson, Esq.

1

Caroline Patterson, Esq.

Parnter | Healthcare Group

Chesterbrook, PA and
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Overview

- Representspractices and professionals in the health care industry in a variety of transactional, corporate, and regulatory matters.
- Experience ranges from providing counsel in mergers, acquisitions, sales and private equity investments to helping establish strategic partnerships and joint ventures among organizations.
- Provides advice to health care organizations on compliance with the Health Insurance Portability and Accountability Act (HIPAA) and federal and state fraud and abuse laws, as well as drafts and advises on ownership and compensation arrangements and assists with employment negotiations.
- **Degrees**
  - J.D., cum laude, Villanova University School of Law, 1998
  - B.A., magna cum laude, Cabrini University, 1995
- **Honors & Awards**
  - Named to The Best Lawyers in America list, Health Care Law, 2023 to present
- **Professional Involvement**
  - American Academy of Ophthalmology, 2013 to present
  - Member, Healthcare Businesswomen's Association, 2019-2021
  - American Health Lawyers Association, 2021 to present
  - Member, Pennsylvania Bar Association
  - Member, New Jersey Bar Association
  - Member, Montgomery County Bar Associatio

2

Define the Factors That Lead to Success

- Productivity
- Executive Efforts
- Clinical Quality
- Call
- Ownership Timing
- Succession Planning
- Other

3

Owner Compensation - Key Factors

- Careful Definition of Key Concepts
- Modeling Systems
- Reconcile Group and Individual Goals
- Refinement and Selection of Models
- Keep it Simple
- Reduce to Writing
- Legal Compliance

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Different Models

- 100% Equal
- 100% Production
- Equal/Production Combination (2 tiered)
- Cost Accounting
- Mega Groups

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Equal

- Requires Relatively Equal Contributions by Physicians
  - Production
  - Management/Administration
  - Generation
  - Other
- Advantages/Disadvantages
- Issues
  - Unequal Contribution
  - Disproportionate Vacation/Schedules
  - Specialist

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Production

- Advantages/Disadvantages
- Issues
  - Recognizing Non-Revenue Producing Activities
  - Competition Within
  - Allocation of Expenses
  - Specialist

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Cost Accounting

- Separate Allocation of Income
  - Production
  - Equal
  - Other
- Separate Allocation of Expenses
  - Equal
  - Production
  - Personal
- Variations on "Cost Accounting"
- Layered over "Site-Based" , "Pod", "Division" or "Care Center" Plans

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Mechanics

- Base Draws
- Bonuses/Semi-Personal Payments
- Periodic Reconciliations
- Addressing Overpayments

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Associate Compensation

Key Factors

- Aligning with Owner Compensation
  - Philosophy
  - Expectations
- Timing to Partnership
- Ensure Legal Compliance

Options

- Base Salary
- Bonus Options
- Call
- Net Colletions
- Retina Drugs

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Legal Compliance

- Anti-kickback Statute - punishes payments for referrals and is intent based
- Stark - prohibits referrals of particular kinds of services and billing for them when the referrer has a financial interest arising out of the referral. Intent is unimportant.
- Measuring and Paying for Personal Production
  - No Direct Linkage to Referrals of Any Kind
  - No Formulas Linked to the Value or Volume of Referrals
- Areas of Concern—ASC "production" and DHS

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Questions?

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12

Growth in the Retina Practice: Adding a new doc, new office or expanding office

David Chin Yee
ASRS Business of Retina 2025
Atlanta, GA
GEORGIA RETINA

1

Financial Disclosures

Regeneron
Speaker and consultant

Genentech
Speaker and consultant

Apellis
Speaker and consultant

Astellas
Speaker and consultant

Alcon
Consultant

Eyepoint Pharmaceuticals
Consultant

2

Agenda

- Introduction
- Why growth or expansion
- Adding a Doctor
- Adding or expanding an Office
- How to expand – Practice Resources
- Final tips & takeaways

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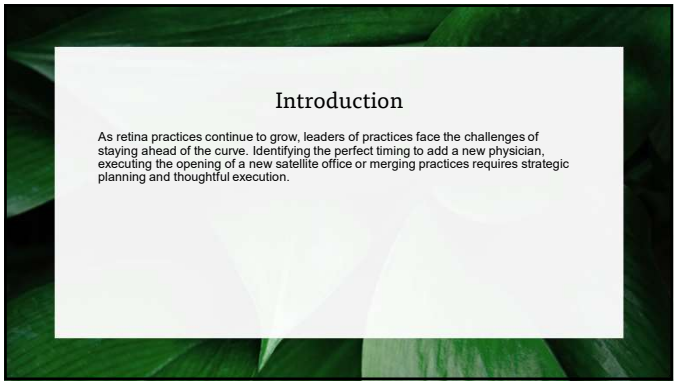
Introduction
As retina practices continue to grow, leaders of practices face the challenges of staying ahead of the curve. Identifying the perfect timing to add a new physician, executing the opening of a new satellite office or merging practices requires strategic planning and thoughtful execution.

4


Why growth or Expansion
In the Weeds in clinic, it can be hard to identify when growth might be needed.
If noticing on a day to day you are experiencing added stress and burden with rapid growth and facing limitations in scheduling for patients or talking with referring doctors or overwhelmed with complex or emergent patients. These could be factors to indicate growth or expansion is needed. But we need metrics to verify if it's the right timing.
Objective might be to make referring docs happy, but ultimately can you maintain quality of care and meet patient needs!

5


Some Key Factors to Consider
•Patient load:
• If the practice is consistently booked solid with long wait times for appointments, it may be time to add another doctor to manage the volume.
•New treatment options:
• If the practice is adding new, complex treatments that require additional physician expertise, hiring a new doctor can be beneficial.
•Geographic expansion:
• When looking to expand services to a new location or community, adding a doctor can facilitate growth.
•Succession planning:
• If a senior doctor is nearing retirement, adding a new physician can ensure a smooth transition and continuity of care.
•Practice efficiency:
• If current doctors are overworked and experiencing burnout due to high patient volume, adding another physician can alleviate stress and improve overall practice efficiency.

6

Important Considerations Before Adding a Doctor

- **Financial analysis:**
- Evaluate the potential costs associated with adding a new doctor, including salary, benefits, and practice infrastructure adjustments. (including malpractice ins/tail coverage)
- **Market research:**
- Assess the local patient demand for retina services to ensure there is sufficient patient volume to support a new doctor.
- **Recruitment strategy:**
- Develop a plan to attract qualified retina specialists with the necessary expertise and experience.

7

Financial Analysis

Pro Forma: A financial statement that outlines projected or forecasted income, expenses, and profitability for the practice over a certain period of time (usually a year).

It is used to assess the potential financial performance and viability of the business. Important to be able to assess if feasible to add a new doctor

8

Financial Analysis

Revenue Forecast

- **Patient Visits**: Estimate the number of patients expected to visit based on historical data or market research.
- **Billing Codes**: For retina services, include the specific procedure codes (ICD, CPT) relevant to retina care (e.g., retinal exams, intravitreal injections, laser treatments).
- **Insurance Payments**: Account for reimbursements from various insurance providers (private, Medicaid, Medicare), including any changes in reimbursement rates.
- **Out-of-pocket Payments**: Estimate the portion patients will pay out of pocket (copays, deductibles).
- **Ancillary Services**: If the practice provides services like OCT scans, fluorescein angiography, or laser treatments, include the revenue from these procedures.

Expense Forecast

- **Staffing Costs**: Salaries and benefits for doctors (retina specialists), technicians, office staff, nurses, and administrative personnel.
- **Medical Equipment & Supplies**: The cost of specialized retina equipment (e.g., OCT machines, laser equipment, injectables for retinal diseases).
- **Facility Expenses**: Rent or mortgage, utilities, and maintenance.
- **Insurance**: Malpractice insurance for the practice and employees.
- **Marketing & Advertising**: Costs for promoting the practice through various channels.
- **Administrative & Miscellaneous**: Software for electronic health records (EHR), office supplies, continuing education, etc.

9

Pro Forma

Balance Sheet

•Includes assets, liabilities, and equity to show the financial position of the practice at a given point in time.

Key Performance Indicators (KPIs)

•**Patient Volume Growth**: Projected increase or decrease in the number of patients treated.

•**Revenue per Visit**: Average revenue generated per patient visit or procedure.

•**Expense per Visit**: Average expenses incurred per patient visit.

•**Gross Margin**: The difference between revenue and the cost of goods/services provided.

•**Operating Margin**: Earnings before interest and taxes (EBIT), showing the practice's operational efficiency.

Components Specific to Retina Practice:

•**Intravitreal Injections**: Revenue per injection, cost of medication (e.g., Lucentis, Eylea, Avastin).

•**Surgical Procedures**: Costs and reimbursement for retinal surgeries like vitrectomy.

•**Retinal Imaging**: Potential revenue from advanced imaging services such as OCT (Optical Coherence Tomography) and angiography.

This pro forma would be used to plan for the financial future of the retina practice, secure funding, or help with internal decision-making.

10

Adding a Doctor

After assessing metrics from doing financial and market research

# of pts physician seeing – capacity of doctor (saturation rate)

Vary significantly based on geographic location, demand for services, and the overall healthcare market.

What is your ideal Clinic workflow and does it align with your personal and professional goals. Consider 10 per half day when making analysis.

Remember lag of 60-90 days for new physician billing and collections – practice will have to carry those expenses

11

Discussion Highlights when adding a Doctor

Compensation and how and when salary is paid

Benefits

Hours and days of the week

Surgery or procedure times

Work location

Their ability to dictate schedules, exam room space, physician office space

Membership coverage for national, state, local organizations

Cellphone plans

Transportation

Entertainment perks

Marketing requirements

12


How to add Partner/Friend– Recruitment strategy (Tips)
Important to self evaluate and know your culture to express for interviews
Have candidates meet with all doctors or provide opportunity to interact with all doctors. Introduce or have candidate interact with staff/administrator.
Keep in mind adding doc also means adding staff. Techs (8-10 weeks before doc starts), RCM, and marketing to help growth
Important to draft a partnership agreement outlining the terms, including profit-sharing, decision-making processes, and exit strategies – Biggest mistake to avoid
Consulting with a legal advisor to navigate the regulations and ensure compliance with healthcare laws is also advisable.
Credentialing - https://www.aao.org/practice-management/practice-forms-library/business-operations

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Expanding Practice resources
Not only Adding a Physician
– Facilities – Office Space
– Staff – Clinical and marketing
– Equipment – advance diagnostic and treatment technologies
- Think outside the box - Collaborating with other healthcare providers or specialists can also help broaden service offerings and referral networks
Forward thinking - Invest ahead when the opportunity comes
Physicians are used to delayed gratification – re-invest in growth
Remember practice growth not linear

14


When to Add an Office or Expansion
Rely back on your data Analytics – health market research to determine if there is a need.
Are you at capacity at location or per doctor – Patient satisfaction score can be an indicator
Guide from who your referring doctors are:
- Are they expanding into a new area
- Who they are currently referring to/areas of improvement/assess needs (Competition)
- Where do current patients live or coming from

15

Suggestions/Thoughts to consider on how to expand

Where to setup new office or expand

- partnering with medical real estate specialists
- Lease or buy

Think of expansion capacity

Ease of Access

Location within building

Parking

Equipment and staff acquisition – group buy, staff multi-task versus focus role

Which doctors go to expansion or new office – More seasoned doc or new doc

Marketing – generating new patient volume and improving relationship with referral doctors

16

How to keep ahead and improve

Regularly assessing operational efficiency can identify areas for improvement and resource optimization. Rely and update your pro forma and check in on referring doctors.

17

Final tips & takeaways

Look at your why or Metrics	Market Research for your area
Consider your ideal work flow	Align with personal and professional goals
Plan ahead – limit short sighted views	Upgrade practice resources
Assess operational efficiency	Key performance indicators

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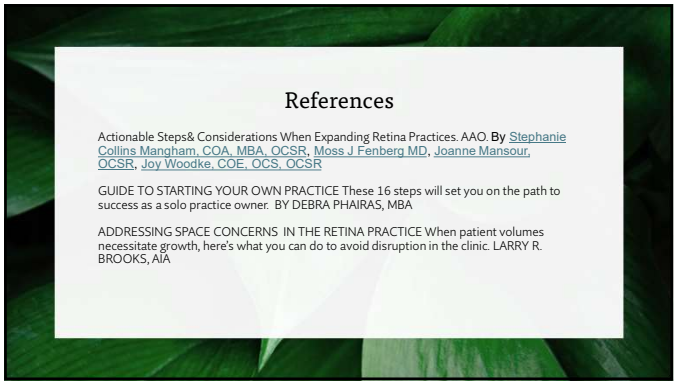
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GUIDE TO STARTING YOUR OWN PRACTICE These 16 steps will set you on the path to success as a solo practice owner. BY DEBRA PHAIRAS, MBA
ADDRESSING SPACE CONCERNS IN THE RETINA PRACTICE When patient volumes necessitate growth, here's what you can do to avoid disruption in the clinic. LARRY R. BROOKS, AIA

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Thank you
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20

Retinal Coding Essentials

Ankoor R. Shah, MD, FASRS
Retina Consultants of Texas
3/29/2025

RETINA CONSULTANTS OF AMERICA

Retina Consultants of Texas

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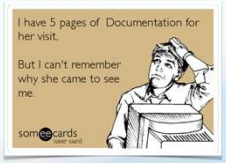
Outline

Retinal Coding Essentials

- Coding Goals
- Modifiers
  - Exam
  - Surgical
  - -25
- Diagnostics
- Eye vs E/M



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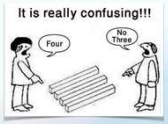
Coding Goals

- Convert the physical work the physician has done into codes reflecting the services provided
- Avoid - Undercoding for services actually provided
- Avoid - Inaccurate Coding
- Getting paid for the work you've done - no more, no less

3

Coding Modifiers

- Why do we need them?
  - When appropriate allow for modification of reimbursement
- Types:
  - Level 1 - AMA (ie -25)
  - Level 2 - CMS (ie -TC)



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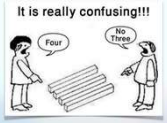
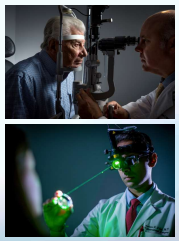
Coding Modifiers

- Common Level 1 Clinic Modifiers
  - -24 (Exam)
  - -25 (Exam)
  - -57 (Exam)
  - -58 (Procedure)
  - -78 (Procedure)
  - -79 (Procedure)





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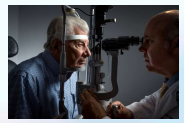
Coding Modifiers



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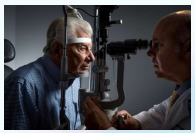
Coding Modifiers

- **Starting** a Global Period (**Exam** on same day or day before procedure)
  - -25 for minor procedure (injections, *laser/cryo for RD/tear*)
  - -57 for major procedure (OR surgery, focal laser, pneumatic retinopexy)



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Coding Modifiers

- **Within** a Global Period (**Exam** during a global period)
  - -24 exam for unrelated procedure during global
  - Examples:
    - PDR treated OD with PRP, Pt has new floaters OS and found to have PVD
    - S/p PPV for RRD OD, develops floaters OS which on exam shows retinal tear

8

Coding Modifiers

9

Coding Modifiers

- **Related Procedure Modifiers**
- -58 **Planned**/Staged or Related Procedure During the Postoperative Period
  - Lesser to Greater
  - Pre-planned or staged
  - Treatment post diagnostic procedure
- -78 **Unplanned** return to the OR/procedure for a Related Procedure during Postoperative Period

10

Coding Modifiers

- -79 Return to the OR/Procedure for an **Unrelated** Procedure during Postoperative Period

- S/p PPV for RRD OD, develops floaters OS which on exam shows retinal tear

11

Coding Modifiers

- S/p PPV for RRD OD, develops floaters OS which on exam shows retinal tear
- -24 Modifier for the exam
- -79 Modifier for the procedure

12

Modifier Codes

- -25 Significant, Separate Identifiable Evaluation and Management Service by same physician on the same day of the procedure/service
  - Applies to minor procedures same day as exam
  - Minor Procedure defined - procedures with 0-10 day global

13

Modifier Codes

- How frequently can you use?
  - No perfect answer - as these are frequent targets of audits
  - The key is documentation to delineate the reason for the exam as separate and identifiable from the procedure.

14

Modifier Codes

- Case 1
  - Pt with h/o AMD returns for injection in the right eye and assessment of new floaters in the left eye
  - -25 modifier applies
  - Link injection to wet AMD, and -25 modifier to the exam should be linked to the diagnosis for PVD

15

Modifier Codes

- Case 2
  - Pt with h/o AMD s/p injection 1 week ago OD, now with blurry VA OS. Exam finds Wet AMD OS and is treated
  - -25 modifier applies
  - Link injection to wet AMD OS, and -25 modifier for the same diagnosis

16

Modifier Codes

- Case 3
  - 32 yo Pt c/o curtain in their vision. Diagnosed with RD and treated with laser
  - Would use -25 modifier because it is a minor procedure

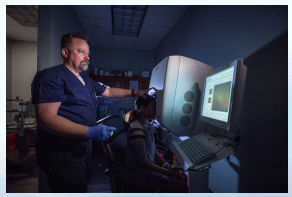
17

Diagnostics

18

Diagnostics

- Common Imaging Types:
- OCT/OCTA (92133/4/7)
- Fundus Photos (92250)
- FA (92235)
- ICG (92240)
- FA/ICG (92242)
- B-scan (76512)



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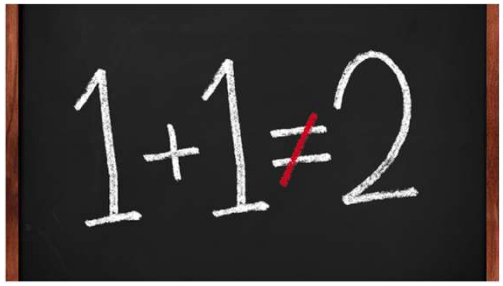

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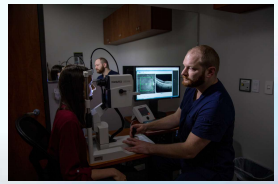
OCT/OCTA

- 92137 (OCTA w/Retina OCT)
  - Newly introduced 1/1/2025
- 92134 (Retinal)
  - Reduced Reimbursement 1/1/2025
- 92133 (Optic Nerve)

- Mutually exclusive - if multiple are done ONLY bill one



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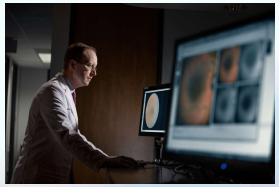
Fundus Photography

- 92250
- Bilateral code
- Includes Autofluorescence photos

22

IVFA

- 92235 or 92242 (if done with ICG)
- Unilateral or bilateral



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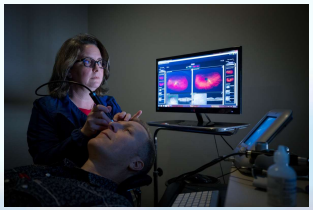
ICG

- 92240 or 92242 (if done with FA)
- Unilateral or bilateral

24

B-scan

- 76512
- UNILATERAL



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Imaging/Injections

- Current CCI Edits for Imaging:
- 92134/7 OCT and 92250 Photos are mutually exclusive
- 92240 ICG and 92250 Photos are mutually exclusive
- 92242 ICG/FA is mutually exclusive with 92235, 92240 & 92250 but NOT 92134
- 92235 FA and 92250 Photos are NOT mutually exclusive

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What to Do?

- If 92137 OCTA and 92134 OCT Retina, bill 92137
- If 92250 Photos and 92134 OCT, bill most relevant to diagnosis
- If 92235 FA with everything, co-list 92250 Photos
- If 92240 ICG with everything (except IVFA), co-list 92134 OCT
- If 92242 ICG/FA with everything, co-list 92134 OCT

27

What Would You Do?

- 52 yo F suspected to have wAMD vs CSR and undergoes OCT, Fundus Photos, IVFA, and ICG - how would you code imaging
  - ICG/IVFA 92242
    - Mutually exclusive with 92235 (IVFA), 92240 (ICG) & 92250 (Fundus)
    - But can bill 92134 (OCT)
    - **Correct: 92242 and 92134**
    - Incorrect: 92242, 92250, 92134

28

Exams - Eye vs E/M

29

Coding Clinical Exams

Elements of Medical Decision Making (MDM)

Based on meeting 2 of 3 requirements:

1. The number and complexity of problems.
2. The amount and/or complexity of the external data review
3. The risks of complications / morbidity of the patient's condition

30

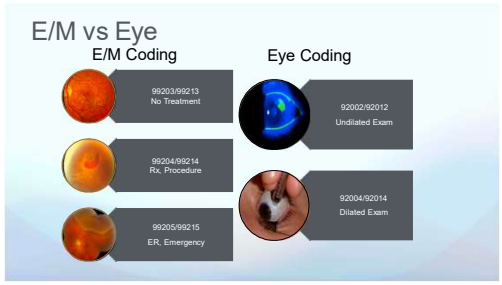
E/M Coding

Elements of Medical Decision Making (MDM)

E/M CPT Code: New PT / Est PT	Problems/Diagnoses	Morbidity / Risk of Complications from additional testing or treatment	Amount and/or Complexity of Data Reviewed & Analyzed (Testing & Interpretation)
99202/99212 (Mod)/(forward)	• 1 self limited or minor problem	• Minimal	• Minimal or None
99203/99213 (Low)	• 2 minor problems **or** • 1 stable, **chronic** illness **or** • 1 **acute**, uncomplicated illness/injury	• Low Risk	**Meet at least 1 category** Category 1 - Any combination of 2 from the following: • Review of prior external note(s) • review of the result(s) of each test • ordering of each unique test Category 2 - Assessment requiring an independent historian

31

E/M vs Eye



32

Short Cuts

- PVD, Dry AMD, othe
  no treatment – Level
- Wet AMD, RVO, DM
  with prescription dru
  need for surgery – L
- Some Oncology, an
  Endopthalmitis, Mac
  with referral to ER -

33

New Situations

For prescriptions drug management and changes. (ie K abrasion – and start erythromycin ointment = level 4 E/M f/u)

Uveitis with intensive medication management (labs to follow immunosuppressive meds)

If you pick up the phone and speak with a physician document it

If you have a patient with dementia, language barrier, etc and you speak with the daughter for history, document independent historian

34

Questions?

35

Washington Update

Odette M. Houghton, MD, FASRS
Chair
ASRS Federal Affairs Committee

1

Financial Disclosure

- EyePoint – public stock

2

ASRS Priority Issues

- Ensure adequate Medicare physician payment.
- Protect patient access to Part B drugs and preserving physician autonomy to provide appropriate treatment.
- Curb the use of prior authorization and step therapy.

3

What is ASRS's Message?

- Retina specialists have the most training expertise in treating potentially-blinding vitreoretinal disease and are the most appropriate practitioners to make clinical judgements and provide care for those conditions
- We can protect patient access to this highest quality care by:
  - Minimizing burdensome regulations
  - Adequately reimbursing physicians for their work and practice expense
- **When we meet these goals, retina specialists can focus on what's most important: patient care**

ASRS

4

What do we Want Policymakers to Do?

- Comprehensive Medicare physician payment reform
  - End year-to-year cuts by modifying budget neutrality
  - Update payments to reflect inflation
  - Increase post-operative visit values in global surgery codes
  - End or modify the MIPS Program

ASRS

5

What do we Want Policymakers to Do?

- Restrain insurers' ability to dictate care decisions and eliminate the burden associated with their demands
  - Ban step therapy
  - Improving Seniors Timely Access to Care act: guardrails on MA prior authorization
- Maintain access to retina specialist care
  - VA Supremacy – scope of practice

ASRS

6

How is our Agenda Faring?

7

Where We Were in December 2024

- Congress negotiated a bipartisan, bicameral deal to fund the government through the end of the 2025 fiscal year (9/30)
  - **Prevented the 2.8% cut to the Medicare physician fee schedule for calendar year 2025**
  - Comprehensive pharmacy benefit manager reform
  - Other popular healthcare provisions
  - *Likely to have been included through amendment:* Improving Seniors Timely Access to Care Act (prior auth reform)

8

Incoming Administration Opposition

- Trump, Musk issue opposition to the negotiated deal
- Want full GOP control to make funding decisions
- Congress passes a short-term funding extension that expired March 14, 2025

9

Managing Short Time Tables

- March 14 deadline pushed the spending fight to coincide with other Administration priorities
- Republican leaders are focused on FY 26 Budget/Reconciliation bill:
  - Border security
  - Tax cuts
- Republicans kept defections at bay to pass funding for the remainder of 2025 without any policy changes – **no relief for Medicare cuts**

ASRS

10

The Fight Continues

- H.R. 879 – stop the cuts and adjust for inflation – 120 bipartisan co-sponsors

- House GOP Leadership support for long-term reform in the reconciliation bill?

ASRS

11

Outlook on the Administration

HHS Secretary Robert F. Kennedy, Jr.

- Focused on chronic disease, nutrition, and healthy lifestyle
- Skeptical of the pharma industry

CMS Administrator-Designee Mehmet Oz, MD

- Physician experience with Medicare and other payers
- Advocated MA plan enrollment, but open to curbing insurer abuses
- Supports Medicare drug price negotiation, but open to reference pricing

ASRS

12

What about Changes to MIPS?

- No MIPS-related policy proposals from the administration yet
- **Key change for 2025: <u>Voluntary</u> Ophthalmology "MVP"**
  - MIPS Value Pathway
  - Aimed at reducing burden/improving clinical relevance
  - Main difference for retina: report 4 quality measures, rather than 6
  - Select measures during a registration period April to December
  - Visit asrs.org for full details

ASRS

13

How Can I Get Involved?

- Sign-up to be an ASRS Grassroots Contact
- **Respond to ASRS calls to action**
  - Instant, pre-written messages
- Represent ASRS at the annual Alliance of Specialty Medicine Advocacy Conference in Washington, D.C.
  - July 14-16, 2025

ASRS

14

THANK YOU!

ASRS

15

AMERICAN SOCIETY OF RETINA SPECIALISTS

Resources & Offerings
Presented by:
Claire M. Murphy

1

Financial Disclosures

Apellis – Speaker Bureau, Advisory Board
Cencora – Consultant
EyePoint – Advisory Board
Iveric – Consultant, Advisory Board
Opthea – Advisory Board
Outlook – Advisory Board
PX Technology – Advisory Panel
Regeneron – Speaker Bureau, Consultant

2

PATIENT RESOURCES

3

www.asrs.org

4

- Retina Specialist Directory
- Disease Overviews that are easy for patients to understand
- Patient Education in English and Spanish and Disease Fact Sheets
- Medicare Overview
- Clinical Trial Information
- Patient Advocacy including the End of Step Therapy Campaign
- Patient Personal Stories and a Patient Podcast
- The Foundation of the ASRS

5

ADMIN RESOURCES

6

- Retina Career Center – Post & Find Jobs
- Billing & Coding, Billing and Practice Management Resources
- Human Resources checklists and articles
- RETAP: Retina Education and Training for Allied Health Professionals
- New Physician & Employee Check Lists
- Webinars, Podcasts and Articles
- Payer Policy Information

Resources to help retina practices appropriately maximize reimbursement, stay up to date on health care trends, successfully manage their practices and patients, and thrive in a competitive

7

- Spreadsheets: Expense Tracking, Pharma P&L Calculator, Pharma Financial Planning Tool
- Customizable Marketing Tools
- Articles on All Areas of Retina Financial Structure
- ASRS Commitment to Quality Award
- Documentation Resources
- Mentoring Programs
- Annual Meeting and Annual Business of Retina Meeting

8

PHYSICIAN RESOURCES

9

- Adverse Event Reporting
- Clinical and Surgical Videos
- Patterns and Trends Survey Identify new and evolving therapies and surgical techniques, controversies, preferences, and trends
- Retinal Image Bank
- Case Studies, Clinical Updates, Virtual Lectures
- The Retina Challenge

10

PUBLICATIONS

11

- Retina Times
- JVRD Journal of Vitreoretinal Diseases
- JVRD Author's Forum Podcast
- Retina FYI
- Tuesday afternoon *Retina Advocacy and Practice News*

12

SPECIAL SECTIONS

13

- Women in Retina
- DEI Ad Hoc Committee
- International Affairs Committee
- Early Career Section
- Sections for Residents, Fellows & Fellowship Directors, and Practice Administrators

14

ADVOCACY

15

- Direct Resources to get Involved at Grassroots Level
- ASRS Communication: Solving the World's Problems
- Pre-populated Letters & Communication for Local, State, and National Representatives
- Medicare & MIPS Resources
- Comment Letters

16

QUESTIONS?

17

WWW.ASRS.ORG

18

PHYSICIAN BURNOUT

Vivek Chaturvedi, MD FASRS
Section Director, Retina, Rush
Wellness Director, Rush
Partner, Illinois Retina

RUSH UNIVERSITY MEDICAL CENTER
Illinois Retina Associates
CELEBRATING HISTORY • IMAGINING THE FUTURE

1

BECOMING A RETINA SPECIALIST:

THIS WAS SUPPOSED TO BE HARD.

2

BUT WHEN DOES "HARD" BECOME "BURNOUT"?

3

HISTORY OF 'BURNOUT'

1974 Psychologist Herbert J. Freudenberg, PhD, in psychiatric journal

2019 WHO added to 11th International Classification of Diseases

Freudenberger HJ, Richelson G. Burn-out: The High Cost of High Achievement. Anchor Press; 1980.

4

BURNOUT DEFINED

Feelings of depleted energy or exhaustion

Mental distance or cynical feelings about one's job

Reduced professional efficacy

5

SOURCES OF BURNOUT

Administrative Burden
Too many hours at work
Lack of financial independence
Insufficient compensation
Lack of control (small to large)
Lack of meaningful work

Source: Medscape 2024 Survey

6

CONSEQUENCES OF BURNOUT

- Increased risk of alcohol abuse, depression, & suicide
- Higher risk of
  - medical errors
  - elevated financial burden
  - poor patient care
- Reduced physician productivity
- Increased physician turnover
- Increased malpractice suits

Oreskovich MR, Kaups KL, Balch CM, et al. Prevalence of alcohol use disorders among American surgeons. *Arch Surg*. 2012;147(2):168-174.

Dutheil F, Aubert C, Pereira B, et al. Suicide among physicians and health-care workers: a systematic review and meta-analysis. *PLoS One*. 2019;14(12):e0226361.

Shanafelt TD, Balch CM, Bechamps G, et al. Burnout and medical errors among American surgeons. *Ann Surg*. 2010;251(6):995-1000.

Hall LH, Johnson J, Watt I, Tsipa A, O'Connor DB. Healthcare staff wellbeing, burnout, and patient safety: a systematic review. *PLoS One*. 2016;11(7):e0159015.

7

Purpose
Intensity
Financial

Financial illiteracy
Perfectionism
Workaholic
Patient Responsibility
Lack of Autonomy
Non-Physician Tasks
Staff Turnover
Reimbursement
Patient Volume
Toxic/Leadership
Work Engagement
Personal Stress

8

WHAT DOES THE DATA SAY?

Physicians

Ophthalmologists

Retina Specialists

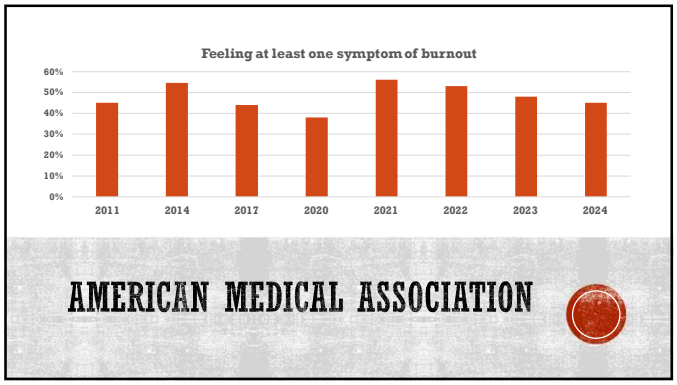
9

PHYSICIAN DATA

American Medical Association

Medscape

10



11

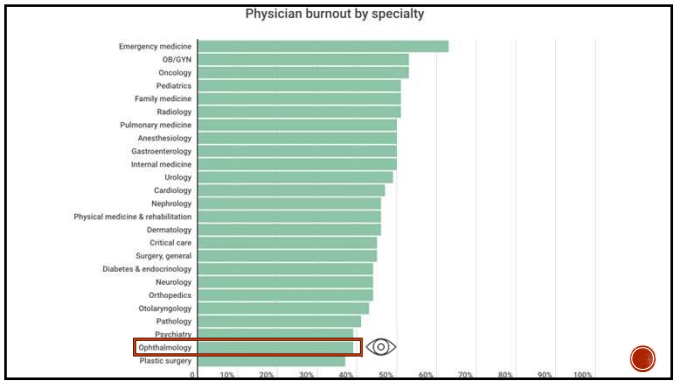
MEDSCAPE

- 9,226 physicians in 29 specialties (3 month) in 2023
- 49% said they were burnt out
  - Female 56% vs Male 44%

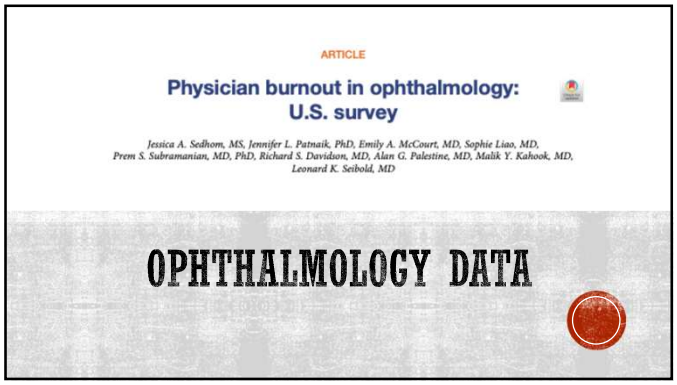
With symptoms going back at least 1, sometimes 2 years

14%-16% considering leaving medicine altogether

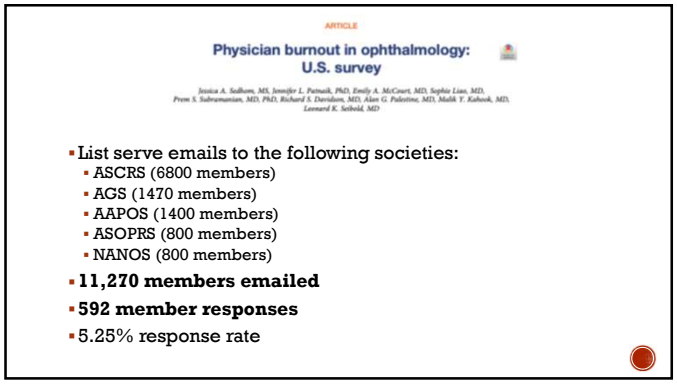
12


Physician burnout by specialty
Emergency medicine
OB/GYN
Oncology
Pediatrics
Family medicine
Radiology
Pulmonary medicine
Anesthesiology
Gastroenterology
Internal medicine
Urology
Cardiology
Nephrology
Physical medicine & rehabilitation
Dermatology
Critical care
Surgery, general
Diabetes & endocrinology
Neurology
Orthopedics
Otolaryngology
Pathology
Psychiatry
Ophthalmology
Plastic surgery
0
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

13


ARTICLE
Physician burnout in ophthalmology: U.S. survey
Jessica A. Sedhom, MS, Jennifer L. Patnaik, PhD, Emily A. McCourt, MD, Sophie Liao, MD, Prem S. Subramanian, MD, PhD, Richard S. Davidson, MD, Alan G. Palestine, MD, Malik Y. Kahook, MD, Leonard K. Seibold, MD
OPHTHALMOLOGY DATA

14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List serve emails to the following societies:
ASCRS (6800 members)
AGS (1470 members)
AAPOS (1400 members)
ASOPRS (800 members)
NANOS (800 members)
11,270 members emailed
592 member responses
5.25% response rate

15

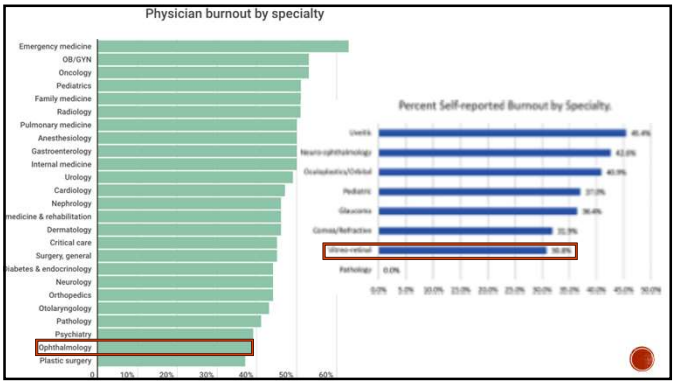
ARTICLE

Physician burnout in ophthalmology: U.S. survey

Jessica A. Sedhom, MS, Jennifer L. Patnaik, PhD, Emily A. McCourt, MD, Sophie Liao, MD, Prem S. Subramanian, MD, PhD, Richard S. Davidson, MD, Alan G. Palestine, MD, Malik Y. Kahook, MD, Leonard K. Seibold, MD

- 592 responses
- 224 reported symptoms of burnout (37.8%)
  - Mild (146/224)
  - Moderate (66/224)
  - Severe (12/224)
- Female 46.2% vs male 31.2%
- Employed 40.3% vs private 31.9%

16

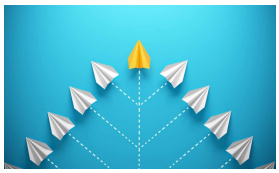


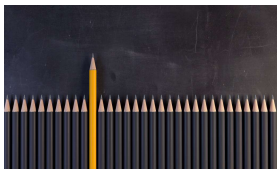
17

RETINA SPECIALIST

- Very little data
- Previous study, 1/3 retina specialists feel some degree of burnout
- Opportunity:
  - Leverage societies with access to retina specialists
  - **Identify Patterns and Trends**
  - Demographics
  - Employment Type
  - With the data can come intervention

18





INTERVENTION

19

TRADITIONAL INTERVENTION 2.0

Individual level
- Reduce Hours*
- Change Jobs*
- Exercise*
- Family/Friends*
- Spirituality*

Therapy/PCP

Coaching
- Time Management
- Resilience & Gratitude

Training Level
- Financial Literacy
- Debt Management

Organizational Level
- Leadership
- Protect
- Mentorship
- Reduce ~~burden~~
- Culture
- Schedules
- Compensation
- Provide Purpose

Physician Well-being 2.0: Where Are We and Where Are We Going? Shanafelt, Tait D. Mayo Clinic Proceedings, Volume 96, Issue 10, 2682 - 2693

20

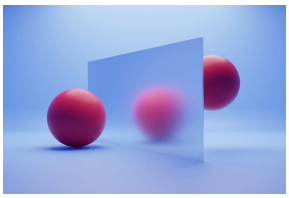
Journal of
Vocational
Behavior

Burnout and work engagement:
Independent factors or opposite poles?

Vicente González-Romá [a,*], Wilmar B. Schaufeli [b],
Arnold B. Bakker [b], Susana Lloret [a]

[a] University of Valencia, Department of Methodology of Behavioral Sciences,
Av. Blasco Ibanez, 21, 46010-Valencia, Spain
[b] Utrecht University, Department of Social and Organizational Psychology, The Netherlands

(2006) 165–174



21

Create Meaningful Work

Meet physicians where they are

70% of employees said their sense of purpose is defined by their work

Those employees who say that they live their purpose at work are:
5X more likely to report higher **resilience**.
4X more likely to report better **health**.
6X more likely to want to stay at the **company**.
5X more likely to go **above** and **beyond** to make their company successful.

https://www.mckinsey.com/featured-insights/mckinsey-guide-to-getting-unstuck/how-centering-purpose-in-the-workplace-fosters-empowerment

22

23

24

NATIONAL SUICIDE STATISTICS

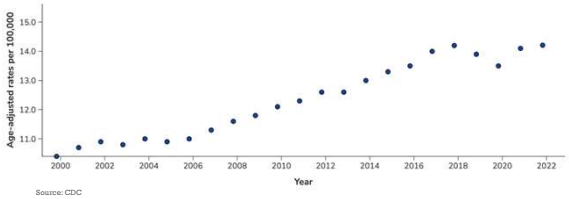
- 49,000 died by suicide in 2022
- 13.2 million with serious suicidal ideation
- 3.8 million made a plan
- 1.6 million attempted suicide

Source: CDC

25

NATIONAL SUICIDE RATES

Suicide rates increased 37% between 2000-2018 and decreased 5% between 2018-2020. However, rates returned to their peak in 2022.



Source: CDC

26

SUICIDE: PHYSICIAN STATISTICS

- One of several occupational groups linked to a higher risk of death by suicide
- More than double the risk compared to the general population
- ~300 physician suicides/year

- Less likely to receive mental health treatment compared to nonphysicians
- Suicide rate among **male** physicians is 1.41x higher than general male population
- Suicide rate among **female** physicians is 2.27x higher than general female population

Center, C., Davis, M., Detre, T., Ford, D. E., Hansbrough, W., Hendin, H., Laszlo, J., Litts, D. A., Mann, J., Mansky, P. A., Michels, R., Miles, S. H., Proujansky, R., Reynolds, C.F. 3rd, ... Silverman, M. M. (2003). Confronting Depression and Suicide in Physicians. JAMA, 289(23), 3161. doi:10.1001/jama.289.23.3161

27

AMERICAN FOUNDATION OF SUICIDE PREVENTION

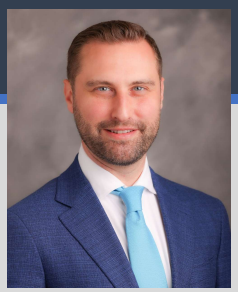
28

988 SUICIDE & CRISIS LIFELINE

YOU OK?

29

American Society of Retina Specialists



Business of Retina Meeting
Sunday, March 30th, 2025

Scott D. Walter, MD, MSc, FASRS
Vice President, Retina Consultants, PC
Vice Chief, Ophthalmology, Hartford Hospital
Clinical Assistant Professor, UConn Medicine

ASRS American Society of Retina Specialists

1

Virtual and AI Scribing in Retina

Current and Future Trends in Clinical Documentation for the Retina Specialist

2

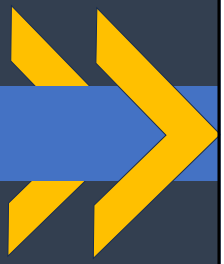
3

Disclosures

SPEAKER	ADVISOR	INVESTIGATOR
Apellis Bausch & Lomb Genentech/Roche Regeneron	4D Molecular Therapeutics, Abbvie/Allergan, Alimera/EyePoint Pharma, Apellis, Astellas/Iveric Bio, Bausch & Lomb, Genentech/Roche, Ideaya Bioscience, Lupin, Novartis, Regeneron	Castle Biosciences/COOG Notal Vision/DRCR EyeBio Ocular Therapeutix RegenexBIO

4

Introduction



5

Terminology

- Medical Scribing is the process of documenting patient encounters on behalf of a physician or healthcare provider
- A Certified Opthalmic Scribe (COS) has
  - ✓ Completed a JCAHPO-approved training program, OR has
  - ✓ Documented relevant work experience in ophthalmology, AND has
  - ✓ Passed the COS exam

6

Rationale

- Medical scribes may increase provider efficiency by increasing time available for provider-level tasks
  - ✓ Formulating diagnosis and treatment plan
  - ✓ Patient education and counselling
  - ✓ In-office procedures
- Scribes possess specific knowledge of billing requirements and best practices for clinical documentation

7

Terminology

- With In-Person Scribing, the scribe is physically present in the exam room, directly observing the encounter
- With Virtual Scribing (VS), the scribe is observing remotely via a secure audio or audiovisual connection

8

Advantages of In-Person

- Ease of communication between provider and scribe
- Minimal tech requirements
- Greater sense of connection with the patient
- Able to assist with rooming patients, procedures, and other clinical tasks

9

Potential Advantages of VS

- Accommodates people who need to work remotely
- Allows the scribe to focus solely on EHR documentation
- May assist with other telecommunications-based tasks
  - ✓ Tracking down labs/imaging
  - ✓ Patient portal/email communications
  - ✓ Sending letters
  - ✓ Completing electronic forms
- Often more cost-effective
- Patients may feel a greater sense of privacy

10

Potential Disadvantages of VS

- Complex tech requirements
  - ✓ Stable internet connectivity
  - ✓ High-fidelity audio
  - ✓ Secure communication systems
  - ✓ Remote access to EHR
- Limited opportunities for in-person training and feedback
- Lack of continuity, especially when outsourcing

11

Terminology

- With Synchronous VS, observation and documentation of the patient encounter occurs in real-time
- With Asynchronous VS, documentation occurs ***after*** the encounter, based on audio or audiovisual recordings

12

Advantages of Synchronous VS

- Scribe can interact with provider in real-time to confirm details or seek clarification
- Documentation typically complete at end of visit

13

Advantages of Asynchronous VS

- Scribe can speed up or slow down the recording as needed
  - ✓ Skip over dead air
  - ✓ Fast forward through small talk
  - ✓ Focus on the important parts
  - ✓ Replay audio if unable to understand
- Provider can speak quickly and move at their own pace
- Doesn't depend on live uninterrupted connections
- Patients are less aware that someone is listening

14

Terminology

- With Active Documentation, the provider dictates structured data and the scribe transcribes verbatim (or adapts it to a pre-formed template)
- With Ambient Documentation, the provider has a natural conversation with the patient, and the scribe intuitively formulates the documentation

15

Advantages of Active Documentation

- Accurately reflects provider's own thought process
- Reduces risk of missing important details
- Reduces likelihood of including irrelevant data in EMR
- Requires minimal review by the provider

16

Disadvantages of Active Documentation

- Consumes provider time
- May take even longer for the scribe
  - ✓ Difficult to capture active documentation synchronously

17

Advantages of Ambient Documentation

- Minimizes workflow disruption for the provider
- May do a better job of capturing the patient's own words and sentiments without filtering them through the provider's mind

18

Disadvantages of Ambient Documentation

- More prone to errors and inaccuracies
- May capture irrelevant data
- May lack contextual awareness
- Requires more careful review by the provider

19

Terminology

- Artificial intelligence (AI) refers to computer algorithms that can perform tasks that typically require human cognition
  - ✓ Pattern recognition
  - ✓ Language understanding
  - ✓ Decision-making
  - ✓ Problem solving

20

Terminology

- Natural language processing (NLP) is the ability of AI to interpret, generate, and respond to human language.
  - ✓ Text analysis
  - ✓ Speech recognition
  - ✓ Sentiment analysis
  - ✓ Text generation
  - ✓ Machine translation
  - ✓ Chatbots and virtual assistants

21

Terminology

- Machine Learning (ML) is the ability learn from data without being explicitly programmed, allowing AI algorithms to adapt and improve model performance over time
  - ✓ Identifying data patterns
  - ✓ Forming weighted "neural networks", decision trees, and support vector machines
  - ✓ Supervised learning
  - ✓ Unsupervised learning
  - ✓ Reinforcement learning

22

Rationale for AI-based Scribing

- AI can listen and formulate ambient documentation in real time
- A hybrid approach allows ambient tools to passively capture data, while the human scribe ensures precise terminology, structured data entry, and quality control

23

Rationale for AI-based Scribing

- Provider and scribe can "teach"/refine the AI model
  - Tailor the AI model to your specialty by feeding it specialty-specific language
  - Expose the AI model to diverse patient presentations of similar clinical scenarios
  - Actively flag inaccuracies, ambiguities, or misinterpretations in AI-generated notes
  - If there are recurring errors, notify developers to modify model behavior

24

25

Fellowship Years in Academia

2015 2017 2020 2021 2023 2025

- Fellow completed most of the EMR documentation; attending revised and signed off
- Some attendings had a dedicated in-person scribe

26

First Years in Private Practice

2015 2017 2020 2021 2023 2025

- One "lead scribe" plus 1-3 additional rotating scribes

27

The Pandemic Hits

2015 2017 2020 2021 2023 2025

- Sudden reduction in patient volume and workforce
- Some initial experiments with virtual medicine
  - ✓ Pre-visit questionnaires
  - ✓ Testing-only visits
  - ✓ Telehealth and hybrid-THVs
  - ✓ Working while quarantined

28

Emerging from the Pandemic

2015 2017 2020 2021 2023 2025

- Recovery of patient volume with a sustained reduction in workforce
- Increased pressure to embrace remote work
  - ✓ Many employees with young children
  - ✓ "Great Resignation"
  - ✓ Limited responses to job postings

29

Emerging from the Pandemic

2015 2017 2020 2021 2023 2025

- Back to "business as usual"
  - ✓ Practice manager reluctant to allow work-from-home (WFH)
  - ✓ Difficult to monitor productivity when WFH
- Team mentality became more solidified
  - ✓ Smaller, more stable team of employees working with each doctor
  - ✓ Explored new divisions of labor, e.g. "loader", "prepper", "lead", and "float"

30

Going Virtual

2015 2017 2020 2021 2023 2025

- A key employee announced plans to relocate
  - ✓ JCAHPO-certified with 15+ years of experience
  - ✓ Consistent high-quality documentation
  - ✓ Tech-savvy
- VS worked "in office" for first 6mos
  - ✓ Worked out the kinks in terms of tech
  - ✓ Able to assist with lunch breaks, call outs, etc.

31

Going Virtual

2015 2017 2020 2021 2023 2025

- VS went "fully remote"
  - ✓ Stable/increased productivity
  - ✓ Able to work outside of normal business hours
  - ✓ In-office team was able to adapt with minimal changes to workflow
- Discovered additional synergies
  - ✓ VS follows up on outstanding items (labs/imaging, provider-to-provider communications) and documents accordingly
  - ✓ VS identifies gaps and omissions, and places reminders in the chart

32

Going Virtual: Advantages

2015 2017 2020 2021 2023 2025

- Notes are more detailed, accurate, and consistent
  - ✓ Able to bill a higher proportion of level 4-5 E/M, comprehensive visits, and EOs
  - ✓ Charting has passed both internal and external audits
  - ✓ Documentation for each encounter is highly unique
- Provider spends less "active time" on documentation
  - ✓ Most routine office visits completed with ambient documentation
  - ✓ New and improved templates developed by provider and VS
  - ✓ VS authorized to close charts and send letters without provider review

33

Going Virtual: Challenges and Limitations

2015 2017 2020 2021 2023 2025

- Some encounters require active documentation +/- review
  - ✓ New patients
  - ✓ Level 5 office visits
  - ✓ Referral letters
- Growing backlog of charts
  - ✓ Currently 400+ incomplete notes
  - ✓ Occasionally patients return before last note has been finished
- Other employees less efficient/confident in charting

34

Exploring AI-based Scribing

2015 2017 2020 2021 2023 2025

- Recently completed a free trial of Freed
  - ✓ HIPPA-compliant web-based platform
  - ✓ Currently utilized by >17,000 US clinicians
- Capable of producing instantaneous documentation
  - ✓ Active: Creates a verbatim transcript of the patient encounter
  - ✓ Ambient: Summarizes each encounter with a one-liner, visit summary, "SOAP" note, and patient handout

35

Exploring AI-based Scribing

2015 2017 2020 2021 2023 2025

- Model evaluation and fine-tuning
  - ✓ Remove extraneous information
  - ✓ Reorganize information
  - ✓ "Magic edit" functionality
- Feedback from VS
  - ✓ Worth continuing, but needs careful review
  - ✓ Allows her to multitask

36

Exploring AI-based Scribing

2015 2017 2020 2021 2023 2025

- Capable of ML
  - ✓ HIPPA-compliant web-based platform
  - ✓ Currently utilized by >17,000 US clinicians
- Capable of producing instantaneous documentation
  - ✓ Active: Creates a verbatim transcript of the patient encounter
  - ✓ Ambient: Summarizes each encounter with a one-liner, visit summary, "SOAP" note, and patient handout

37

Current Perspectives on VS/AI

38

CONCIERGE RETINA

VIVIAN KIM, MD, MPH, FACS, FASRS
ASRS BUSINESS OF RETINA MEETING
MARCH 30, 2025

1

Financial disclosure:

Founder & CEO of TrailblazerMD, LLC

2

BY THE END OF THE PRESENTATION …

1) WHY practice a concierge model in Retina?

2) WHAT does it look like?

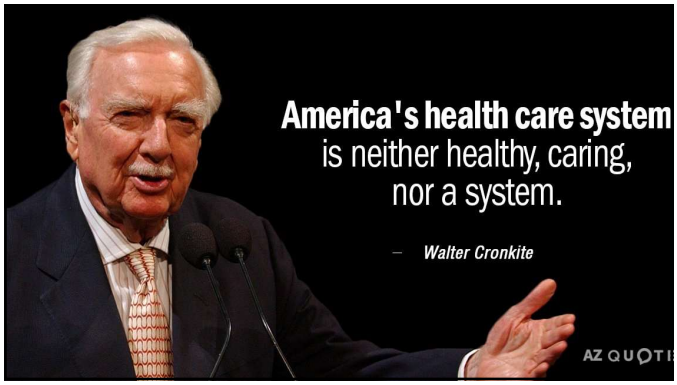
3) HOW to overcome obstacles in becoming concierge

4) WHAT is the ultimate endgame

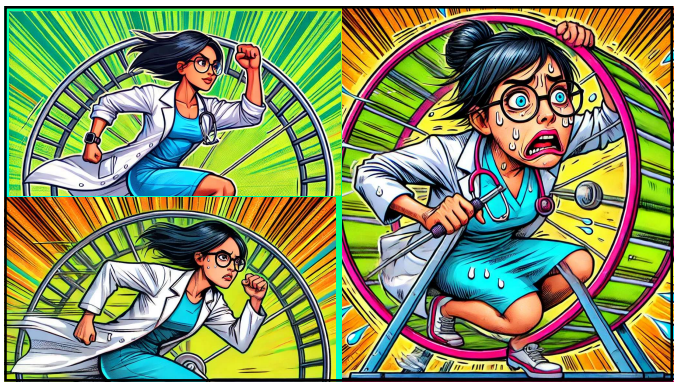
3


7:27
Monday, February 24
acer

4


America's health care system
is neither healthy, caring,
nor a system.
– Walter Cronkite
AZ QUOTES

5



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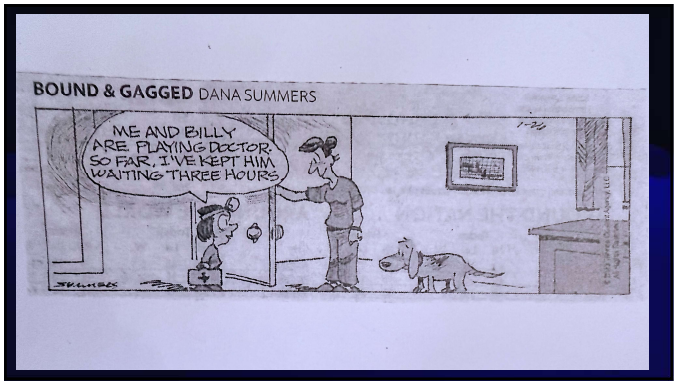
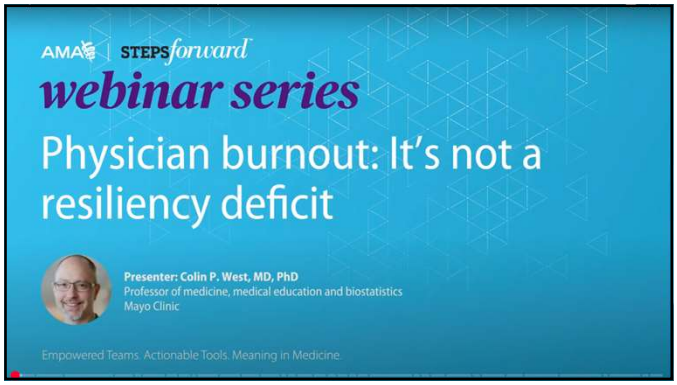

BOUND & GAGGED DANA SUMMERS
ME AND BILLY ARE PLAYING DOCTOR. SO FAR, I'VE KEPT HIM WAITING THREE HOURS

7


AMA STEPSforward
webinar series
Physician burnout: It's not a resiliency deficit
Presenter: Colin P. West, MD, PhD
Professor of medicine, medical education and biostatistics
Mayo Clinic
Empowered Teams. Actionable Tools. Meaning in Medicine.

8


THE WALL STREET JOURNAL.
HEALTH | WELLNESS | TURNING POINTS
Why We Don't Trust Doctors Like We Used To
Patients often feel ignored and complain about disjointed care and a lack of communication
728
Gift unlocked article
Listen (6 min)
"They see a series of time-pressed physicians who keep visits short and struggle to build rapport with patients. That often makes it seem as if they are dismissing concerns or letting biases creep into care."
Feb 23, 2025

9

10

CLEARLY THERE ARE LIMITATIONS TO A VOLUME-DRIVEN PRACTICE MODEL

11

SO WHY GO CONCIERGE ??

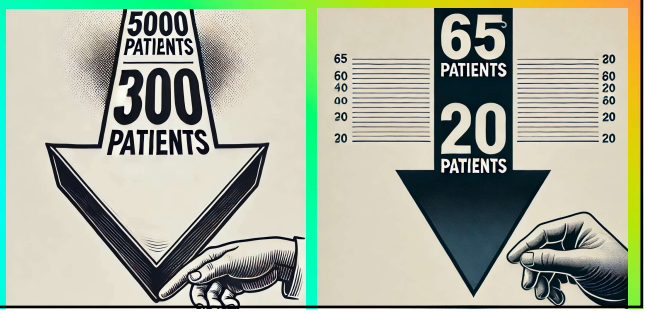
12

Considerations for a Concierge Conversion

- Care for Chronic diseases or diseases that can be prevented
- Reputation in your area of expertise
- Good Interpersonal relationship skills
- Awareness of the pain points in healthcare delivery from patient perspective
- Belief that Time and Attention assures better patient outcomes
- Desire for improved work/life balance
- Entrepreneurial MINDSET

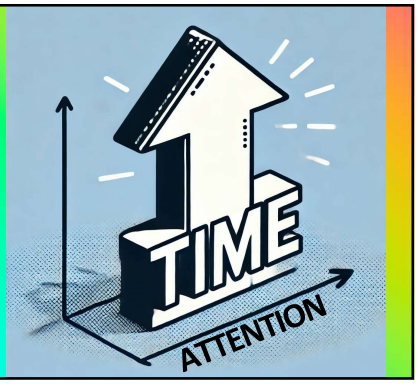
13

MORE TIME FOR QUALITY CARE WITH FEWER PATIENTS



14

TIME AND ATTENTION LEAD TO BETTER HEALTHCARE OUTCOMES



15

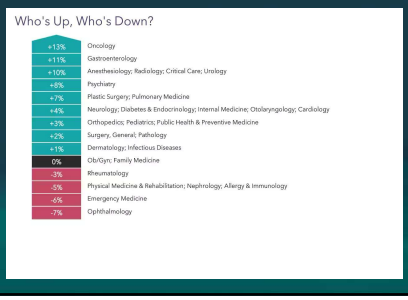
PATIENT DEMAND FOR PERSONALIZED SERVICES AND PREMIUM HEALTHCARE DELIVERY

16

VARIABLE OPPORTUNITIES FOR REVENUE OUTSIDE OF INSURANCE-DRIVEN REIMBURSEMENT

17

Medscape Physician Compensation Report 2023
Decreasing Reimbursement Landscape in Ophthalmology



2005 IVI $202

2023 IVI $118

44% reduction

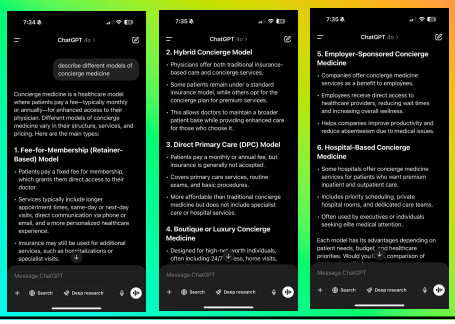
2025 IVI $113

18

MULTIPLE CONCIERGE MODELS

QUERY TO CHATGPT

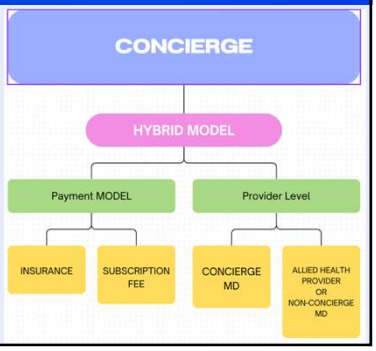
WHICH ONE TO CHOOSE?



19

HYBRID MODEL

DUAL DEFINITION



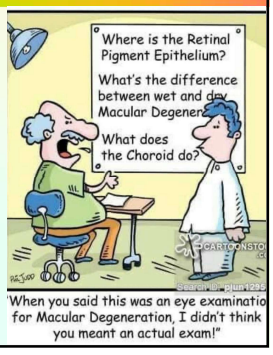
20

TRANSITION CHALLENGES

Regulatory and legal considerations

SOLUTION: Understand the requirements of your insurance carriers' provider obligations and what is not covered by insurance ie. A wellness exam

VIVIAN KIM, MD, MPH, FACS, FASRS



21

TRANSITION CHALLENGES

FEW MODELS IN SURGICAL OR SPECIALTY FIELDS OF MEDICINE SUCH AS RETINA.

We can learn from primary care practice models but this is not sufficient since they're not a procedural-based specialty.

22

WHY CONCIERGE?

--Limitations of a volume-driven insurance based model

--more time for quality care with fewer patients

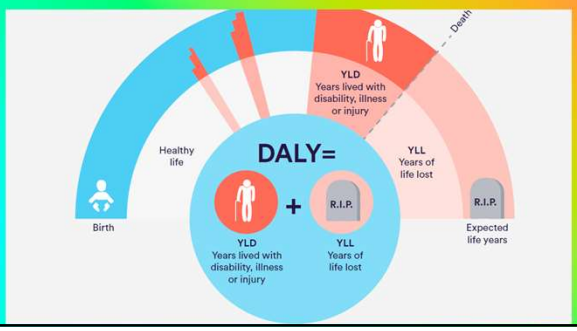
--variable opportunities for increased revenue outside of insurance-driven reimbursement

--patient demand for personalized services and premium healthcare delivery

VIVIAN KIM, MD, MPH

23

DALY = Disability Adjusted Life Years

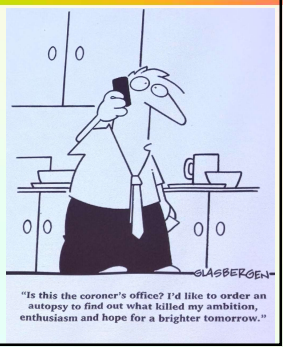


24

IS CONCIERGE RIGHT FOR YOU?

Are you wanting to provide a higher level of care than the standard?

Are you wanting a higher level of connection and relationship with your patients



25

OVERCOMING TRANSITION CHALLENGES

1) Not many models in surgical or specialty fields of medicine

SOLUTION: Borrow or adapt from Primary Care and other industries outside of medicine

VIVIAN KIM, MD, MPH

26

TRANSITION CHALLENGES

Overcoming guilt about exacerbating the physician shortage and access in an already stressed system

SOLUTION: Change your mindset regarding medicine's role in health...more proactive versus reactive. You are not the cause of the shortage.

VIVIAN KIM, MD, MPH

27

"THERE COMES A POINT WHERE WE NEED TO STOP JUST PULLING PEOPLE OUT OF THE RIVER. WE NEED TO GO UPSTREAM AND FIND OUT WHY THEY'RE FALLING IN"

BISHOP DESMOND TUTU

28

$4.3 TRILLION (18% OF NATIONAL GDP) IS SPENT ANNUALLY ON HEALTHCARE, BUT LESS THAN 3% IS DIRECTED TOWARD PUBLIC HEALTH AND PREVENTION AND ONLY 8% OF AMERICANS CURRENTLY UNDERGO ROUTINE PREVENTATIVE SCREENINGS.

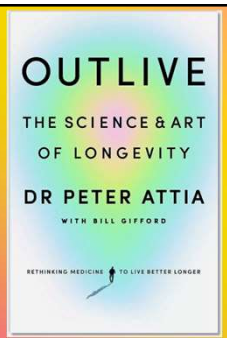
MAOSEEK, M. V., COFFIELD, A. B., EDWARDS, N. M., FLOTTEMESCH, T. J., GOODMAN, M. J., & SOLBERG, L. I. (2010). GREATER USE OF PREVENTIVE SERVICES IN US HEALTH CARE COULD SAVE LIVES AT LITTLE OR NO COST. HEALTH AFFAIRS, 29(9), 1634–1640.

EVANS, R. G., ET AL. (2014). THE ROLES OF CLINICAL AND COMMUNITY PREVENTIVE SERVICES IN PROMOTING HEALTH AND HEALTH CARE. ANNUAL REVIEW OF PUBLIC HEALTH, 35, 267–286.

SCHROEDER, S. A. (2018). WE CAN DO BETTER—IMPROVING THE HEALTH OF THE AMERICAN PEOPLE. NEW ENGLAND JOURNAL OF MEDICINE, 378(25), 713–719

29

"MEDICINE 3.0 REALLY IS AIMED AT PREVENTING RATHER THAN TREATING DISEASE BY ACTING EARLY, ACTING AGGRESSIVELY, AND TAILORING THE THERAPIES TO THE INDIVIDUALS BASED ON THE BEST AVAILABLE EVIDENCE."



PETER ATTIA, MD. FROM "OUTLIVE: THE SCIENCE AND ART OF LONGEVITY"

30

TRANSITION CHALLENGES

Communication challenges with patients

SOLUTION: Scripting and over-communication thru repetition and using multiple communication modalities. Through action, change what patients will accept as standard of care delivery. Rejuvenate the trust in doctors.

31

TRANSITION CHALLENGES

Understanding how to add value to patient services

SOLUTION: Many different ways that can be personalized to the individual patient.

More time, more education, more scheduling flexibility, or alternative treatments...telehealth, webinars, home visits, technological wearables, genomics, etc

32

TRANSITION CHALLENGES

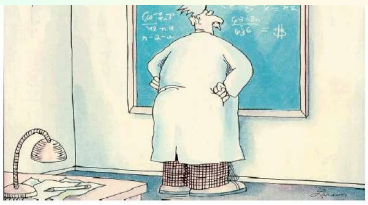
...and what about surgical procedures?

SOLUTION: Figure out how different membership models or subscription packages that address surgical or procedural needs

33

IS CONCIERGE RIGHT FOR YOU?

Are you ready to slow down?



"Einstein discovers that time is actually money" - Gary Larson

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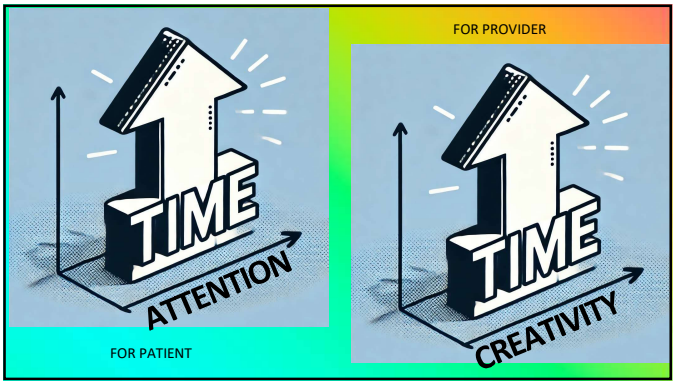

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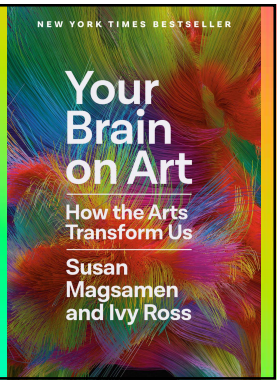
"Creativity is not just for artists—it's a cognitive tool that enhances the ability to solve complex problems in any field."



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37

IS CONCIERGE RIGHT FOR YOU?

Are you ready to put on your entrepreneurial hat, think outside the box, and think differently about healthcare delivery at a foundational level?

38

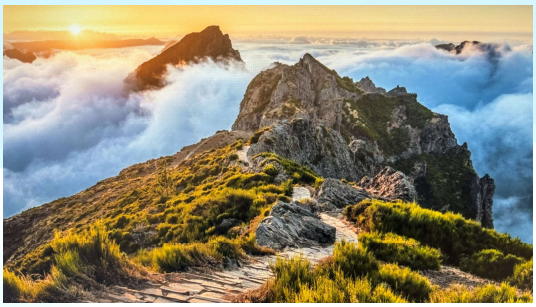
ESSENTIAL ELEMENTS OF A SUCCESSFUL RETINA PRACTICE DELIVERED THROUGH A CONCIERGE MODEL

- Delivering a premium level of care
- Adding value to patients' membership
- Valuing relationship and connection
- Happy doctor, Happy patients
- Change the culture of medicine one practice at a time through creativity and innovation nurtured by TIME not VOLUME

VIVIAN KIM, MD, MPH, FACS, FASRS

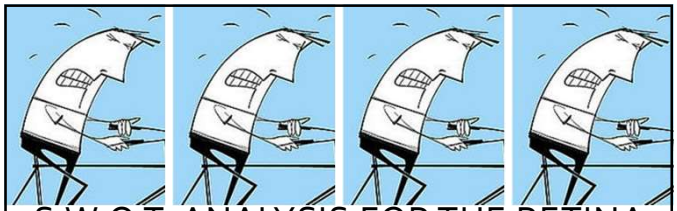
39

Thank you for being a trailblazer



Contact info: drkim@arcretina.com

40



S.W.O.T. ANALYSIS FOR THE RETINA PRACTICE– WHY ARE YOU WORKING TOO HARD?

Robert Lea, CEO Illinois Retina Associates

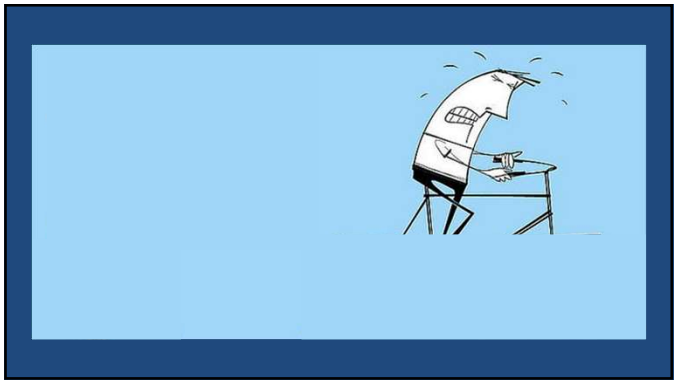
ASRS 2025

1

FINANCIAL DISCLAIMER

- Apellis – Speaker Board
- Eyepoint – Advisory Board
- Genentech – Advisory Board
- Opthea – Advisory Board
- Regeneron – Advisory Board

2



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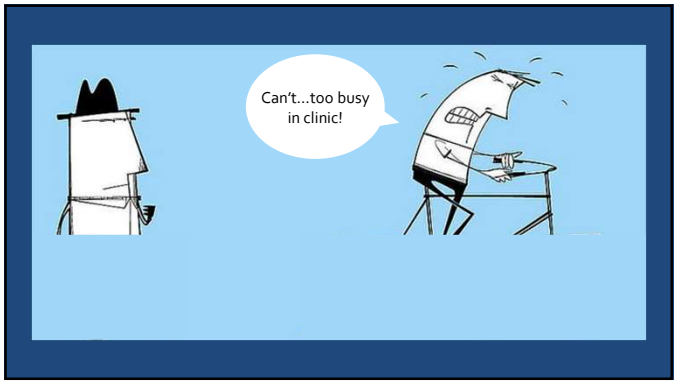
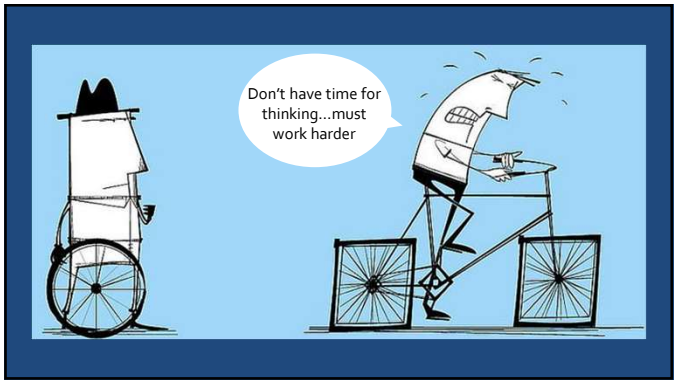

Can't…too busy in clinic!

4


I think a SWOT analysis could really help…

5


Don't have time for thinking…must work harder

6


THINK
QUICK CASE STUDY

7


THINK
Think different.
QUICK CASE STUDY

8


THINK
Think different.
THE RESULT?

9

"We cannot solve our problems with the same kind of thinking we used when we created them"

Albert Einstein

10

Think Different

S.W.O.T ANALYSIS

11

Internal	S	trengths
	W	eaknesses
External	O	pportunities
	T	hreats

12

Strengths	Weaknesses
What do you do well? What unique resources can you draw on? What do others see as your strengths?	What could you improve? Where do you have fewer resources than others? What are others likely to see as weaknesses?
Opportunities	**Threats**
What opportunities are open to you? What trends could you take advantage of? How can you turn your strengths into opportunities?	What could harm you? What is your competition doing? What threats do your weaknesses expose you to?

13

S.W.O.T ANALYSIS

Time to practice

14

BRAINSTORMING GROUND RULES

- Participate
- Put away distractions
- Brainstorming… not problem solving

15

PAPERCLIP CHALLENGE

1. Come up with the most ideas for how to use a paperclip?
2. Come up with the most unique way to use a paperclip?

16

Paperclip Challenge

1. The most creative idea?
2. The most number of ideas?

STOP

17

Strengths

What do you do well?
What unique resources can you draw on?
What do others see as your strengths?

STOP

18

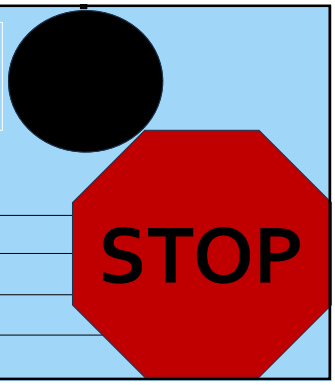
STRENGTHS

- Staff retention
- Doctor's attitude
- Culture
- Employee training
- Billing support
- Hiring
- Technology

19

Weaknesses

What could you improve?
Where do you have fewer resources than others?
What are others likely to see as weaknesses?



20

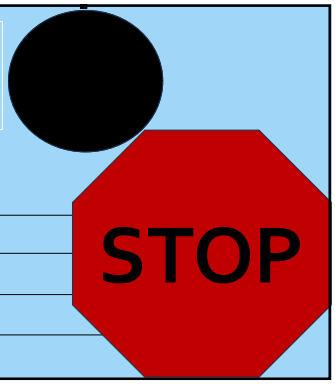
WEAKNESSES

- Staff retention
- Doctor's attitude
- Culture
- Employee training
- Billing support
- Hiring
- Technology

21

Opportunities

What opportunities are open to you?
What trends could you take advantage of?
How can you turn your strengths into opportunities?



22

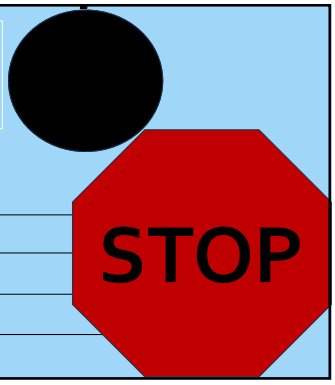
OPPORTUNITIES

1. Open a new location
2. Start participating in research
3. Negotiate better reimbursement rates
4. Competitor retiring

23

Threats

What could harm you?
What is your competition doing?
What threats do your weaknesses expose you to?



24

THREATS

1. Declining reimbursements
2. Increasing cost of new hires
3. Foundations not getting funded
4. Medication Shortages
5. Competition

25

TIPS AND TRICKS

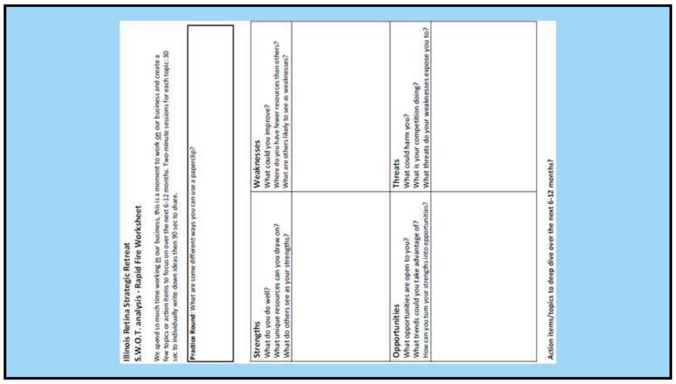
1. Get the right people in the room
2. Help get buy in
3. Stay on target…don't solve the problem yet
4. Dig deeper…'tell me more about that'
5. Don't boil the ocean…narrow it down to 2-3 action items

26

Think Different

What 2-3 action items can you focus on over the next 6-12 months?

27



Illinois Retina Strategic Retreat
S.W.O.T. analysis - Rapid Fire Worksheet

We spend so much time working in our business, this is a moment to work on our business and create a few topics or action items to focus on over the next 6-12 months. Two-minute sessions for each topic: 30 sec to individually write down ideas then 90 sec to share.

Practice Round: What are some different ways you can use a paperclip?

Strengths What do you do well? What unique resources can you draw on? What do others see as your strengths?	**Weaknesses** What could you improve? Where do you have fewer resources than others? What are others likely to see as weaknesses?
Opportunities What opportunities are open to you? What trends could you take advantage of? How can you turn your strengths into opportunities?	**Threats** What could harm you? What is your competition doing? What threats do your weaknesses expose you to?

Action items/topics to deep dive over the next 6-12 months?

28

Bay Area Retina Associates
Diseases and Surgery of the Retina and Vitreous

BOR 2025:
Insurance Gap Analysis
Do you know your gaps?

Tushar Ranchod, MD

1

What is an insurance gap analysis?

- Do you have the **types of insurance** your practice needs?
- Do you have the right **amount of coverage** for each policy?

What are we discussing today?

- Insurance that **benefits the practice**,
  - NOT individual MD insurance (individual disability, life)
  - NOT employee benefits (medical, dental, vision, life, etc)

2

2

What kinds of insurance does your practice need to consider?

- **General business** liability
- **Labor**-related liability
- **Crime**-related liability
- **Manpower**-related liability
- **Disaster**-related liability
- **Professional** liability

3

3

General business liability coverage

Business/Property/Umbrella Insurance is broad, necessary coverage, also known as "all risk" coverage

- "Slip & fall" coverage for bodily harm to patients/visitors
- Property damage, damage to landlord's property
- Personal injury (non-physical) such as libel or slander

- Typically has specific exclusions such as professional services, D&O, employee injury, intentional acts

Example:

- A $4M policy might cost $20k in annual premiums for a 5-doctor practice

Do I need this?

4

4

Employment Practice Liability

- Protects your business from employee lawsuits for wrongful employment practices.
- **Harrassment, retaliation**
- **Wrongful Termination**
- **Discrimination**: discrimination based on age, gender, etc
- **Wage violation**: wrongful calculation of hours or overtime
- **Wrongful job classification**: misclassified employee status

Do I need this?

5

5

Workers compensation insurance

- Required by law in all states except Texas.
- Requirements vary by state.
- Most of the determination of premiums are not ones that your practice can control
  - Location, business classification, payroll size, claims history

Do I need this?

6

6

Commercial Crime

- Employee **theft, embezzlement**
- Third party theft, **robbery**
- **Forgery** including manipulation of checks
- **Fraud** including unauthorized fund transfers

Example:

- A policy with $500k of coverage might only cost $300/yr

Do I need this?

7

7

Cyber

- **Data recovery** if data is lost or stolen
- **System damage**: repair of damaged computers, networks
- **Extortion** coverage
- **Customer notification** and customer credit monitoring
- Should include **dependent system coverage** (coverage for cyber attack on a system that your practice depends on, like your clearinghouse or EMR)

- Some policies are healthcare specific
- **Policies often include access to useful resources** such as cyber preparedness tools, phishing tests, cyber risk reports

Do I need this?

8

8

Key person insurance(s)

Bigger groups are more able to self-insure

Insures the practice against **lost revenue** if a doctor is unable to work.

- **Disability**:
  - Usually has 90 day waiting period
  - Renewed every 3-5 years: higher cost with increasing physician age / decreasing health.
  - Example: Premium of $300-$1,000/month per MD for $20k/month benefit
- **Life**:
  - Always better to buy the policy when the MD is younger/healthier: get enough coverage!
  - Cost of policy goes up exponentially with age, may not make sense for late career MDs

Do I need this?

Do I need this?

- **Disability policies**: Apply if doctor is unable to perform work duties. Would **NOT** apply to a doctor who has to take time off work for a family tragedy, for example.

9

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Buyout insurance

- Insures the practice against the **cost of buying out** a partner who becomes disabled or dies.
  - This is distinctly **different from key person** coverage for **lost revenue**.
- **Disability trigger**
  - Triggered if disabled long enough to force exit from the practice, typically 12-18 months after disability starts
  - Most practices with discipline can self-insure against this risk
- **Death trigger**
  - Since this coverage is for the buy-out (not lost revenue), risk to practice depends heavily on structure/amount of buy-out

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Buyout insurance: Example

5 physician partner practice
Assumptions:

- Buyout would cost the practice $750k paid over 3 years ($250k/yr x3 years)
- Policy would pay out $500k over 3 years ($167k/yr x3 years)
- Policy premium for all 5 docs would cost $10k/yr

If a partner dies or becomes disabled, forcing a buyout from the practice, this policy will cover most of the cost to the practice.

Unless a practice is so large that it can self-insure effectively by saving on the premiums, this type of policy can provide good value.

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Business interruption insurance

- **Reimburses** expenses to help cover **overhead** in the event of a business interruption.
  - If MD death/disability, only reimburses overhead expenses
    - **Does not address lost revenue** which far exceeds overhead cost
  - Relevant for a natural disaster that prevents business operations.
  - Typically has 30, 60 or 90-day waiting period.
- **A disciplined practice may be able to self-insure** against this type of liability. Working capital can also help offset this risk.

Example:

- A policy covering up to $15k/mo per MD might cost $30k/yr for 8 doctors
- This adds up to coverage of $1.4M/yr, but only covers overhead costs, not lost revenue
- In the event of a disaster, if you cut payroll and still collect outstanding AR…

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Malpractice insurance

- We all generally know what this is for, but malpractice coverage **often includes additional coverage** beyond medical malpractice
- Examples:
  - May include **cyber coverage** such as network asset protection and cyber extorsion
  - May include coverage for **errors & omissions** related to billing and coding. This includes defense/negotiations/fines.

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D&O (Directors & Officers)

- Has value if your practice has executive leaders who are making decisions that could be targeted in a lawsuit.
- If the physicians are making those decisions as business owners, or if the non-physician leadership is making decisions that are deemed low risk from a litigation standpoint, this may not be needed.
  - There are no easy lines to determine when D&O is relevant in a physician-owned practice that has non-physician executive leadership. Consider consulting legal counsel.

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E&O (Errors & Omissions) coverage

- Errors and omissions liability coverage is relevant if your practice is sued for billing mistakes.
  - As noted earlier, this **may already be covered in your malpractice insurance**. Make sure to check!
- Separate E&O insurance is relevant if your practice **determines utilization** for managed care or workers compensation plans.
  - Assuming your retina practice is not involved in utilization determination, separate E&O coverage is not needed.

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Ok, I'm scared. Now what?

1. Find out who is responsible for reviewing and updating insurances for your practice. Maybe it's you!
2. Make a list of every insurance policy your practice carries including the carrier, policy number, effective date, expiration date, premium amount, etc.
3. Are all your doctors covered? Do you have all the policies you need? Have policies expired and need to be renewed?
4. Can you self-insure in some areas?
5. What system do you have in place to review your insurances regularly?

It hurts when you identify a gap after you fell into it!

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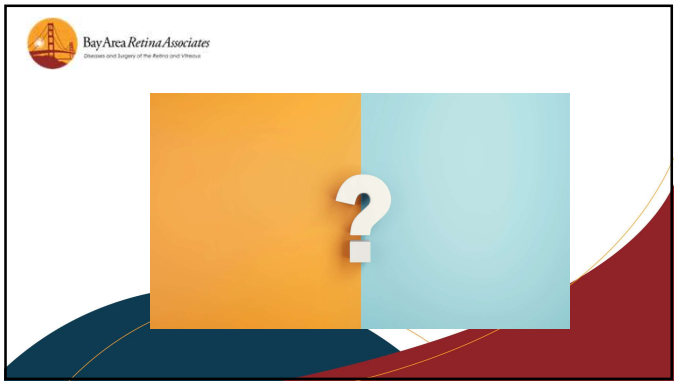

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Retina Coding Update

Presented by:
Joy Woodke, COE, OCS, OCSR

ASRS Business of Retina
Sunday, March 30, 2025

1

Speaker Financial Disclosure

- Joy Woodke, COE, OCS, OCSR
  - Academy Director of Coding and Reimbursement

- Speaker has no financial relationships to disclose.
- All relevant financial relationships have been mitigated.

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Course Agenda

What's New for 2025?
- CPT and Category III codes
- E/M vs Eye comparison
- Transfer of care modifier policy updates

Audit Excellence
- Elevate your documentation

Master Retina Injections

Retina Coding Competency Challenge

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2025 Retina Coding Update

Current as of January 10, 2025

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New Category III Code: Photobiomodulation Therapy (**0936T**)

Category III Codes

- **0936T** Photobiomodulation therapy of retina, single session

►(For bilateral procedure, report 0936T with modifier 50)◄

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Category III Codes

Temporary codes for new and emerging technology

Sunset date

Must report if procedure meets the definition

Should not assume payer has noncoverage policy

Examples:

- 0936T – new in 2025
- 0810T – subretinal injection of pharmacologic agent, including vitrectomy and 1 or more retinotomies

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Avoid ADRs: Category III Codes Claim Submission

- *Reminder:*
- First Coast and Novitas Introduce New Requirements
  - Must submit supporting documentation (eg, OP Report)
  - Submit electronic claim with corresponding item 19 PWK (paperwork) indicator and reference attachment control number (ACN)
  - After claim is accepted with 7-10 days business days:
    - Fax with coversheet, reference ACN

For more information, access Ask the Coding Experts at https://www.aao.org/practice-management/news-detail/first-coast-novitas-introduce-new-category-code

- Other MACs and payers may have unique processes to submit

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Revised: OCT (92132, 92133, 92134)

Medicine/Ophthalmology/Special Ophthalmological Services

▲**92132** ~~Scanning c~~Computerized ophthalmic diagnostic imaging (eg, optical coherence tomography [OCT]), anterior segment, with interpretation and report, unilateral or bilateral

(Do not report 92132 in conjunction with 0730T)

►(For computerized ophthalmic diagnostic imaging of the optic nerve and retina, see 92133, 92134, 92137)◄

(For specular microscopy and endothelial cell analysis, use 92286)

(For tear film imaging, use 0330T)

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Revised: OCT (92132, 92133, 92134)

Medicine/Ophthalmology/Special Ophthalmological Services

▲**92133** ~~Scanning c~~Computerized ophthalmic diagnostic imaging (eg, optical coherence tomography [OCT]), posterior segment, with interpretation and report, unilateral or bilateral; optic nerve

▲**92134** retina

~~(Do not report 92133 and 92134 at the same patient encounter)~~

~~(For scanning computerized ophthalmic diagnostic imaging of the optic nerve and retina, see 92133, 92134)~~

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New: OCT with OCT angiography (92137)

Category I Codes

#● **92137** retina, including OCT angiography

►(Do not report 92133, 92134, 92137 at the same patient encounter)◄

►(Report 92137 separately when performed at same encounter as 92235, 92240, 92242)◄

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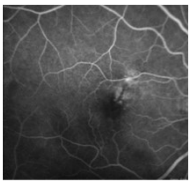
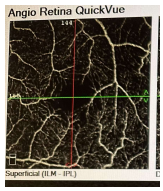
Retinal Angiography

- Fluorescein dye – 92235
- Indocyanine green dye – 92240
- Fluorescein + ICG = 92242

- Now OCT with no infusion, just technology analysis – infusion free angiography = 92137



IV fluorescein dye



OCT angiography – no dye

Courtesy of Michael Repka, MD

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CPT 92137: FAQs

What are the frequency limitations?	Is fundus photography (CPT code 92250) bundled?	What are the covered ICD-10 codes? • MACs starting to publish LCAs
Some payers are denying as experimental. Medicare is sending ADRs. • Other denials: item 17	If OCT is performed on one eye and OCT-A on the fellow eye, is it appropriate to bill 92137?	What are the requirements for the test interpretation?

92137 added to 2025 CMS DHS list – what does that mean?

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2025 MPFS: Atlanta, GA

As of February 20, 2025

New Patient

E/M	Office	RVU
99202	$ 70.05	2.16
99203	$ 109.51	3.37
99204	$ 164.13	5.05
99205	$ 216.88	6.67
Eye	**Office**	**RVU**
92002	$ 81.12	2.51
92004	$ 142.89	4.42

Established

E/M	Office	RVU
99212	$ 55.10	1.70
99213	$ 89.24	2.75
99214	$ 125.63	3.87
99215	$ 176.28	5.43
Eye	**Office**	**RVU**
92012	$ 85.35	2.64
92014	$ 120.92	3.74

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RVU – increase, decrease or neutral

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E/M vs Eye Visit Codes – how to choose?

1. New patient: medically relevant history, comprehensive exam, **low** MDM

E/M	
99203	$ 109.51
Eye	
92004	$ 142.89 ☑

2. New patient: medically relevant history, comprehensive exam, **moderate** MDM

E/M	
99204	$ 164.13 ☑
Eye	
92004	$ 142.89

For all payers: over **$20** difference

3. Est patient: medically relevant history, comprehensive exam, **low** MDM

E/M	
99213	$ 89.24
Eye	
92014	$ 120.92 ☑

4. Est patient: medically relevant history, problem-focused exam, **moderate** MDM

E/M	
99214	$ 125.63 ☑
Eye	
92012	$ 85.35

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February 20, 2025

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Transfer of Care Modifiers

CMS Policy Changes
New G-Code

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Existing Transfer of Care (ToC) Modifier Policy

- **Modifier -54**
  - Surgical Care Only
- **Modifier -55**
  - Postoperative Management Only
- **Modifier -56**
  - Pre-operative Management Only

Medicare always required the ToC modifiers to be appended in cases where there is a **formal documented transfer of care agreement**, that is, "in the form of a letter or an annotation in the discharge summary, hospital record, or Ambulatory Surgical Center (ASC) record".

Not new to ophthalmology! Not just for **cataracts!**

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Transfer of Care Modifier Expansion

CMS now requires the use of ToC modifiers for all 90-day global surgical codes when a practitioner plans to furnish only the surgical procedure portion of the global package (modifier 54).

Including, but not limited to, when there is a formal, documented transfer of care as under current policy, or an informal, undocumented, but expected, transfer of care).

- No change to the use of modifier –24, unrelated visit during the global period

Modifiers –55 and –56 will continue to be used when there is a documented formal transfer of care.

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G0559 Add-on Code

- G0559, *Post-operative follow-up visit complexity inherent to **evaluation and management** services addressing surgical procedure(s), provided by a physician or qualified health care professional who is **not the practitioner who performed the procedure (or in the same group practice)**, and is of the same or of a different specialty than the practitioner who performed the procedure, within the 090-day global period of the procedure(s), once per 090-day global period, **when there has not been a formal transfer of care**.*

Captures additional time and resources providing postop care when the physician did not perform the surgery or involved in a formal transfer of care agreement

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G0559 E/M Add-on Code Criteria

Documentation requires the following elements, when possible and applicable:	-Reading available surgical note to understand the relative success of the procedure, the anatomy that was affected, and potential complications that could have arisen due to the unique circumstances of the patient's operation. -Research the procedure to determine expected post-operative course and potential complications (in the case of doing a post-op for a procedure outside the specialty). -Evaluate and physically examine the patient to determine whether the post-operative course is progressing appropriately. -Communicate with the practitioner who performed the procedure if any questions or concerns arise.

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G0559 Add-on Limitations

- E/M office add-on - Not billable with Eye visit codes
- Cannot be used by the practitioner who performed the procedure
- Cannot be in the same group practice as the surgeon
- Billable only once during the 90-day global period
- Medicare Part B assigned code. Most likely not recognized/covered by other payers.
- Not billable by the surgeon or co-manager when a formal agreement is executed

Work RVU of 0.16, time 5.5 min, PE RVU of 0.08, total RVU 0.27, $8.73 national average

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Audit Excellence

Elevate your documentation

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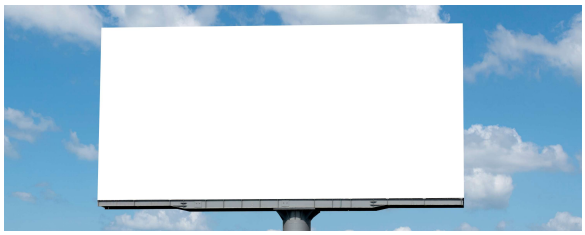

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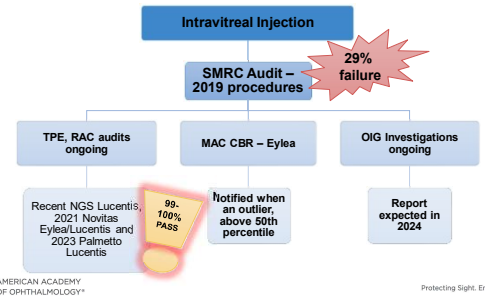
Audit Realities



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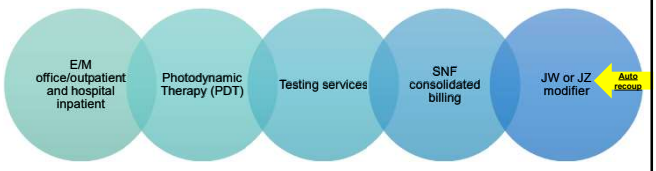
Retina Audit Targets

Expand beyond intravitreal injections



and more....

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Case #1: Vabysmo Injection

Procedure note documentation

- Vabysmo #3, RE. Diagnosis: Neovascular AMD with active CNV.
- Prep, anesthesia, RBA complete
- The lids were retracted from the injection site. Intravitreal injection of Vabysmo 6 mg was given. Injection site: intravitreal.
- Patient tolerated well. Post procedure instructions given.
- Lot #, expiration date and inventory ID documented

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Be the Auditor

- Great documentation?
- What's missing or incorrect?

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Case #1: Vabysmo Injection

Procedure note documentation

- Vabysmo #3, RE. Diagnosis: Neovascular AMD with active CNV.
- Prep, anesthesia, RBA complete
- The lids were retracted from the injection site. Intravitreal injection of Vabysmo 6 mg was given. Injection site: intravitreal.
- Patient tolerated well. Post procedure instructions given.
- Lot #, expiration date and inventory ID documented

?

WASTAGE? Residual medication less than 1 unit was discarded

Is this complete? 3-4 mm from limbus

Volume in ML? Vial, sample or prefilled syringe?

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Vabysmo 6 mg/0.05 mL

Medication type	NDC in 5-4-2 format (11 digits)
Single-dose vial with needle	50242-0096-01
Single-dose vial	50242-0096-03
Single-dose prefilled syringe with injection filter needle	50242-0096-06

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Audits Realties

Focus of SMRC, TPE, CERT and OIG investigations

29% failure

Review LCDs/LCAs

Utilize the Academy Intravitreal Injection checklist

aao.org/retinapm

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Audit Realities

Evaluation and Management (E/M)

Noridian TPE - 99215

(April 1, 2024 - June 30, 2024)

56% failure

Documentation does not support the medical necessity of the level of service billed

Documentation did not include a valid signature and a response to attestation or signature log request was not received

Failure to return records

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E/M Level 5

Pitfalls to avoid:

- Blinding disease in the future
  - Must be as assessed during the encounter today
- "Severe" disease
- Emergent vs urgent surgery –
  - **Decision for RD surgery are not all level 5**

Must meet 2 of 3 categories

- Illness that poses a threat to body function, with treatment in the near term (problem) or the patient will go blind or have severe vision loss, today
  - Decision regarding emergency major surgery (risk) or hospitalization

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Audit Realities

Evaluation and Management (E/M)

89% Minor
7% Moderate
4% Major

First Coast TPE
(Aug 2023-Feb 2024)

Novitas TPE JH and JL
(June 2023 – June 2024)

JH
59% Moderate
32% Major

JL
43% Moderate
38% Major

Documentation did not support the level of care billed.
Non-response to documentation request

Does not support medical necessity as listed in coverage requirements.

Insufficient documentation was provided to support the services as billed

Documentation supported a **higher or lower level** of medical decision making

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Final Determination Table for Medical Decision Making

To arrive at the final level of exam, 2 of 3 components (problems, data and risk) must meet or exceed the same level of complexity (straightforward, low, moderate or high).

COMPONENT	STRAIGHT-FORWARD	LOW	MODERATE	HIGH
Number and/or Complexity of Problems Addressed at the Encounter	**Minimal** 1 self-limited or minor problem	**Low** 2 or more self-limited or minor problems; **Or** 1 stable chronic illness; **Or** 1 acute, uncomplicated illness or injury; **Or** 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Moderate** 1 or more chronic illnesses with exacerbation, progression or side effects of treatment; **Or** 2 or more stable chronic illnesses; **Or** 1 undiagnosed new problem with uncertain prognosis; **Or** 1 acute illness with systemic symptoms; **Or** 1 acute complicated injury	**High** 1 or more chronic illnesses with severe exacerbation, progression or side effects of treatment; **Or** 1 acute or chronic illness or injury that poses a threat to life or body function
Amount and/or Complexity of Data to be Reviewed and Analyzed	**Minimal or none**	**Limited** 1 of 2 Categories must be met Category 1: Tests, documents, or independent historian(s). Any combination of 2 from the following: • Review of prior external note(s) from each unique source; • Review of test(s); • Ordering of each unique test; **Or** Category 2: Assessment requiring an independent historian(s)	**Moderate** At least 1 of 3 Categories must be met Category 1: Tests, documents, or independent historian(s). Any combination of 3 from the following: • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Assessment requiring an independent historian(s) **Or** Category 2: Independent interpretation of tests performed by another physician/QHP (not separately reported); **Or** Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/QHP/appropriate source (not separately reported)	**Extensive** 2 of 3 Categories must be met Category 1: Tests, documents, or independent historian(s). Any combination of 3 from the following: • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test; • Assessment requiring an independent historian(s) **Or** Category 2: Independent interpretation of tests performed by another physician/QHP (not separately reported); **Or** Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/QHP/appropriate source (not separately reported)
Risk of Complications and/or Morbidity or Mortality of Patient Management	**Minimal** Minimal risk of morbidity from additional diagnostic testing or treatment	**Low** Low risk of morbidity from additional diagnostic testing or treatment	**Moderate** Moderate risk of morbidity from additional testing or treatment. Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health	**High** High risk of morbidity from additional diagnostic testing or treatment Examples only: Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Decision regarding parenteral controlled substances
Final Determination	99202 99212	99203 99213	99204 99214	99205 99215

CPT is a registered trademark of the American Medical Association.

Source: *CPT 2025 Professional Edition*. Amer Medical Association; 2024.

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Master Retina Injections

Delve into the anatomy and coding nuances

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Pop Quiz #1

- Which code should be billed for the initial implant for Susvimo?

A. Category III code 0810T

B. CPT code 67027

C. CPT code 67028

D. CPT code 67516

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Pop Quiz #1

- Which code should be billed for the initial implant for Susvimo?

A. Category III code 0810T

B. CPT code 67027

C. CPT code 67028

D. CPT code 67516

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Access fact sheet at aao.org/retinapm

**NEW indication: DME

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Posterior Segment Injections

CPT code 67028

Where:

- Into the vitreous cavity, 3-4 mm posterior to the limbus

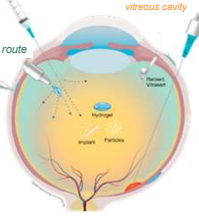
Intravitreal route

Suprachoroidal route

CPT code 67516

Where:

- Suprachoroidal space is a potential space between sclera and choroid



Intravitreal device, vitreous cavity

Subretinal route

CPT code 67027

Where:

- Sustained-release intravitreal device into the vitreous cavity
- What? Susvimo (Note: DME new indication)

CPT code 0810T

- Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies
- Why? Gene therapy (eg Luxturna)

Where:

- Subretinal space

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From Pharmaceutics | Free Full-Text | Ocular Drug Delivery to the Retina: Current Innovations and Future Perspectives (mdpi.com)

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Pneumatic Injections

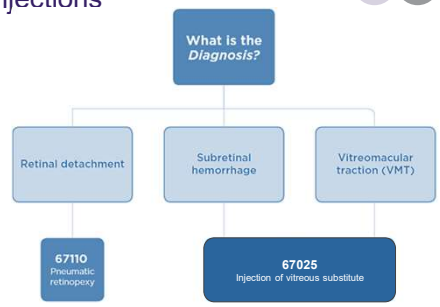
CPT code 67110

- Repair of retinal detachment; by injection of air or other gas

vs.

CPT code 67025

- Injection of vitreous substitute (fluid-gas exchange)



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Code the "What"

- Table of Common Retina Drugs
  - aao.org/retinapm

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How? Clean Claim

- CPT or Category III code
- HCPCS code
- Billing units
- National drug code (NDC)
- Indication
- Unit of measure (UOM)
- Modifiers

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Pop Quiz #2

- The unit of measure (UOM) should be reported:

A. CMS-1500, item 24a

B. ME2

C. ML0.05 (0.05 mL injected)

D. Both A and C

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Pop Quiz #2

- The unit of measure (UOM) should be reported:

A. CMS-1500, item 24a

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C. ML0.05 (0.05 mL injected)

D. Both A and C

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Unit of Measure (UOM)

- Report in item 24a of CMS-1500 after NDC
  - ML = liquids
  - Not: UN = unit, for tablets, capsules, powder filled vials. *Exception: implants*
    - *Example: Ozurdex*
- Commercial and Medicaid plans often deny (and recoup) if missing or reported incorrectly

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Why is my injection claim denied?

- Missing modifier
  - Anatomical, global, JZ or JW
- Frequency per FDA label
- ICD-10 to CPT link
- Lack of prior authorization
- Step therapy policy not followed
- Unique payer policy
- Patient eligibility

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Newer FDA-Approved Drugs and CPT codes

Drug	HCPCS	NDC 5-4-2 Format Report in item 24a	CPT code	Indication(s)
Eylea HD 8 mg/0.07 mL	J0177 -JZ, 8 units	61755-0050-01 61755-0050-51(sample)	67028	Neovascular age-related macular degeneration, diabetic macular edema, diabetic retinopathy (be aware of frequency edits)
Izervay (avacincaptad pegol) 2 mg/0.1 mL	J2782 -JZ, 20 units	82829-0002-01	67028	Geographic atrophy (GA) secondary to age-related macular degeneration
SYFOVRE (pegcetacoplan) 15 mg/0.1 mL	J2781-JZ, 15 units	73606-0020-01	67028	Geographic atrophy (GA) secondary to age-related macular degeneration
XIPERE (triamcinolone acetonide injectable suspension) 0.9 mL (40 mg/mL) Suprachoroidal use	J3299, 4 units J3299-JW, 32 units	71565-0040-01	Eff 1/1/24 67516 0465T deleted 12/31/23	Macular edema associated with uveitis Procedure note should include dose and wastage: 4 mg/0.1 mL was injected, and 32 mg/0.8 mL was wasted from the single-dose vial labeled as 0.9 mL (40mg/ml) of medication from one tray included in the Xipere carton.

Visit aao.org/retinapm for updates.

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Recent Anti-VEGF and GA Therapy Challenges

- The Academy and ASRS fight dual administration claim denials
  - February 20, 2025
- Advocacy Works!
  - March 4: CMS responded and confirmed system edits were added for Syfovre and after reconsideration is removing the edit.

The Academy and the American Society of Retina Specialists (ASRS) sent letters to the Centers for Medicare & Medicaid Services (CMS) and Medicare administrative contractors (MACs) this week regarding recent claim denials for dual administration of geographic atrophy and anti-vascular endothelial growth factor (anti-VEGF) drugs.

Members recently reported that that all seven MACs have denied claims for geographic atrophy and anti-VEGF drugs when Medicare patients are treated with both types of drugs. The denied claims appear to be for injections of both drugs within 25 days of each other, but the reasoning behind the denials is unclear, and our members have received conflicting rationales when appealing the denials.

In addition to seeking clarity for the claim denials, our joint letters emphasized the medical necessity of both complement factor inhibitor drugs and anti-VEGF injections in treating geographic atrophy and exudative age-related macular degeneration, respectively. We urged for the reversal of the previously denied claims and called for edits to be published to the public for review prior to taking effect so that care can be managed prospectively.

We will continue to engage with CMS and the MACs on this issue to ensure ophthalmology patients have access to sight-saving treatments.

https://www.aao.org/advocacy/eye-on-advocacy-article/fight-dual-administration-claim-denials

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Aflibercept Biosimilars

Yesafili (aflibercept-jbvf): Biocom Biologic	Opuviz (aflibercept-yszy): Samsumg Bioepis	Ahzantive (aflibercept-mrbb): Klinge Biopharma	Enzeevu (aflibercept-abzv): Sandoz	Pavblu (aflibercept-ayyh): Amgen
5/24	5/24	7/24	8/24	8/24

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New Drug Treatment Checklist

Review
Review FDA label for indications and frequency

Identify
Identify any published payer policies

Setup
Electronic chart templates, PM libraries

Report
Report with NOC HCPCS code, (J3490 or J3590) until assigned a permanent code

Include
Include on CMS-1500:
- Item 19: medication name, dosage in mg/mL
- Item 24a: NDC in 5-4-2 format and unit of measurement (UOM) (e.g. ML0.05)

Monitor
Monitor remittance advices for appropriate payment

EyeNet Practice Perfect: How to Add a New Retina Drug to Your Practice
https://www.aao.org/eyenet/article/how-to-add-a-new-retina-drug-to-your-practice

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Pop Quiz!

Coding Competency Challenge

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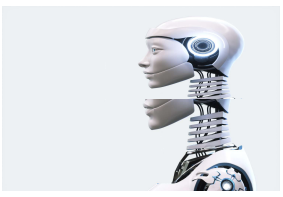
Competency #1



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Competency #1

- How would you find the answer to this question?

A. Google it
B. Look up NCCI edits on CMS website
C. Confirm in Retina Coding or Coding Coach
D. B or C
E. All of the above

Is CPT code 67036 bundled with 66850?

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Competency #1 AI Answer

- Is this correct?

AI Overview

According to the American Academy of Ophthalmology (AAO), **yes, CPT code 67036 (pars plana vitrectomy) is bundled with 66850 (removal of lens material by phacoemulsification)**, meaning if you perform both procedures together, you typically only bill for the vitrectomy code (67036) as the lens removal is considered included in the vitrectomy procedure; you would not separately bill 66850 in most cases.

Key points to remember:

Bundling:
This bundling is due to the National Correct Coding Initiative (NCCI) rules, which state that certain procedures performed together are considered one procedure for billing purposes.

When to use 66850:
You would only use 66850 separately if you are removing lens material during a vitrectomy procedure where an intraocular lens (IOL) is not being placed.

Consult with a coding expert:
Always consult with a qualified medical coder to ensure you are accurately billing for complex surgical procedures involving both vitrectomy and lens manipulation.

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Competency #1 AI Answer

- Is this correct?
- No!

AI Overview

According to the American Academy of Ophthalmology (AAO), **yes, CPT code 67036 (pars plana vitrectomy) is bundled with 66850 (removal of lens material by phacoemulsification)**, meaning if you perform both procedures together, you typically only bill for the vitrectomy code (67036) as the lens removal is considered included in the vitrectomy procedure; you would not separately bill 66850 in most cases.

Key points to remember:

Bundling:
This bundling is due to the National Correct Coding Initiative (NCCI) rules, which state that certain procedures performed together are considered one procedure for billing purposes.

When to use 66850:
You would only use 66850 separately if you are removing lens material during a vitrectomy procedure where an intraocular lens (IOL) is not being placed.

Consult with a coding expert:
Always consult with a qualified medical coder to ensure you are accurately billing for complex surgical procedures involving both vitrectomy and lens manipulation.

Question: Our retina specialist performed a lensectomy with an insertion of intraocular lens. What is the correct coding?

Answer: Additional clarification from the operative report is necessary to confirm which of the following options is best:

- When a dislocated IOL is removed and replaced, along with a pars plana vitrectomy, submit CPT codes 66986 IOL exchange and 67036 Pars plana vitrectomy.
- If the retina specialist removed remaining fragments of the natural lens (CPT code 66850), inserted an IOL, CPT code 66985 (patient is aphakic) and performed a pars plana vitrectomy, submit CPT codes 67036 Pars plana vitrectomy and 66850. CPT code 66850 Removal of lens material is bundled with 66985 Secondary IOL and has the higher RVU.
- If the retina specialist removed the natural lens and inserted an IOL, submit CPT code 66984 Cataract surgery with IOL

Learn more about billing multiple procedures in the Retina Coding: Complete Reference Guide.

https://www.aao.org/practice-management/news-detail/cpt-code-lensectomy-iol-insertion

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Competency #1

- How would you find the answer to this question?

A. Google it

B. Look up NCCI edits on CMS website

C. Confirm in Retina Coding or Coding Coach

D. B or C – go directly to a trusted source!
   - Avoid "hallucinations"

E. All of the above

Is CPT code 67036 bundled with 66850?

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Competency #2

62 year old male s/p uncomplicated vitrectomy/laser/gas for RD (**67108**-RT)

1 month after surgery detachment recurs with extensive PVR
- Gets surgery with PPV/Scleral buckle/membranectomy/laser/gas

Does well, but 2 weeks later a new detachment with PVR develops
- Gets surgery with PPV/membranectomy/laser/oil

Does well, but 3 weeks later a new detachment with PVR develops
- Gets PPV/retinectomy/membranectomy/laser/oil

Case courtesy of Robert Beardsley, MD

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Competency #2A

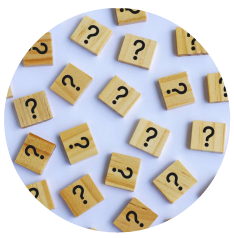
- CPT code for retina surgeries #2-4

A. 67108

B. 67110

C. 67113

D. 67036



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Competency #2A

- Retina surgeries #2-4

A. 67108

B. 67110

C. 67113

D. 67036

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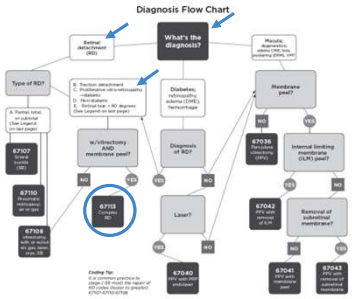
Complex RD



2025 Retina Coding: Complete Reference Guide

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Competency #2B

- Surgery #1 67108
- Surgery #2 67113
  - Which modifier in addition to -RT?

A. 58

B. 78

C. 79

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Competency #2B

- Surgery #1 67108
- Surgery #2 67113
  - Which modifier in addition to -RT?

A. 58 – lesser to greater

B. 78

C. 79

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Competency #2C

- Surgery #1 67108-RT
- Surgery #2 67113-58-RT
- Surgery #3-4
  - Which modifier in addition to -RT?

A. 58

B. 78

C. 79

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Competency #2C

- Surgery #1 67108-RT
- Surgery #2 67113-58-RT
- Surgery #3-4 67113
  - Which modifier in addition to -RT?

A. 58

B. 78

C. 79

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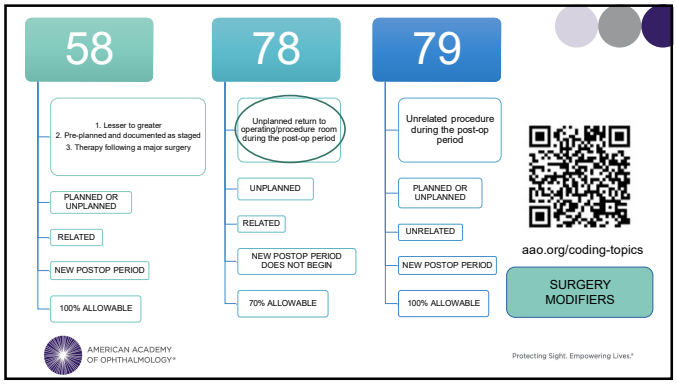
58
1. Lesser to greater
2. Pre-planned and documented as staged
3. Therapy following a major surgery
PLANNED OR UNPLANNED
RELATED
NEW POSTOP PERIOD
100% ALLOWABLE
78
Unplanned return to operating/procedure room during the post-op period
UNPLANNED
RELATED
NEW POSTOP PERIOD DOES NOT BEGIN
70% ALLOWABLE
79
Unrelated procedure during the post-op period
PLANNED OR UNPLANNED
UNRELATED
NEW POSTOP PERIOD
100% ALLOWABLE
aao.org/coding-topics
SURGERY MODIFIERS
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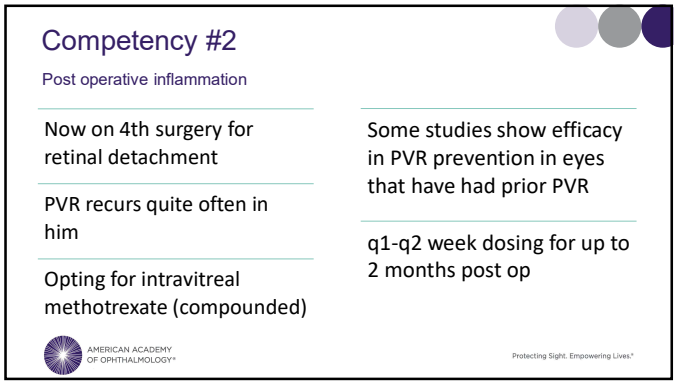
Competency #2
Post operative inflammation
Now on 4th surgery for retinal detachment
PVR recurs quite often in him
Opting for intravitreal methotrexate (compounded)
Some studies show efficacy in PVR prevention in eyes that have had prior PVR
q1-q2 week dosing for up to 2 months post op
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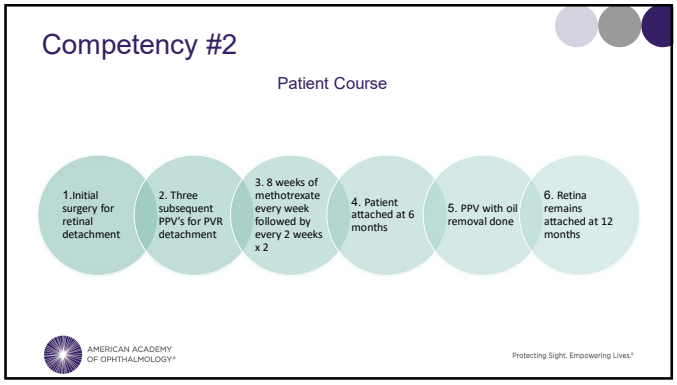
Competency #2
Patient Course
1.Initial surgery for retinal detachment
2. Three subsequent PPV's for PVR detachment
3. 8 weeks of methotrexate every week followed by every 2 weeks x 2
4. Patient attached at 6 months
5. PPV with oil removal done
6. Retina remains attached at 12 months
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Competency #2D

- Intravitreal injection of compounded methotrexate
- Correct coding:

A. 67028 -RT, J9260-JZ 1 unit, single-use vial

B. 67028 -RT, J9260, 1 unit, J9260-JW, 1 unit

C. 67028 -RT, J9260-JZ 8 units

D. 67028 -RT, J7999-JZ, compounded

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Competency #2D

- Intravitreal injection of compounded methotrexate
- Correct coding:

A. 67028 -RT, J9260-JZ 1 unit, single-use vial

B. 67028 -RT, J9260, 1 unit, J9260-JW, 1 unit

C. 67028 -RT, J9260-JZ 8 units

D. 67028 -RT, J7999-JZ, compounded
   - What else? CMS-1500
   - Consent? Off-label
   - Frequency?

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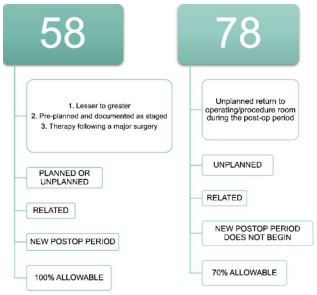
Competency #2D

- Are we missing a modifier?
- Injection was performed in the global period of the complex RD surgery.
- 58 or 78?



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Methotrexate

Table of Common Retina Drugs

- Compounded
  - J7999-JZ
- Single-dose vial
  - J9260-JZ
  - Methotrexate, 50 mg

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Table of Common Retina Drugs

Lucentis®	3 units	Diabetic retinopathy, diabetic macular edema	J2778	JZ
Lucentis®	5 units	Wet age-related macular degeneration, macular edema following retina vein occlusion, myopic choroidal neovascularization	J2778	JZ
Methotrexate (MTX)	1 unit for 50 mg or less *J9250 deleted from ASP pricing effective 4/1/24	Off-label use for ophthalmology** Used for specific ocular inflammatory conditions, including uveitis secondary to systemic disease	J9260	JZ
Ozurdex®	7 units	Macular edema following retina vein occlusion, diabetic macular edema, Non-infectious uveitis affecting the posterior segment	J7312	JZ

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G2211 Checklist

Verify payer coverage.	
Office/outpatient E/M visit.	
Modifiers 24, 25, or 53 are not billed on the same day	
Primary reason for the visit is a single, serious or complex condition.	•Chronic uveitis, diabetic retinopathy, AMD, etc.
Not an acute or time limited condition resolved with intervention	•E.g. RD, macular hole, ERM
The physician is providing ongoing medical care for this condition.	•Established physician-patient relationship
Documentation supports the use of G2211.	•*Collaborative care plan for each unique patient encounter including patient education, shared decision-making around therapeutic goals and commitments to achieve those goals. to support visit complexity and the physician-patient relationship*

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Academy Resources

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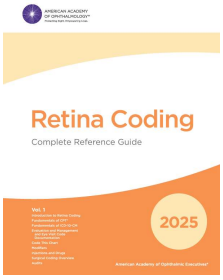
- aao.org/audits
- aao.org/coding
- aao.org/em
- aao.org/lcds
- aao.org/consulting



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Retina Practice Management & Coding

- Intravitreal Injection Checklist
- Modifier JW and JZ Fact Sheet
- Table of Common Retina Drugs
- Medication Inventory Management
- And more!

Work smarter, not harder!

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Questions?

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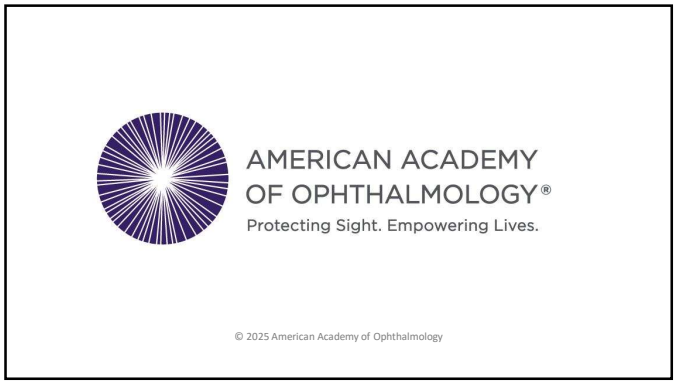
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