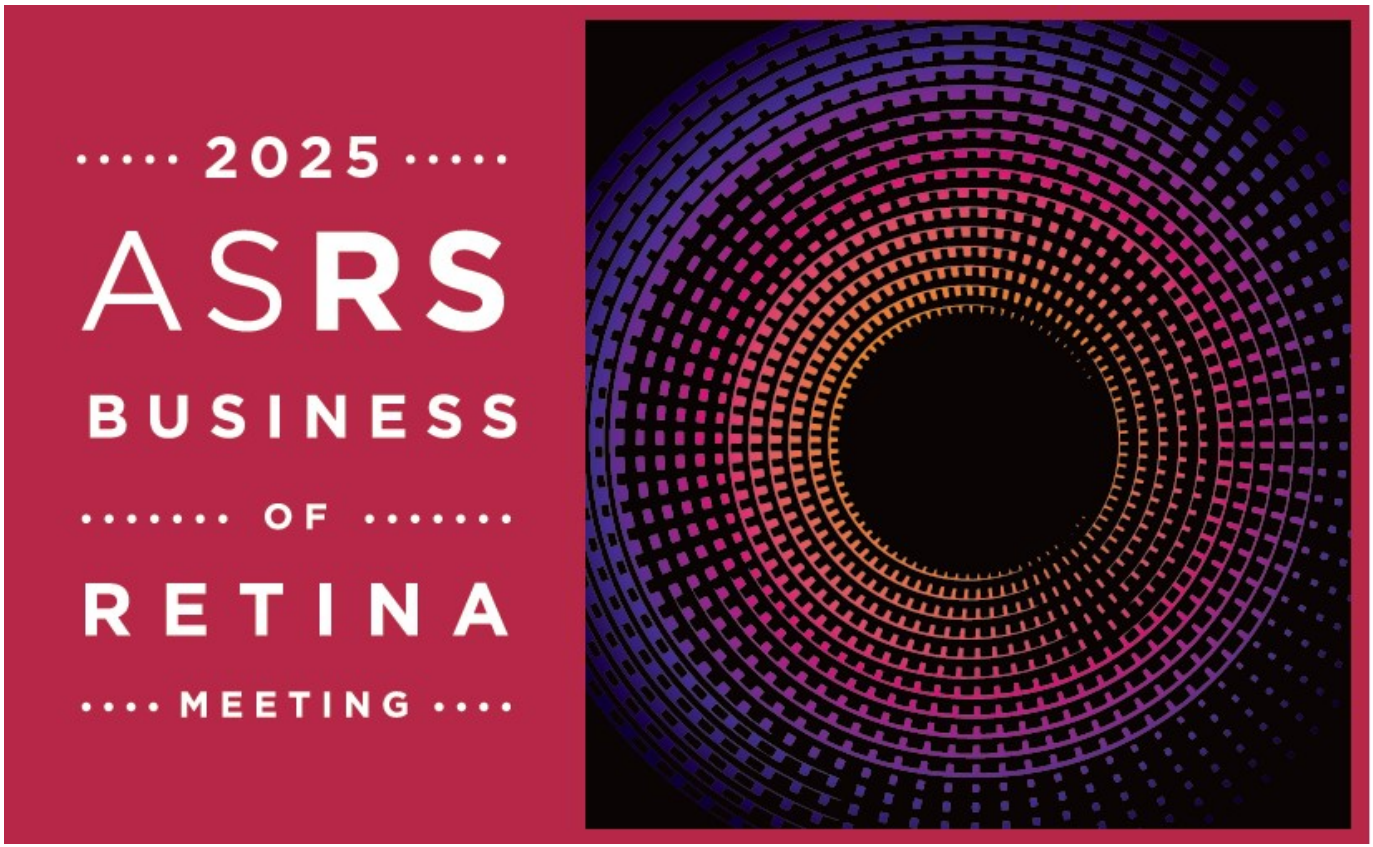


2025 American Society of Retina Specialists Business of Retina Meeting Fellows Seminar Handout Book

Table of Contents .....

JOINING A PRACTICE

THE INFLUENCE OF PRIVATE EQUITY

Thomas Stone, MD
Retina Associates of Kentucky

ASRS Business of Retina

March 28, 2025

1

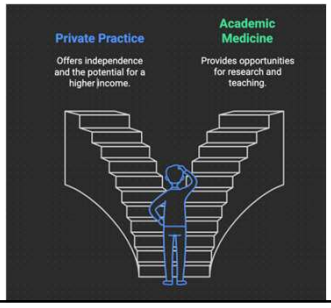
Financial Disclosures

Company	Relationship	Has Ended?
Regeneron	Advisory Board Member	Has not ended
Genentech	Advisory Board Member	Has ended
Alcon	Advisory Board Member	Has ended
Ocular Therapeutix	Advisory Board Member	Has ended
Beyeonics	Consultant	Has ended
Alimera	Advisory Board Member	Has ended
Vortex surgical	Stock Private	Has not ended
Evolve Medical Education	Speaker Bureau	Has ended

- Member of a private practice group acquired by Private Equity in 2021

2

The Traditional Pathway



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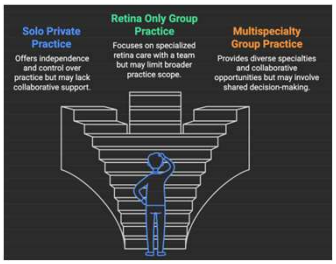
Private Practice



- Any of these can join with Private Equity

4

By The Numbers

- 2022: 8% Ophthalmology in PE
- 2024: Over 35 Organizations
- Particular interest in Retina Injectables

A 2019 study identified 3,113 retina providers in the US, consisting of 2,113 retina specialists and 1,000 comprehensive ophthalmologists who also perform retina procedures (referred to as "hybrid providers")[5]. However, it's worth noting that this data is now several years old and the numbers have likely increased since then, given the growth trend in the industry.

5

The Typical View of PE

ORIGINAL ARTICLE · Volume 132, Issue 2, Pages 158, February 2025 · Download Full Issue

Increases in Medicare Spending and Use after Private Equity Acquisition of Retina Practices

Yashaswini Singh, PhD, MPA [1] · Christopher M. Adamson, MD [2] · Zirui Song, MD, PhD [3] · Daniel Polsky, PhD, MPP [1,4] · Jane M. Zhu, MD, MPP [5,6] ⊠

Affiliations & Notes · Article Info · Linked Articles

Managed Healthcare Executive

News · Media · Conferences · Partners · Publications · Events · CME/CE · Resources

"Your staff will always view the PE (private equity) sale as harmful to them," argued Richard S. Kaiser, M.D., a retina surgeon at the Wills Eye Hospital in Philadelphia. "They will not be motivated to work as hard for you or the practice. Junior partners feel universally betrayed by sale."

When it came time for the AAO audience to vote on who won the debate, Kaiser prevailed by a wide margin, 91% vs. 9% over the private equity's proponent, David M. Brown, M.D., an officer and stockholder in Retina Consultants of America, one of the largest private equity-owned retina groups in the country, which lists 104 locations on its website.

6

Types of Private Equity Entities

- Traditional Private Equity with or without prior healthcare assets
- Management Service Organizations (MSOs)
- Platform Companies
- Secondary Strategics with Eyecare Experience
  - This is mainly what we're seeing in this space

7


BECKER'S
ASC REVIEW

10 private equity giants behind the ophthalmology industry

Claire Wallace - Wednesday, May 10th, 2023

Ten private-equity backed giants control over 300 ophthalmology practices nationwide, having a major hand in the industry. Here are the 10 largest private equity companies in ophthalmology:

1. Blue Point Capital Partners is a private equity firm and a value-added partner that provides business growth solutions. Blue Point controls several eyecare brands, including reading glasses company Eyebobs and eyewear frame designer Europa Eyewear.

2. Ascend Vision Partners is a private equity fund offering operational, administrative, revenue cycle and marketing services to its 11 practices in the Southeast.

3. Retina Consultants of America is the largest retina care provider in the nation, managing over 220 physicians at 200 practices across 20 states.

4. Prism Vision Group is an integrated eye care organization that affiliates with independent eye practices to strengthen them. It is affiliated with 22 practices on the East Coast.

5. Eyesouth Partners is a private-equity-backed management firm with 35 affiliated practices and 290 physicians across 100 locations.

6. Vision Integrated Partners is a private-equity-backed medical and ASC management company. It has 23 practices and 12 ASCs across 56 locations.

7. Unifeye Vision Partners provides growth opportunities for its partners. It has 17 ophthalmology and ASC partners nationwide.

8. Sight360 is a multidisciplinary team providing services for its 16 vision care centers and nine ophthalmologists across Florida.

9. EyeCare Partners is a physician-led, private-equity-backed management organization with 65 ophthalmology and optometry practice partners nationwide.

10. Advancing Eyecare is backed by private equity firm Atlantic Street Capital. It has one of the largest portfolios of ophthalmic products and instruments in the U.S.

- EYECARE PARTNERS
- RETINA CONSULTANTS OF AMERICA
- EYESOUTH PARTNERS
- PRISM Vision Group®

8

My Background

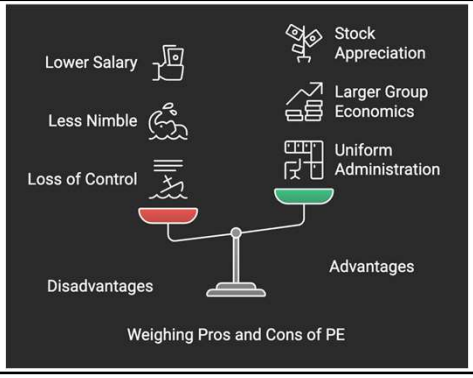
- Training
- Retina Only Private Practice 2002
  - 4 Retina Surgeons RETINA ASSOCIATES OF KENTUCKY
  - Expanded Clinically 2013-2020 to 8
- Acquired by EyeCare Partners 2021

9

Why Should You Care?

- Will I have control over my practice?
  - Schedule, locations, staffing, equipment
  - How much control do I want?
- What is my potential income?
  - Salary and benefits
  - Capital appreciation

10



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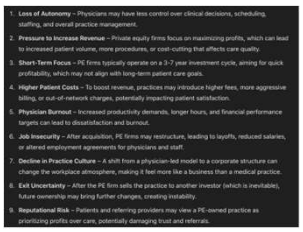
Disadvantages of Private Equity

- Disadvantages
  - Loss of administrative control
  - Less nimble
  - Lower salary

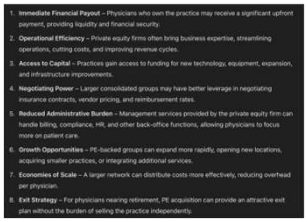


1. **Loss of Autonomy** – Physicians may have less control over clinical decisions, scheduling, staffing, and overall practice management.
2. **Pressure to Increase Revenue** – Private equity firms focus on maximizing profits, which can lead to increased patient volume, more procedures, or cost-cutting that affects care quality.
3. **Short-Term Focus** – PE firms typically operate on a 3–7 year investment cycle, aiming for quick profitability, which may not align with long-term patient care goals.
4. **Higher Patient Costs** – To boost revenue, practices may introduce higher fees, more aggressive billing, or out-of-network charges, potentially impacting patient satisfaction.
5. **Physician Burnout** – Increased productivity demands, longer hours, and financial performance targets can lead to dissatisfaction and burnout.
6. **Job Insecurity** – After acquisition, PE firms may restructure, leading to layoffs, reduced salaries, or altered employment agreements for physicians and staff.
7. **Decline in Practice Culture** – A shift from a physician-led model to a corporate structure can change the workplace atmosphere, making it feel more like a business than a medical practice.
8. **Exit Uncertainty** – After the PE firm sells the practice to another investor (which is inevitable), future ownership may bring further changes, creating instability.
9. **Reputational Risk** – Patients and referring providers may view a PE-owned practice as prioritizing profits over care, potentially damaging trust and referrals.

12

Advantages of Private Equity

- Control
  - Uniform administration
  - HR issues, Coding/billing issues
- Financial
  - Larger group economics
    - Drugs, equipment and supplies
  - Appreciation of Stock



1. **Immediate Financial Payout** – Physicians who own the practice may receive a significant upfront payment, providing liquidity and financial security.
2. **Operational Efficiency** – Private equity firms often bring business expertise, streamlining operations, cutting costs, and improving revenue cycles.
3. **Access to Capital** – Practices gain access to funding for new technology, equipment, expansion, and infrastructure improvements.
4. **Negotiating Power** – Larger consolidated groups may have better leverage in negotiating insurance contracts, vendor pricing, and reimbursement rates.
5. **Reduced Administrative Burden** – Management services provided by the private equity firm can handle billing, compliance, HR, and other back-office functions, allowing physicians to focus more on patient care.
6. **Growth Opportunities** – PE-backed groups can expand more rapidly, opening new locations, acquiring smaller practices, or integrating additional services.
7. **Economies of Scale** – A larger network can distribute costs more effectively, reducing overhead per physician.
8. **Exit Strategy** – For physicians nearing retirement, PE acquisition can provide an attractive exit plan without the burden of selling the practice independently.

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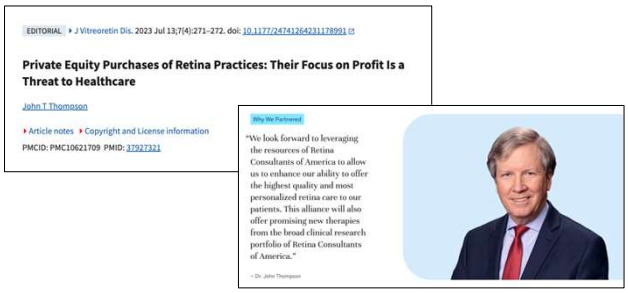
The Debate



EDITORIAL ▸ J Vitreoretin Dis. 2023 Jul 13;7(4):271–272. doi: 10.1177/24741264231178991

Private Equity Purchases of Retina Practices: Their Focus on Profit Is a Threat to Healthcare

John T Thomason

▸ Article notes ▸ Copyright and License information

PMCID: PMC10621709 PMID: 37927321

Why We Partnered

"We look forward to leveraging the resources of Retina Consultants of America to allow us to enhance our ability to offer the highest quality and most personalized retina care to our patients. This alliance will also offer promising new therapies from the broad clinical research portfolio of Retina Consultants of America."

– Dr. John Thompson

14

Your Decision

- Geography
- Family Considerations
- Reputation of the Group
- Position within the Group
- Financial Considerations

15

More Considerations

- If I join a private practice, will it be acquired by Private Equity?
- If I join a Private Equity owned practice, what are my opportunities for getting stock?

16

My Opinion

- The best PE practice is better than most Private Practices
- Former Fellows Experience
- RAK Experience
  - Pros: Admin help, larger group
  - Cons: Not as nimble, unsure financial

17

Thank You

18

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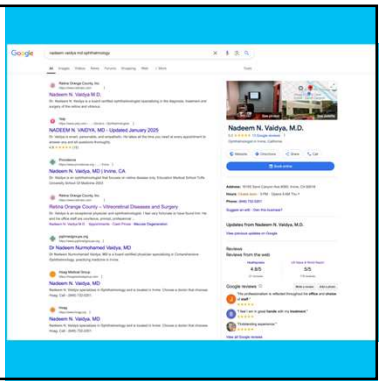
NADEEM N. VAIDYA, M.D., RETINA ORANGE COUNTY, INC. ASRS BUSINESS OF RETINA 2025 - FELLOW'S SEMINAR

MARKETING FOR THE GRADUATING FELLOW

1

TAKE CONTROL - SEARCH ENGINE PRESENCE

- Google Thyself!
  - Search Engine Thyself!
  - Don't Stop at Page 1 …
- Google My Business
- Government Registration
  - PECOS
  - NPI
- Doximity
- Review Websites
  - Healthgrades
  - WebMD
  - Vitals

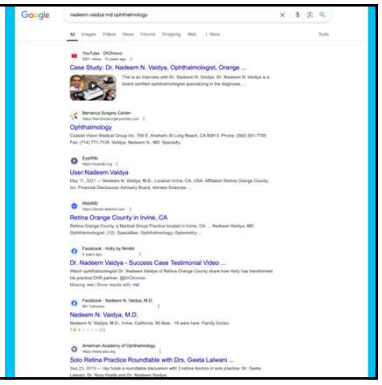


2

TAKE CONTROL- SOCIAL MEDIA

- Doximity
- Facebook
- Instagram
- X
- Other

- Plant your flag
  - Physician not influencer



3

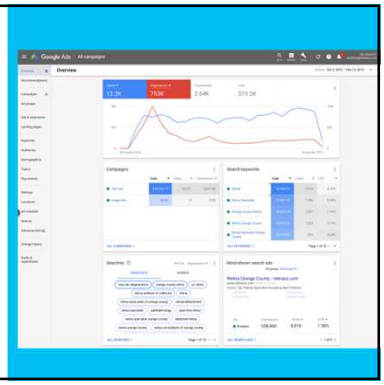
ADVERTISING

- 3 A's - availability, affability, ability
- Word of mouth is great, but takes time
  - Reviews help a great deal (more on this later)
- Cultivating referral sources important, but difficult to change referral patterns without being established, or without word of mouth
- Direct mail is difficult to monetize/analyze
- Advertising
  - Google Ads
  - Bing Ads
  - ? Facebook Ads

4

ADVERTISING - GOOGLE

- Efficiency
  - 1-2% click rate is excellent
  - Extremely cost effective
    - Roughly a 10 to 1 return on investment
    - Easy to analyze metrics
    - Target certain key demographics
- Don't just use the keywords Google suggests
  - Aim for keywords that people would actually use



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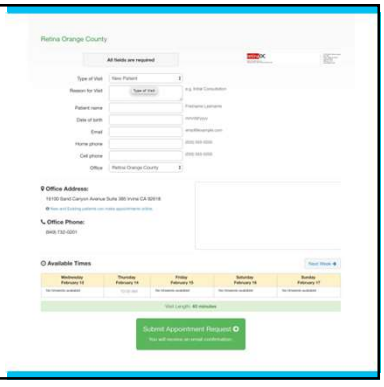
PATIENT ACQUISITION

- Appointments
  - Practice Management system integration with your website
  - Direct patients there straight from Google search



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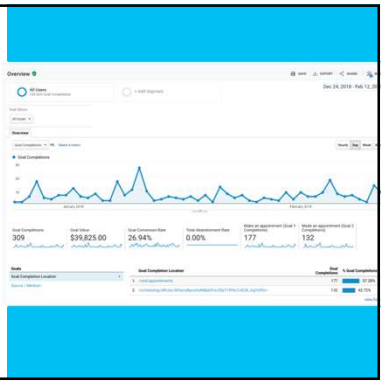
EFFICIENCY - ANALYTICS

- Create goals to see what patients do on your site
  - How many follow through to make an appointment
  - How many are visiting certain pages?



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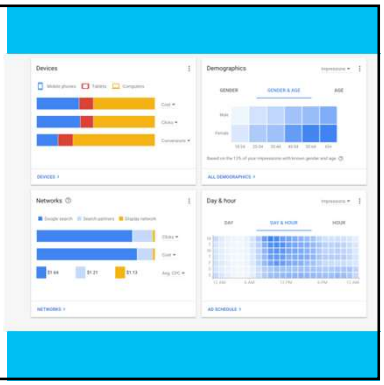
ANALYTICS AND DEMOGRAPHICS

- Learn who is coming to your website and from where
  - Continue to target key demographics and efficient sources of search volume
  - Greater efficiency of mobile search - make sure your webpage is mobile friendly



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Know what people are searching for and what they want, and where they coming from to further increase the efficiency of each dollar spent

9

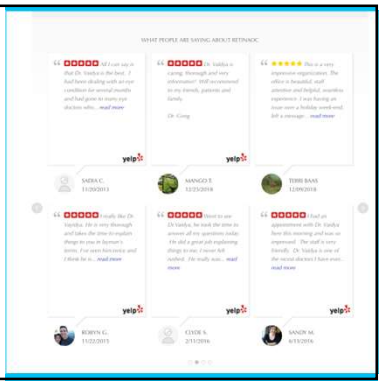
ADVERTISING - FACEBOOK

- Micro-targeting
- Do enough old people use Facebook, Instagram, Whatsapp?

10

REPUTATION

- Reviews, reviews, reviews
  - Quality over Quantity
  - Prompt every patient
  - Filter good reviews to Yelp, Google, Facebook, Healthgrades, Vitals, etc.
  - WP Review Slider Pro
  - DemandForce, SolutionReach, etc.



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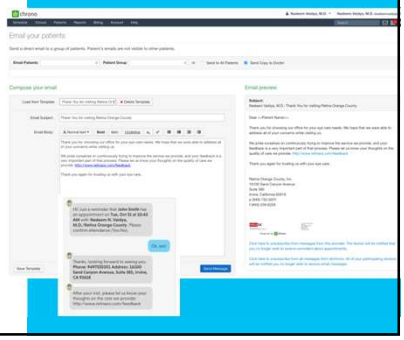
ENCOURAGING REVIEWS

- Prompt every patient
  - Every patient gets an email generated from my EMR the week after their visit
  - Every reminder text comes with a feedback link



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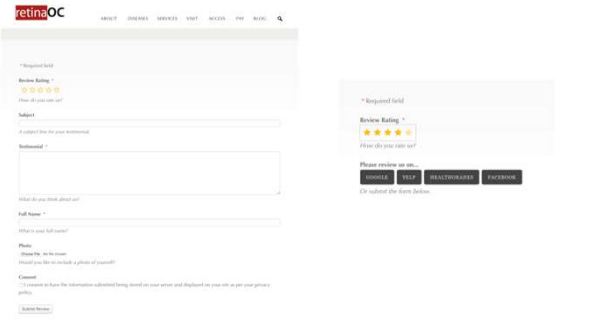

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AUTOMATED REMINDERS

- Reduce no show rate by 72%
- Get confirmation for appointments with active patient input
- Reduce staff time making calls
  - Patients screen calls
- If you give patients the opportunity to cancel, will they cancel at a higher rate?
  - Generally, no
  - Plan with certainty for walk-ins
  - Inform patients of the opening

14

CANCELLED APPOINTMENTS

- When a patient cancels how do you fill the slot?
  - Automated wait list apps text patients with appointments that match the cancelled appointment type
  - Limits prevent revisits within a certain time frame
  - All without human intervention

15

IN PERSON VISITS

- 3A's
- Visit your local PCPs, optometrists, ophthalmologists
- Do CE talks
- Do talks to patients where they are
- Always remember to bring treats…it's hard to get past the front desk without them

16

CONCLUSION

- Marketing is hard starting out
- Investments made now will pay off in the future
- Direct to patient marketing is underutilized in retina
- Direct to physician marketing is thought of as the cornerstone but is the hardest, and should be thought of as the last option

17

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

BOR 2025:
Practice Structures & Compensation
What are you getting into?

Tushar Ranchod, MD

1

What will we cover today?

- Legal structures of retina practices
  - Corporations, partnerships, management services organizations
  - **What happens when you "buy in" to one of these?**
- Compensation structures
  - **What are the various structures you may encounter?**
- Benefits and how to value them
  - Disability and parental leave
  - Health insurance and retirement benefits
  - **How should you value these?**

2

2

Legal Structures of Retina Practices

- Practicing physicians need the legal protection of a corporation
  - Safeguard personal assets from (some) liabilities of professional work.
- **Associate physicians** are usually employees
  - Corporate structure has little impact on compensation or liability protection.
- Once you become a **partner**, corporate structure matters for:
  - Taxation
  - Benefits
  - Ownership and rights

3

3

Private Practice: Solo

- Sole owner of a Professional Corporation.
  - **C Corporation**: default type of corporation
    - Taxes are paid on profit, separate from the owner's income tax
    - Double taxation is avoided if the C Corp has no profit at year-end
  - **S Corporation**: election at the time of incorporation
    - Taxes are passed through to the owner, not paid at the corporate level
  - **Limited Liability Corporation**
    - Simpler requirements than a Corporation, flexible in how profits are shared
    - Can be taxed like an S Corporation
    - Not allowed in California for physicians
- No difference between structures regarding business expenses
  - Payroll, vendors, etc.

4

4

Private Practice: Group

- **C Corporation:**
  - Profit left in the corporation at year-end is taxed at corporate level. If this money is later distributed to owners, it gets taxed again!
  - Significant planning may be required to flush all profit out at year-end, in order to avoid corporation taxation.
  - Allows for multiple share classes (matters more for complex practice structures)
- **S Corporation:**
  - No taxation of income/profit at the corporate level, so double taxation if money left in corp at year-end.
  - Profit left in the corporation at year-end is taxed at the individual owner level, pro rata by ownership
  - Can only have one share class
- **Limited Liability Corporation**
  - Less formality than a corporation; can lead to problems when owners disagree, so need a very well written operating agreement
  - Ownership (membership interest) can be defined as percentage of the LLC or something more complex; more flexible than Corporation in which ownership is defined by shares of stock.
  - Multi-member LLC may be taxed as a partnership, which is more complex. May elect S-corp taxation in some cases.
  - Not allowed in California for physicians
- **Partnership**
  - Physician autonomy: can be as conservative or aggressive as desired with benefits of various kinds.
  - Partnership of corporations (partnership of individuals would provide no corporate protection!).

Note: For all structures above, assets at risk are limited to those in the corporation (in a partnership of corporations, includes assets in the partner corporations).

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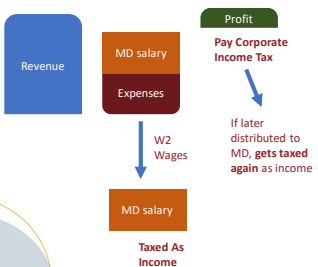
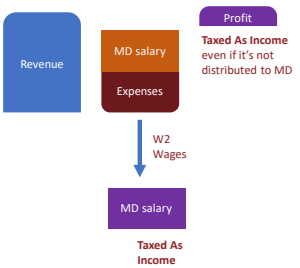
5

C Corp



S Corp



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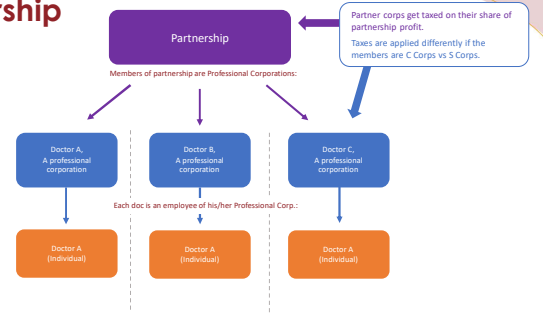
Partnership



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C Corporation: Money & control

- C Corp
  - Physician partners own 100%, control decisions
  - Income from medical service and drug receivables
  - Expenses for payroll, services, drug payables, other overhead
  - If profit is retained in the Corporation, it's taxable
  - Minimal taxes paid by the Corp if no profit left after paying owner
- Owner
  - Gets a W-2 and benefits as an employee of the C Corp
  - Owner pays income tax on compensation received from the Corp

8

8

S Corporation: Money & control

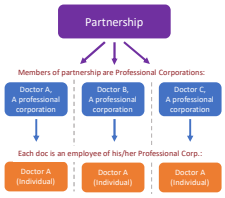
- C Corp
  - Physician partner owns 100%, controls decisions
  - Income from medical service and drug receivables
  - Expenses for payroll, services, drug payables, other overhead
  - If profit is retained in the Corporation, it's not taxed at this level
- Owner
  - Gets a W-2 and benefits as an employee of the C Corp
  - Owner pays tax on income including income left in the corporation (i.e. taxable amount doesn't depend on how much of the profit is paid to the owner)

9

9

Partnership of Corps: Money & control

- **Partnership of S Corps**
  - Owned by physician partners who make the practice decisions
  - Income from medical service and drug receivables
  - Expenses for payroll, services, drug payables, other overhead
  - Profit is distributed to the partners (in this case the partner corporations)
- **Each S Corp**
  - Physician owns 100% of his/her S Corp
  - Money comes in from partnership, goes out via payroll to the owner
  - No taxation at this level
  - Physician controls expenses that are reimbursed by his/her S Corp
- **Individual Physician**
  - Gets a W-2 and benefits as an employee of the S Corp
  - Owner pays taxes based on K-1 and W-2
  - Taxable income is based on profitability at the Partnership level



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10

Management Service Organization (MSO) Model

- MSO entity is typically an LLC or limited partnership.
- MSO has contracts with physician practices (and other entities such as ASCs) for their services.
- The MSO charges management fees from the other entities and has operating agreement with them.
- The physician practices remain intact as legal entities providing medical services.
- Employees and services can remain in the physician practices or can be centralized at the MSO level.

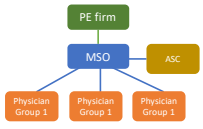
11

11

MSO: MD vs PE-owned

PE-owned MSO
- Jointly owned by PE firm (majority) and physicians.
- MSO typically provides all services to run the practice.
- Long term contracts
- Usually larger scale than non-PE MSOs

MD-owned MSO (non-PE)
- MSO may provide more limited services such as RCM, rather than full scope.



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12

When you buy into a practice, what happens?

A. You become an **equal equity owner**, or…
B. You become a **"junior" owner** without full owner rights
   - There are many variations…

What are the possible forms of a "buy-in" to partnership?
- **Reduction of income** which is redistributed to other partners
  - Reduction could be a percentage or a fixed dollar amount
- **Purchase of a share** of hard assets
  - Objective calculation of cash and other assets on the balance sheet

13

13

Compensation Structures

- **How much of your own productivity do you get?**
  - 100% productivity-based = "eat what you kill"
  - 0% productivity-based = profit shared equally
  - Hybrid = any mix of the two
- **How is productivity measured?**
  - Collections? Can vary by payer mix/geography
  - RVUs? Represents work (doesn't depend on the payer)
  - Building a new office vs walking into a busy office full of patients
- **What about sources of profit other than productivity?**
  - Is drug profit neutral or incentivized?
  - How is study profit, associate profit, other profit divided?
- Are **expenses** divided equally, or do you pay per resources?

Can be further complicated by a productivity floor

14

14

Compensation Structures

- For every dollar of collections for services you provide as a partner, how many cents are distributed to partners?
  - In a privately owned group, everything that's not direct overhead is typically distributed to the partners.
  - In a PE-owned group, a portion of profit goes to the PE entity, reducing the percentage distributed to partners.
    - This reduction in partner share of profit be partially offset by increased overall profit derived from greater scale (higher margins).

15

15

Disability and Parental Leave

- How is **disability** handled for an associate? A partner?
  - Does the practice act like a protection? Or a tap that turns off?
- How is **parental leave** handled, especially for an associate who doesn't have much money saved?
  - Any different from disability in general?
  - State disability only (which is almost nothing)? Or supplemental income to help provide security to a future partner?

16

16

Benefits: Health Insurance

- As an associate:
  - Company pays for physician health insurance premiums.
  - Does the company pay all/part of premium for partner/dependents?
  - What plans can you choose from? Do they meet your needs?
- As a partner:
  - Each partner typically pays the cost of their own premiums out of their own compensation.

17

17

Benefits: Retirement Accounts

- What are all the retirement vehicles available? Safe harbor, profit sharing, 401(k)?
  What is that in $$$/yr? This matters in high tax brackets!
  - Does the company contribute on behalf of an associate?
  - When does eligibility start and how can an associate contribute?
- Does the company have a **cash balance plan**, which allows much greater additional pre-tax savings?
  - If so, when does eligibility start?

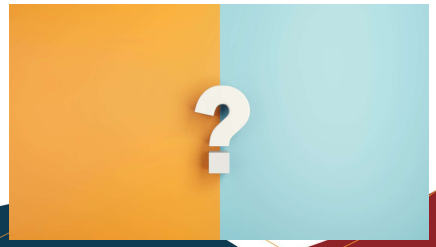
18

18

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

Questions?

tranchod@bayarearetina.com



19

Successful Transition from Fellowship to Independent Practice:
An Administrator's Perspective

Jeff Brockette, CEO Texas Retina Associates
Stephanie Collins, CEO Austin Retina Associates

1

Disclosures

No Relevant Disclosures

2

Introduction

- Overview of the transition from fellowship to independent practice
- Understand both the administrative and operational business
- Other considerations

3

Key Factors for a Successful Transition

- Institutional Expectations
- Financial Considerations
- Professional Development Strategies

4

Institutional Expectations

- Understanding employment contracts and negotiation
- Compliance with credentialing and licensure
- Navigating ASC/hospital privileges
- Meeting performance and quality benchmarks

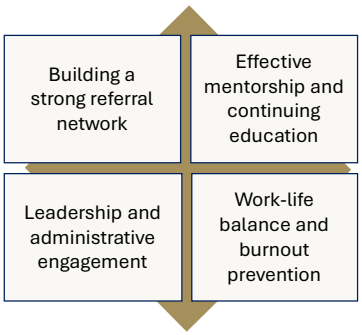
5

Financial Considerations

- Compensation structures and outside activities
- Billing and coding proficiency
- Managing overhead costs in different practice models
- Understanding revenue cycle management

6

Professional Development Strategies



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Administrative and Operational Challenges

- Navigating payer contracts and reimbursements
- Managing clinical workflow and patient volume
- Adapting to EMR systems
- Legal and compliance considerations

8

Implementation Strategies for Success

- Proactive communication with leadership
- Engaging in financial literacy and business education
- Structured onboarding plan
- Utilizing professional resources and mentors

9

Conclusion

- Recap of key takeaways
- Encourage proactive engagement in administrative aspects
- Q&A session.

10

NADEEM N. VAIDYA, M.D., RETINA ORANGE COUNTY, INC.

"IN TODAY'S CLIMATE, A SOLO DOCTOR CANNOT SURVIVE"

...and other myths that you've heard in training

1

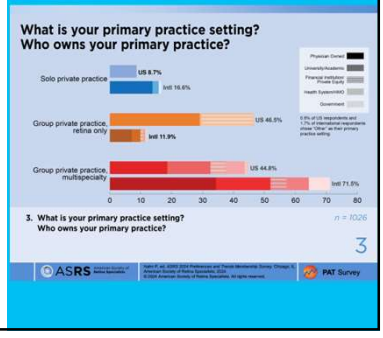
"SOLO PRACTICE IS DEAD!"

— YOUR ATTENDING IN FELLOWSHIP

2

"SOLO PRACTICE IS DEAD!"

- The data fluctuates a bit, but at about 15% in 1999 to about 8-10% today
- Of the approximately 1500+ retina specialists nationwide, that's more than 150 retina folks
- SoloEyeDocs is a group of 245 solo ophthalmologists



3

"IT'S TOO EXPENSIVE!"

— YOUR PARENTS

4

"IT'S TOO EXPENSIVE!"

- ~250k for a very nicely equipped office
- ~150k if you want to get used stuff
- Slit lamp, chair, OCT, laser is all you really need to start
  - add more as you go
- Keep 100k in cash reserve
- Doctors are good investments, banks will likely throw money at you

5

"IT'S TOO HARD TO RUN YOUR OWN PRACTICE!"

— YOUR CO-FELLOW

6

"IT'S TOO HARD TO RUN YOUR OWN PRACTICE!"

- Developers, Developers, Developers
  - Software has made practice management easy
    - Payroll/HR
    - Billing
    - Marketing

7

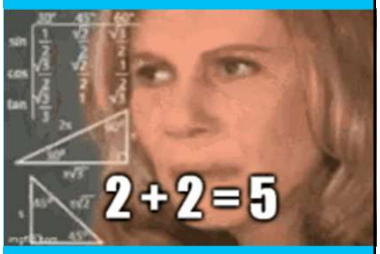
"BILLING IS TOO HARD, I DON'T KNOW ANYTHING ABOUT IT."

— ME, BEFORE

8

"BILLING IS TOO HARD, I DON'T KNOW ANYTHING ABOUT IT."

- Retina only has a small handful of codes that we need to use on a regular basis
- The basics of coding can be learned in an afternoon
- Several resources available from the AAO
- "If someone who went to night school for a few weeks can code, you can too." - solo guru



9

"WILL I EVEN MAKE MONEY?"

— EVERY SOLO PRACTITIONER BEFORE THEY START

10

"WILL I EVEN MAKE MONEY?"

- Yes…Yes you will
- You don't need to see many patients to make money
- It's difficult to NOT make money as a physician, especially as a retina specialist

11

"YOU DON'T KNOW ANYTHING ABOUT BUSINESS! JUST GET A JOB!"

— YOUR SPOUSE

12

"YOU DON'T KNOW ANYTHING ABOUT BUSINESS! JUST GET A JOB!"

- The overhead average for a retina practice is 50-70%
- Solo practices CAN be far more efficient
  - 25-40%
- Working Harder vs. Working Smarter
  - You don't need to see many patients to make money
  - It's difficult to NOT make money as a physician, especially as a retina specialist

13

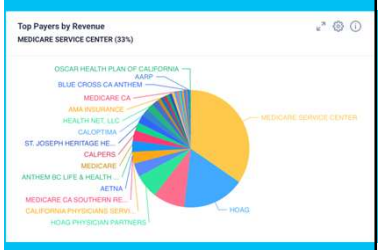
"YOU CAN NEGOTIATE MUCH MORE LUCRATIVE INSURANCE CONTRACTS IN A LARGE GROUP!"
"ONLY PE GROUPS CAN NEGOTIATE CONTRACTS! SOLOS HAVE NO POWER!"
"INSURANCE COMPANIES WILL EAT YOU ALIVE!"

— MULTIPLE PEOPLE

14

"INSURANCE COMPANIES WILL EAT YOU ALIVE!"

- ~60% of your business will be Medicare* in retina
  - pays every retina specialist the same (more or less)
- Even if all you take is Medicare, you can thrive



15

"A COKE IS A COKE AND NO AMOUNT OF MONEY CAN GET YOU A BETTER COKE THAN THE ONE THE BUM ON THE CORNER IS DRINKING. ALL THE COKES ARE THE SAME AND ALL THE COKES ARE GOOD."

— ANDY WARHOL

16

"YOU CAN'T GET ON INSURANCE PANELS!"
"IT TAKES A YEAR TO GET ON MEDICARE!"

17

"YOU CAN'T GET ON INSURANCE PANELS!"
"IT TAKES A YEAR TO GET ON MEDICARE!"

- A clean Medicare application can be approved in 2 weeks
- You all filled out applications for Medical School, Residency and Fellowship
  - Imagine how easy it would have been if you didn't have to write an essay
  - Just filling out demographic information
- Even if all you take is Medicare, you can thrive

18

"THERE ARE TOO MANY REGULATIONS!"

— EVERY ATTENDING IN AN ACADEMIC PROGRAM

19

"THERE ARE TOO MANY REGULATIONS!"

- Many regulations don't apply to small practices
- No JCAHO
- OSHA*, HR rules are substantially less restrictive than for

20

"I DON'T WANT TO MANAGE PEOPLE!"

- EVERYONE

21

"I DON'T WANT TO MANAGE PEOPLE!"

- You are the boss
  - Hire good people
  - Hire slow, Fire fast
- If you go work for a company, you still have to manage people, but you have less power to hire or fire

22

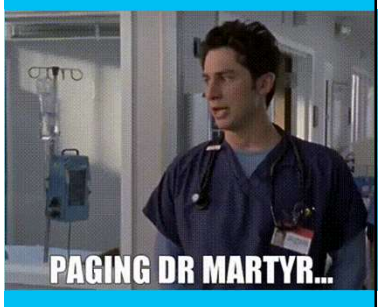
"I DON'T WANT TO BE ON CALL ALL THE TIME!"

— EVERYONE

23

"I DON'T WANT TO BE ON CALL ALL THE TIME!"

- Your referrers are probably working 9-5 on weekdays
- I haven't had to go in "on call" for the last two years
- I get maybe one or two phone calls every month that I answer after hours



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"I WANT TO SEE MY FAMILY EVERY ONCE AND A WHILE."

— NO ONE

25

"I WANT TO SEE MY FAMILY EVERY ONCE AND A WHILE."

- Take Vacation
  - Patient's can take care of themselves
  - Don't be a martyr
  - Occasionally may need to present to fellows at conferences
  - 7 weeks of vacation last year

26

"I DON'T WANT TO FIGHT WITH INSURANCES COMPANIES."

- LUIGI

27

"I DON'T WANT TO FIGHT WITH INSURANCES COMPANIES."

- The vast majority of claims go through cleanly (>98%)
- Payments are generally pretty quick (~2w)

28

"YOU HAVE TO GET A PRIOR AUTH FOR EVERYTHING!"

- MY STAFF

29

"YOU HAVE TO GET A PRIOR AUTH FOR EVERYTHING!"

- Long gone are the days of paper authorizations
- Front desk staff can easily submit prior authorizations through insurance portals
- Real time decisions

30

"[LOCATION] IS A TERRIBLE PLACE FOR DOCTORS!"

— RECRUITER

31

"[LOCATION] IS A TERRIBLE PLACE FOR DOCTORS!"

- Even "saturated" places have plenty of patients
- Your growth may be slower, but you don't need many patients to make a profit/pay rent

32

"NOBODY COMES HERE ANYMORE, IT'S TOO CROWDED."

— YOGI BERRA

33

"I DON'T THINK YOU CAN DO IT STRAIGHT OUT OF FELLOWSHIP."

— ME

34

"I DON'T THINK YOU CAN DO IT STRAIGHT OUT OF FELLOWSHIP."

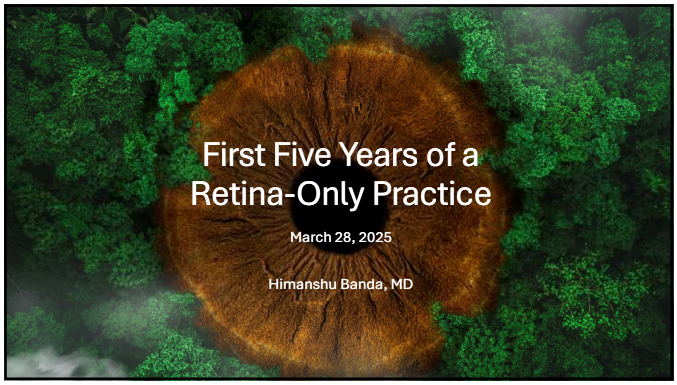
- Probably best to get a little cushion of savings
- 18 months of emergency savings
- 6 months before breakeven point
- 18 months to net positive

35

"THANK YOU"

— ME

36



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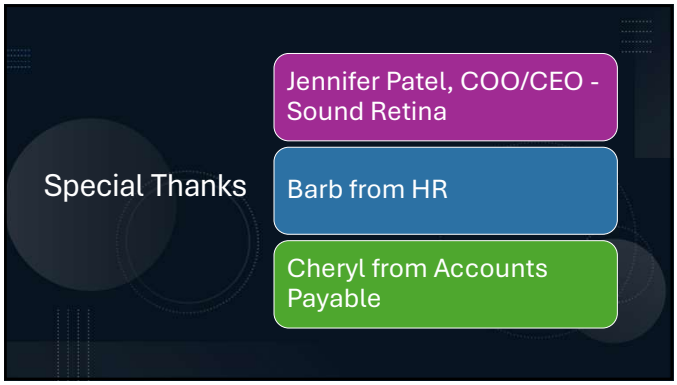

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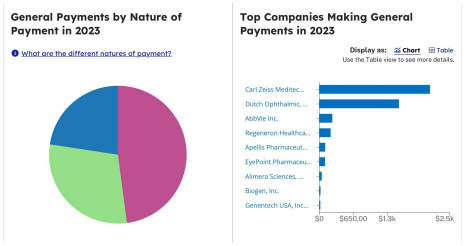
Learning Objectives

- Upon completion of this activity, participants should be able to:
- Implement effective clinical strategies to enhance workflow efficiency, manage diverse case mixes, and foster early career growth within the first five years of practice
- Analyze key business considerations, including contract structures, partnership tracks, and compensation models, when joining a retina-only subspecialty practice
- Recognize that individual experiences and career goals may vary, and adapt their professional development plans accordingly

3

Financial Disclosures:



http://OpenPaymentsData.CMS.gov

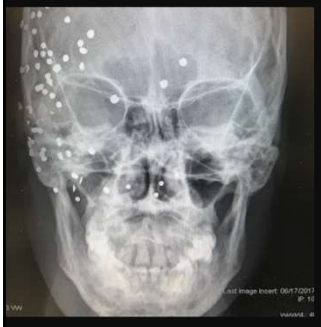
4

Financial Disclosures:

Physician-Practice Ownership As Disclosure

- Private Practice, 5 years – my experience is biased and unique
- This is a business meeting:
  - Understand the potential conflict of interest of each speaker
  - Are they an equity owner of their practice? Employee?
  - Everyone has their lens and experience

5



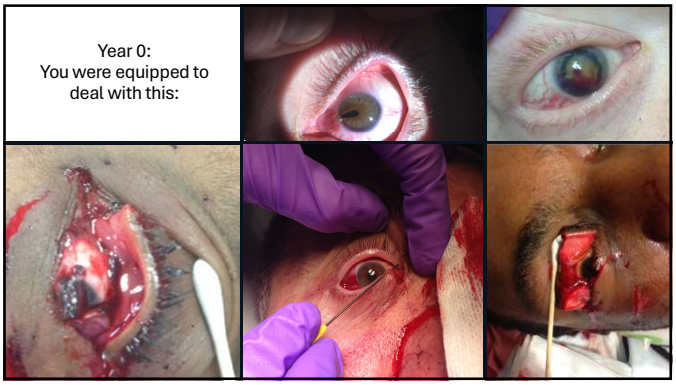
Year 0:

You may have a trauma response/moral injury

- You've seen a lot of trauma, vision loss, and people's hardest moments
- Additionally, your training environment may not have been the most supportive

6

Year 0:
You were equipped to deal with this:



7

Year 0:

But not this….

8

Year 0:

- Graduate Medical Education Taught Interesting Lessons About Contracts

THE MATCH®
NATIONAL RESIDENT MATCHING PROGRAM®

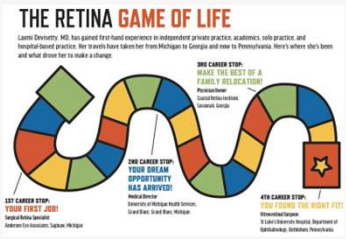
- "I am legally bound to this place, like it or not."

9

Year 0: Deal With Your Baggage

- Remember COVID? Lots to unpack there…
- Managing finances out of training… that's probably another lecture
- Burn out is real! Get help if you need it

10



Devisetty, L. (n.d.). Finding a new job: The midcareer move. *RT Retina Today Business Matters*, 7(4).

Year 1: This May Not Be Your "Forever Job"

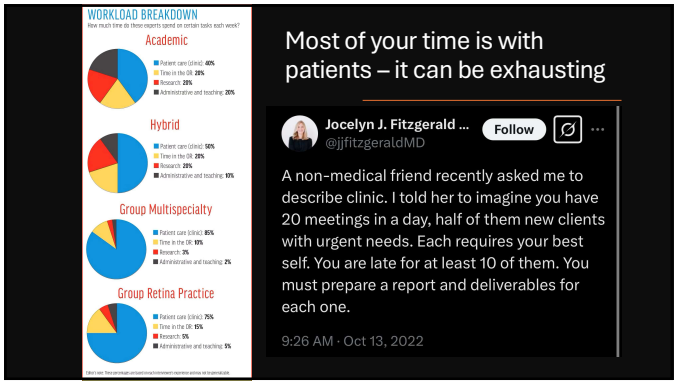
- What to focus on instead?
- Outcomes, mastering surgery
- Patient interactions
- Community Relations
- Practice Relations
- Avoid "Arrival Syndrome"
- Spend every penny of your CME allowance, then spend more!!

11

Year 1: What to focus on? Patient Care!

- Understand your outcomes:
  - Surgical outcomes
  - Endophthalmitis rate
- Record all your cases if able
- This is the best time to try different techniques, or skills you did just a handful of times in fellowship.
  - Don't feel pressured to find a "niche" – do it all
  - Continue to keep up your anterior segment skills – it will keep you competitive in this market
- If this is all you do your first year – that's good enough

12



13

Year 1: PVR

- You down with OPPVR?
- Challenging cases, however you have an opportunity to be objective
- Document your conversations, follow these patients closely – adverse outcomes can breed resentment, and you need to show compassion

14

Year 1: Introductions to the community

- Take opportunities for referral engagement
- Ask your practice to help coordinate
- Share your cases from residency/fellowship, with permission

15

Year 1: Ask for Quarterly Meetings

- What is your production & collections?
- What has it been historically for your most recent associate?
- What is my expectation/goal?

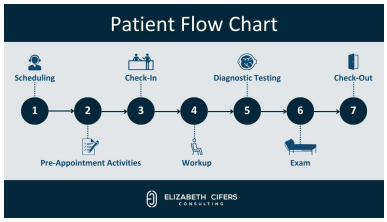
16

Year 2:
Own Your Workflow

How are your clinics run?

What is the patient experience?

What are the bottlenecks in clinic workflow?



Cifers, E. (2024). Improving patient flow at your retina clinic [Chart included]. *Revenue Cycle Management*, May 13.

17

Year 2:

Now, take a step back…

What's the workflow of your claims?

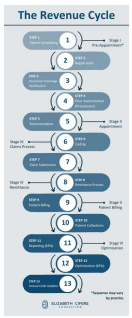
- Understand the basics of the "lifecycle of a bill," and how it relates to your production
- Consume EVERYTHING Joy Woodke Says! Its gold

18

Year 2:

What are the 'bottlenecks' in your claims?

How does this compare to your practice?



Cifers, E. (2025). Revenue cycle fundamentals—Let's start at the beginning. *Revenue Cycle Management,* January 9.

19

Year 2: Think Analytically About Your Practice

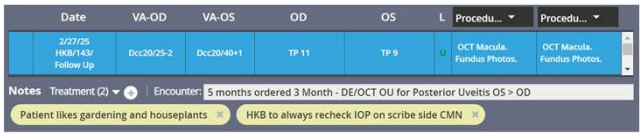
- Would you ask one of the partners, "how much do you make?"
- There will be a time they will have to tell you (partnership negotiations) but there are ways you can ask without asking…
  - What was my yearly collections for year 1?
  - What was the collections for the practice last year?
  - What is my overhead?
  - What is the overall practice overhead?

(Collections – overhead)/ # partners = Voila!

20

Year 2:
Patient Care Still Priority…Go One Extra Small Step

Try and make a personal connection – make a brief note



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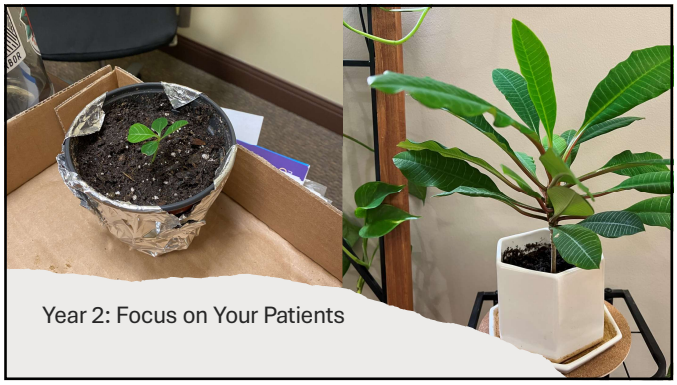

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Year 2:

Develop Relationships With Your Practice

- How are the other doctors/partners working with you?
- Are you fitting in with the culture of your practice? What would change? What *could* you change?
- Is this an environment you can trust? Keep in mind, trust can take years…
- Make an effort to get to know your future partners

23

Year 2: Dealing with your PVR

- Hits differently that OPPVR, and PVR from training
- Manage your emotions, and patient expectations
- PVR is traumatic for the patient – make sure the patient knows they are getting taken care of
- Know how to hand off your PVR when you need to

24

Year 3: Relationship With Your Community

Can you see a life in your chosen location?

What are the most challenging things you can't change?

25

Average Weather in my city

26

27

Year 3: Relationship With Your Community

- Who are your referrals? Who are your fellow YOs? Get to know them!
- "Close the loop" with patient care – talk to your referrals, give feedback
- Referral Engagement is important every year, but make it a point to build relationships – send a holiday card

28

Year 3: Partnership Discussions

- When these discussions start, don't be surprised if they time
- The needs of the practice can change, and so can structure
- How is partnership structured?
  - Equity vs. productivity-based
  - Compensation model: base salary, profit-sharing, bonuses?
  - Governance: Voting rights, decision making process, tie-breaking mechanisms?
  - Exit: what to do when a partner retires, leaves or sells shares?

29

Year 4: Maybe You're A Partner…

- Its ok if it's an underwhelming feeling! Hopefully, both sides made compromises and came to agreements
- How did the discussion go? Consider it the first "argument" with your partners… were you able to conduct business?
- How you and your partners managed the "buy-in" is a good barometer on how you will expect to manage conflict

30

Year 4: Share Administrative "Burden"

- Just because you're a partner doesn't make you an effective administrator
- Learning the "business" is a skill… you can be good at it if you really want to! Don't let people discourage you!
- Learn from your partners, and go to conferences like these

31

Year 4: Perhaps partnership wasn't for you

- There can be benefits in maintaining associate status:
  - Priorities can change throughout your career
  - Guaranteed salary
  - Less administrative duties, more time (hopefully)
  - More options for being part time
- What if business ownership was your goal?

32

Year 5: Work/Life

- Define your priorities
- Create Boundaries
- Learn to delegate
- Stay organized
- Be flexible

Khatib, N. (2022). Work-life balance. *New Retinal Physician*, 19(May), 18-19.

33

Year 5: Other Business Opportunities

- Real Estate
- Surgery Centers
- Research Opportunities
- The world is your oyster!

34

Year 5: Defining Relationship with Industry

Benefits:

Access to treatment/tech
Contribution to fund of knowledge
Educational opportunities

Conflicts:

Undue influence of practice pattern
Industry interest over patient needs
Misleading patients

35

Year 5: Your Panel Is The Most Valuable Commodity in this Industry

- "Ret-onomics" has become a pervasive norm in our clinic culture
- Protect your patients:
  - What educational materials will they have access to?
  - What is the fine print in the copay programs you should let your patients be aware of?
  - What information is being given up or distributed in those "free" genetic panels?
  - What studies will you offer them?
- If a patient is expected to pay in part for a new therapy, how do you ascribe a "value?"
  - If you don't use it, its zero
- 5 years later… guess what, AVASTIN STILL WORKS, AND IS ACCESSIBLE! Its worth protecting

36

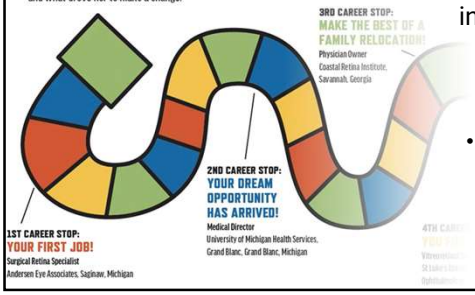
Year 5: There Will Be Conflict

- The purpose of a business is to make money
- The purpose of a practice is to take care of patients
- As a physician owner, your business and practice may be at odds
- Get comfortable talking about $ with patients
- Anyone can be a businessperson, but only a few have taken an Oath and accepted a fiduciary responsibility to their clients
- Whatever happens, its your JOB to protect your patients – it is a privilege few should have access to

37

THE RETINA GAME OF LIFE

Laxmi Devisetty, MD, has gained first-hand experience in independent private practice, academics, solo practice, hospital-based practice. Her travels have taken her from Michigan to Georgia and now to Pennsylvania. Here's where and what drove her to make a change.



The most important year: 0

- You can always have a year 0 again, you can get as many chances as you need

38

Thank you!

drbanda@soundretina.com

39

Citations

- Devisetty, L. (n.d.). Finding a new job: The midcareer move. *RT Retina Today Business Matters*, 7(4).
- Fitzgerald, J. (2022, October 13). [A non-medical friend recently asked me…] [Tweet]. Twitter. https://x.com/jjfitzgeraldMD/status/1580595884189810695?lang=en.
- Cifers, E. (2024). Improving patient flow at your retina clinic [Chart included]. *Revenue Cycle Management*, May 13.
- Cifers, E. (2025). Revenue cycle fundamentals—Let's start at the beginning. *Revenue Cycle Management*, January 9.
- Khatib, N. (2022). Work-life balance. *New Retinal Physician*, 19(May), 18-19.

40

Multispecialty Practice

Srinivas Sai A. Kondapalli, MD
Everett and Hurite Ophthalmic Association

1

Everett and Hurite

- Multispecialty Ophthalmology Group in Western Pennsylvania
- 11 ophthalmologists
  - Glaucoma (2)
  - Cornea (1)
  - Peds (2)
  - Plastics (2)
  - Retina (4)
- 5 optometrists
- 8 locations

2

My Schedule

Monday	Tuesday	Wednesday	Thursday	Friday
BUT	WAR		GBG	WEIR
BUT	WAR	GBG		WEIR
	WAR		GBG	WEIR
	WAR	GBG		WEIR

3

Disclaimers

- Came out of fellowship straight into this practice
- I do not know how other set ups are therefore I can only speak to why this has been a good fit for me
- My schedule has changed and tapered down the longer I have been practicing
- I wasn't really sure I wanted to be a retina specialist/ophthalmologist.

4

Guess the Saying—Multispecialty Practice

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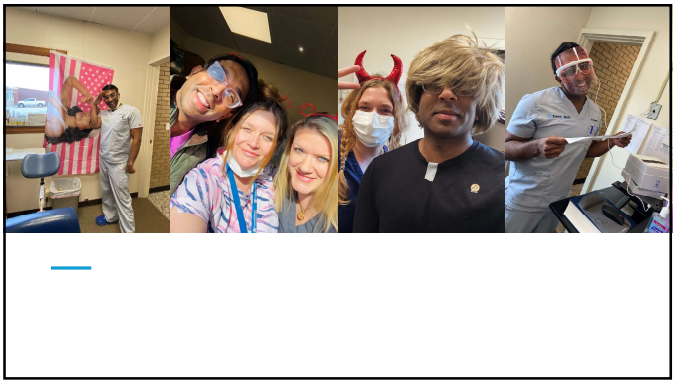


12

2025 Business of Retina Meeting Fellows Seminar:

Early Career Risk Management Issues

Gaurav K. Shah, MD
Linda Harrison, PhD

OMIC
OPHTHALMIC MUTUAL INSURANCE COMPANY

ASRS American Society of Retina Specialists

1

Disclosures

Gaurav K. Shah, MD
- OMIC Board Member

Linda Harrison, PhD
- OMIC Vice President of Risk Management

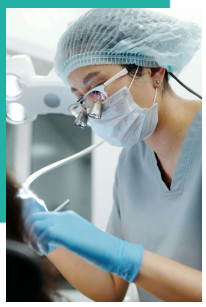
2

Learning Objectives

Upon completion of this course, participants should be able to:

- Understand why patients are motivated to sue physicians
- Apply ethical principles and professional standards that prioritize patient safety and mitigate the risk of claims
- Create a culture of safety in their practice

3



Closed case example:

Excess C3F8 Gas During Pneumatic Retinopexy

4

Chronology

Initial exam	• **Referred** from ED to insured; IOP 35 OD, 13 OS • **Dx**: retinal tear and detachment OD • **Plan:** pneumatic retinopexy scheduled to occur in 2 days
Surgery #1	• **Pneumatic retinopexy with C3F8 gas** resulting in successful retinal adhesion. • Gas bubble to remain in place for several weeks.
POD 1	• **Exam**: VA=CF at 1 foot; IOP 18; retina completely attached; 70% gas fill • **Rx**: Prednisone acetate, Polymyxin B, Cyclopentolate • **Plan**: follow up in 1 week
POD2 to POD9	• **Patient seen 5 times** due to pain, nausea, blurry vision. IOPs as high as 73 • 2 gas release procedures • **Rx:** Diamox, Cosopt • **Exam by tech POD9:** VA = HM at 1 foot, IOP 23; reported to surgeon, who referred patient to 2nd ophthalmologist.

5

Chronology

POD 11	• **Exam by ophthalmologist #2:** VA = HM at 6 inches**;** IOP 15 • **Patient** concerned about loss of vision • **Tx**: gas bubble placed in anterior chamber
POD 13	• **Pressure check:** IOP 13
POD 16	• **Patient seen by ophthalmologist #1 for c/o sharp pain OD** • **Exam**: Swelling cataract, which was aggravating glaucoma; corneal edema; VA still HM at 6 inches; IOP 11. • **Surgery**: lensectomy and vitrectomy; the retina remained completely attached; optic nerve normal.
POD1 (surgery #2)	• **Exam:** Cornea clearing; deep anterior chamber; no clear view of the retina or optic nerve due to 80% gas bubble in back of eye; VA = HM at 1 foot; IOP <4.

6

Chronology

Over the next 2 months	• The patient returned to the insured numerous times. • The optic nerve was eventually visualized, but significant damage was noted. • VA ranged between HM at 1-4 feet, to CF at 1 foot; IOPs between 9 and 15. • ***The patient never returned to the insured.***

7

Litigation

Expert opinions	**Standard of Care** • delay in scheduling pneumatic retinopexy (surgery #1) • The use of 2cc's % C3F8 gas was indefensible and exceeded the normal capacity of the eye. • substandard postop management **Causation** • the excess gas caused the IOP to increase to 73 resulting in damage to the optic nerve and a complete loss of vision OD • the damage would have occurred within 90 minutes after infusion of the excess gas
Disposition	• **The case was settled**

8

Risk Management

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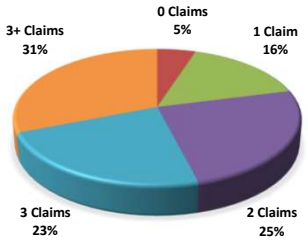
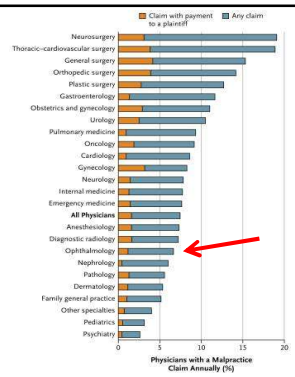
Probability of a claim in a 30-year practice



- *95% of physicians will have at least 1 claim in their career*
- *Probability of a claim in any given year is 8%*

10

Ophthalmology is a "low risk" specialty regarding how frequently ophthalmologists are sued, and the amounts of settlements and verdicts

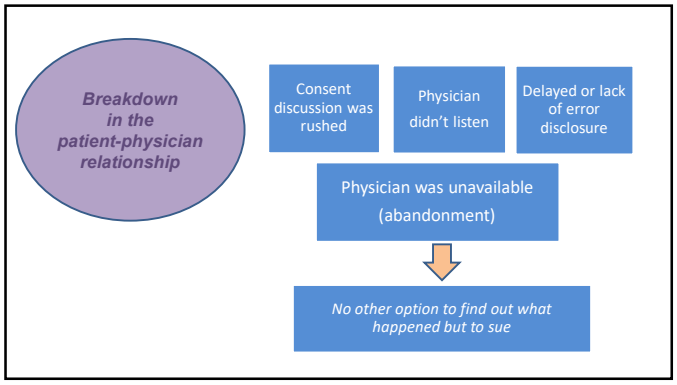


11

What Motivates Patients to Sue?

- Desire for monetary compensation
- Desire to hold physician responsible
- Prevent the same error from happening again

12



13

Mitigate the Risk of Patient Harm and Malpractice Claims

- Documentation
- Informed Consent
- Follow Up
- Disclosure of Adverse Events
- Safety Protocols

14

Documentation

15

Documentation

- Poor documentation makes good care look bad
- "If it wasn't documented it didn't happen."
- If you use a scribe, you are responsible for the accuracy of the record.
- Many cases are *indefensible* due to incomplete or inaccurate documentation.
- Amendments to the record: *late entries, addenda, corrections*
  - May be necessary, and legitimate, but must be done correctly to avoid the appearance of fraud or concealment
  - Such changes should be made infrequently
  - Check with risk management at your carrier if in doubt about whether and how to make an amendment

16

In Litigation…

Medical records scrutiny
Medical records, both paper and electronic, will be scrutinized by the plaintiff's attorney and forensics experts for any entries that suggest credibility is in question.

EHR audit trails
EHR audit trails assist plaintiffs in proving an allegation of medical records credibility.

Records alterations
Records alterations cannot be defended.

17

Electronic Health Record

Watch out for known pitfalls

- Copy and paste, copy forward, cloning
- Wrong choice in pick/dropdown list
- Wrong specialty template
- Failing to update medications
- Use of "normal" defaults
- Insertion of macros that are not edited for the individual patient: "note bloat"
- Information in one part of record contradicts another
- Pre-charting or charting long after treatment

18

Informed Consent

19

What is Informed Consent?

- An oral agreement reached after the surgeon advises the patient of
  - » Diagnosis and proposed treatment
  - » Risks, benefits, alternatives
  - » Consequences of refusing treatment
- Informed consent discussion
  - » Document discussion in the medical record
  - » Include a procedure-specific consent form
  - » Document education materials provided
  - » Not only a signature on a form
- Assess comprehension using teach back method
- Provider's non-delegable duty

20

Follow Up

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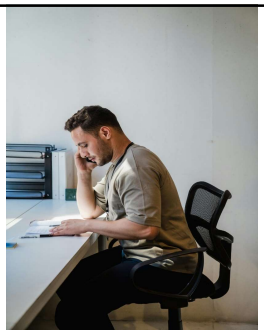


Follow-Up

Why is it a risk management concern?

Delayed diagnosis, failure to diagnose, and delayed treatment are typical allegations in medical negligence claims.

Although clinical mismanagement might have occurred, a delay in or a failure to follow up is often at the root of the problem.

22

Follow-Up Strategies

1. **Explain to Patients**
   Explain recommendations, including when to obtain, the importance of compliance, and consequences to vision if treatment is delayed or declined.
2. **Document**
   Document the discussion.
3. **Implement**
   Tracking systems, safety policies and procedures

* **Terminate**
Terminate patients as a last resort for noncompliance.

23

Disclosure of Adverse Events

24

Disclosure of Adverse Events

Background

- Ethically required (AAO Code of Ethics)
- Patient has a right to know
- Necessary for trust, continuity of care, and future treatment

Risk Recommendations

- Disclose to patient or family as soon as possible
- Express empathy, don't admit negligence; consider apology
- Relay the facts; don't speculate
- Don't place blame on others
- Document the disclosure, the treatment plan, and instructions to patient
- Be available and keep the patient informed

25

Safety Protocols

26

Create a Culture of Safety

- Most errors are not solely the result of an act of an individual.
- Most errors do involve systems or process failures.
- Lack of safety protocols--and failure to adhere to them--lead to wrong events (wrong patient, wrong eye, wrong drug, wrong procedure).
- These events can lead to serious patient harm.
- These cases cannot be defended, and will most likely result in settlement.

27

28

In Summary…

Practice these habits to avoid malpractice claims, enhance patient safety, and develop higher patient satisfaction, which lead to better patient compliance.

- *Documentation*
- *Informed Consent*
- *Follow Up*
- *Disclosure of Adverse Events*
- *Safety Protocols*

29

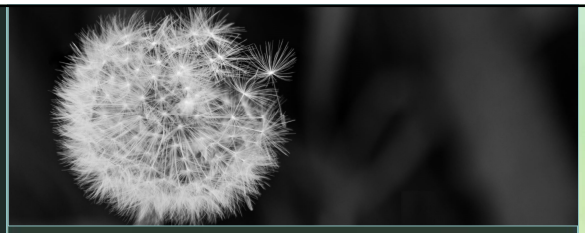
Injection Therapy:

Balancing Treatment Decisions in a Rapidly Changing Landscape

Presented by

Claire M. Murphy

1



A little about me…

2

Claire's Original Slide Deck!!

BEST PRESENTATION EVER!!!!!

3

4

5 "Easy" Steps

1. Pick your Treatment
2. Is the Diagnosis Covered?
3. Is there Step Therapy?
4. Is a Prior Authorization Needed?
5. Who is paying for it?

5

Prescribing the Right Treatment

6

Considerations for Treatment Options

- Physician Choice – The decision of treatment should be a discussion between a physician and their patient
- Factors to also consider – efficacy & safety, prior response to other treatments, what med will give the patient the best clinical outcome
- Will the patient be compliant?
- Choose your destination drug & map a pathway to get there

7

Always Ask… Is it Covered?

8

- Your administrator always wants you to bill the drug!
- Is the drug covered under a BILLABLE diagnosis?
  - Yes? Let's keep going!
  - No… What options do you have instead?
  - Apply with patient's insurance for medical necessity for off label treatment
  - Sample Drugs provided by manufacturer
  - May qualify for off-label charitable programs through manufacturer, speak to your reps!
  - Does your practice have any enrolling research studies?

9


Step Therapy

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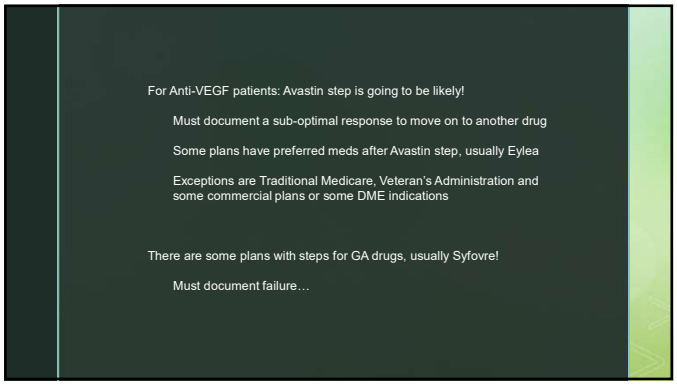
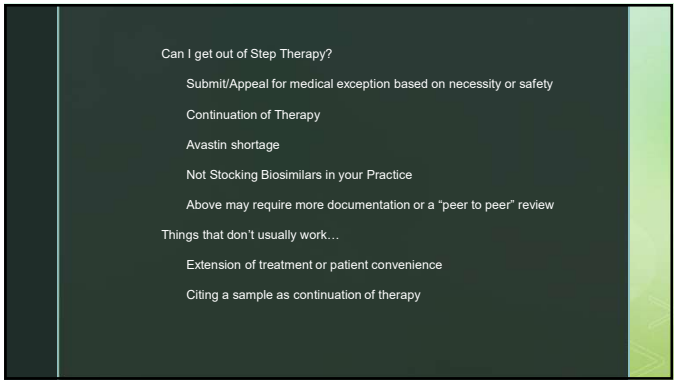

For Anti-VEGF patients: Avastin step is going to be likely!
Must document a sub-optimal response to move on to another drug
Some plans have preferred meds after Avastin step, usually Eylea
Exceptions are Traditional Medicare, Veteran's Administration and some commercial plans or some DME indications
There are some plans with steps for GA drugs, usually Syfovre!
Must document failure…

11


Can I get out of Step Therapy?
Submit/Appeal for medical exception based on necessity or safety
Continuation of Therapy
Avastin shortage
Not Stocking Biosimilars in your Practice
Above may require more documentation or a "peer to peer" review
Things that don't usually work…
Extension of treatment or patient convenience
Citing a sample as continuation of therapy

12

Prior Authorization

13

- Assume you will need it before treating a patient!
- Prior Authorization does not retro and can take several days to come
- Same day injections are difficult!
  - Sample but keep in mind you may have to go back to a step!
  - Avastin may need PA too!
  - PA can be attached to a specific eye or a specific doctor
  - Surgery & Laser, in-office and out, may need PA

14

Payment

15

Commercial vs. Medicare

Commercial

- Usually under 65 years old
- Deductibles and Co-insurance vary plan to plan
- Qualify for copay cards for drugs to help cover out of pocket costs

Medicare

- Usually over 65 years old
- Traditional only covers 80%
- Some patients will have Medicare Advantage plans or Medicare Supplements

16

Commercial Insurance

Run a **BENEFITS IVESTIGATION** for branded drugs

Make sure **PRIOR AUTH** is obtained and **STEP THERAPY** is followed

Enroll patient in **COPAY CARD** to offset patient portion

17

Traditional Medicare Only

RED WHITE AND BLUE with No Supplement

Run a **BENEFITS IVESTIGATION** for branded drugs

PRIOR AUTH and **STEP THERAPY** are not needed!

If patient is only Medicare, the patient will have a copay of 80% of ALL charges, including drugs, after a $257 deductible.

18

J0177 EYLEA HD	$526.49
J0178 EYLEA	$320.43
J2777 VABYSMO	$422.95
J2778 LUCENTIS .3	$74.38
J2778 LUCENTIS .5	$123.97
J2781 SYFOVRE	$439.11
J2782 IZERVAY	$434.82
J7312 OZURDEX	$287.78
J3396 VISUDYNE	$345.09
COMPUNDED AVASTIN	$14.68

19

Medicare and a Supplement

RED WHITE AND BLUE & Supplement

Run a **BENEFITS IVESTIGATION** for branded drugs

PRIOR AUTH and **STEP THERAPY** are not needed!

Supplement helps pay for Medicare co-insurance (the left over 20%)

May have a copay or a deductible and may not cover Medicare deductible. The benefits investigation should tell you all this information so the patient is aware of any out of pocket costs.

20

Medicare Advantage Plans

Run a **BENEFITS IVESTIGATION** for branded drugs

PRIOR AUTH and **STEP THERAPY** are LIKELY needed!

There are usually office visit copays, can have hidden costs and typically only cover buy and bill drug costs at 80% but they will have an out of pocket max

Without foundation assistance, which is currently closed, patient is responsible for 20% balance of drug

Foundations do not cover Avastin

Selection of drug may be dependent on what patient can afford to pay.

Financial Counseling is a good idea to talk over all these factors

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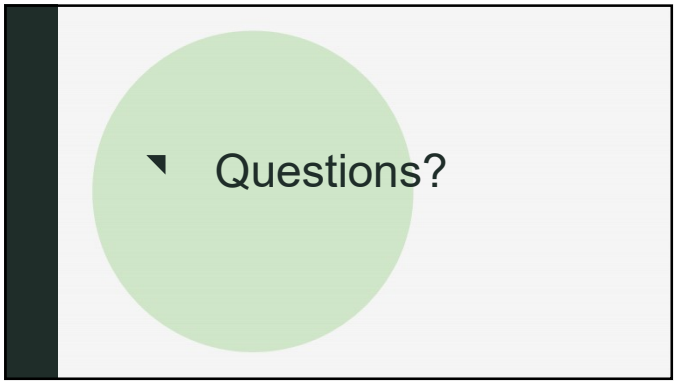


22

23

How Payers Impact Clinical Care

Alex Melamud MD, MA
Retina Group of Washington

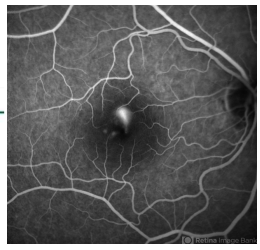
1

limited treatment options
reduced profitability
administrative costs
coverage restrictions
prior authorization
code bundling
narrow networks
payment rates

2

Case 1

- 45-year-old with symptomatic CSR, persistent despite 3-month period of observation



Eye

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Article | Open access | Published: 26 December 2022

Real world outcomes of photodynamic therapy for chronic central serous chorioretinopathy

Samir Khandhadia, Suresh Thulasidharan, Nguyen Thuy Vy Hoang, Sameh Alkhalili Ibrahim, Yanling Ouyang & Andrew Lotery

Eye 37, 2548–2553 (2023) | Cite this article

5235 Accesses | 7 Altmetric | Metrics

3

What is the appropriate next step in this scenario

A. Ask your technician to set up for PDT laser as you plan to treat the patient right away?
B. Give the chart to your office manager to verify that insurance will pay prior to treatment?

4

Procedure Denied

- Diagnosis considered investigational or unproven

aetna

B. *Non-Cancer Indications*

Aetna considers photodynamic therapy experimental, investigational, or unproven for any of the following indications because its effectiveness for these indications has not been established:

- Actinic cheilitis
- Actinic dermatitis
- Atopic dermatitis (eczematous dermatitis)
- Central serous chorioretinopathy
- Chronic rhinosinusitis
- Chronic ulcers (including diabetic ulcers)
- Condyloma (genital warts)
- Darier's disease (keratosis follicularis)
- Denture stomatitis
- Disseminated superficial actinic porokeratosis
- Dyspigmentation
- Endodontic infections
- Extra-mammary Paget's disease (e.g., Paget's disease of the vulva)
- Gingivitis
- Granulomatous dermatitis
- Halitosis
- Herpes labialis

5

Health Care Delivery

- A payer in health insurance is an organization or entity that pays for healthcare services. This could be a health insurance company, government program or employer

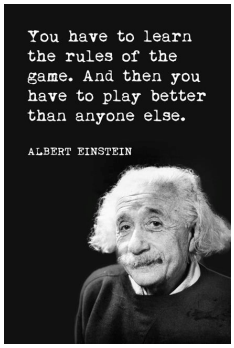
6

A Physician in Practice

Professional responsibility to provide ethical medical care

Financial responsibility to run a profitable business

7



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This label may not be the latest approved by FDA.
For current labeling information, please visit https://www.fda.gov/drugsatfda

NDA 021119/S-034
Page 3

HIGHLIGHTS OF PRESCRIBING INFORMATION
These highlights do not include all the information needed to use VISUDYNE safely and effectively. See full prescribing information for VISUDYNE.

VISUDYNE® (verteporfin for injection), for intravenous use
Initial U.S. Approval: 2000

INDICATIONS AND USAGE

VISUDYNE (verteporfin for injection) therapy is a photosensitizer indicated for the treatment of patients with predominantly classic subfoveal choroidal neovascularization due to age-related macular degeneration, pathologic myopia or presumed ocular histoplasmosis. (1)

DOSAGE AND ADMINISTRATION

- Recommended Dose: 6 mg/m² body surface area. (2.2)
- Reconstitution: Reconstitute each vial of VISUDYNE with 7 mL of Sterile Water for Injection to provide 7.5 mL containing 2 mg/mL of verteporfin. Reconstituted VISUDYNE must be protected from light and used within 4 hours. (2.3)
- Dilution: Dilute desired dose of reconstituted VISUDYNE with 5% Dextrose for Injection to a total infusion volume of 30 mL. (2.3)
- Infusion: Administer intravenously over 10 minutes at a rate of 3 mL/minute, using an appropriate syringe pump and in-line filter. (2.3)
- Light Administration: The recommended light dose is 50 J/cm² of neovascular lesion administered at an intensity of 600 mW/cm². The wavelength of the laser light should be 689±3 nm. This light dose is administered over 83 seconds, starting 15 minutes after the start of the VISUDYNE infusion. (2.4)

DOSAGE FORMS AND STRENGTHS

- For injection: 15 mg of verteporfin as a dark green lyophilized cake in a single-dose vial for reconstitution. (3)
- Each reconstituted vial provides 7.5 mL solution containing 2 mg/mL of verteporfin. (3)

CONTRAINDICATIONS

VISUDYNE (verteporfin for injection) is contraindicated for patients with porphyria or a known hypersensitivity to any component of this preparation. (4)

WARNINGS AND PRECAUTIONS

- Extravasation: If extravasation occurs, the infusion should be stopped immediately. The extravasation area must be thoroughly protected from direct light until swelling and discoloration have faded in order to prevent the occurrence of local burn. (5.1)
- Exposure to Sun or Direct Light: Following injection with VISUDYNE (verteporfin for injection), care should be taken to avoid exposure of skin or eyes to direct sunlight or bright indoor light for 5 days. (5.2)
- Anaphylactic Reactions: Immediately discontinue administration of VISUDYNE and initiate appropriate therapy if an anaphylactic or other serious allergic reaction occurs during or following infusion. (5.4)

ADVERSE REACTIONS

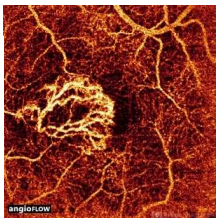
Most common adverse reactions (incidence >10%) are injection site reactions and visual disturbances. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Bausch & Lomb Incorporated at 1-800-553-5340 or FDA at 1-800-FDA-1088 or

9

Case 2

- 77-year-old with new onset Neovascular AMD



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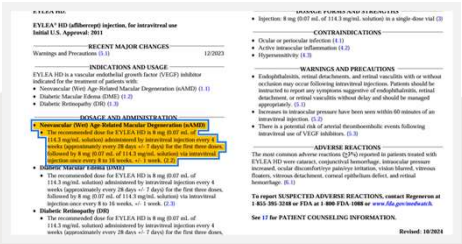


EYLEA® HD (aflibercept) injection, for intravitreal use
Initial U.S. Approval: 2011

RECENT MAJOR CHANGES
Warnings and Precautions (5.1) 12/2023

INDICATIONS AND USAGE
EYLEA HD is a vascular endothelial growth factor (VEGF) inhibitor indicated for the treatment of patients with:
- Neovascular (Wet) Age-Related Macular Degeneration (nAMD) (1.1)
- Diabetic Macular Edema (DME) (1.2)
- Diabetic Retinopathy (DR) (1.3)

DOSAGE AND ADMINISTRATION
- Neovascular (Wet) Age-Related Macular Degeneration (nAMD)
  - The recommended dose for EYLEA HD is 8 mg (0.07 mL of 114.3 mg/mL solution) administered by intravitreal injection every 4 weeks (approximately every 28 days +/- 7 days) for the first three doses, followed by 8 mg (0.07 mL of 114.3 mg/mL solution) via intravitreal injection once every 8 to 16 weeks, +/- 1 week. (2.2)
- Diabetic Macular Edema (DME)
  - The recommended dose for EYLEA HD is 8 mg (0.07 mL of 114.3 mg/mL solution) administered by intravitreal injection every 4 weeks (approximately every 28 days +/- 7 days) for the first three doses, followed by 8 mg (0.07 mL of 114.3 mg/mL solution) via intravitreal injection once every 8 to 16 weeks, +/- 1 week. (2.3)
- Diabetic Retinopathy (DR)
  - The recommended dose for EYLEA HD is 8 mg (0.07 mL of 114.3 mg/mL solution) administered by intravitreal injection every 4 weeks (approximately every 28 days +/- 7 days) for the first three doses,
- Injection: 8 mg (0.07 mL of 114.3 mg/mL solution) in a single-dose vial (3)

CONTRAINDICATIONS
- Ocular or periocular infection (4.1)
- Active intraocular inflammation (4.2)
- Hypersensitivity (4.3)

WARNINGS AND PRECAUTIONS
- Endophthalmitis, retinal detachment, and retinal vasculitis with or without occlusion may occur following intravitreal injections. Patients should be instructed to report any symptoms suggestive of endophthalmitis, retinal detachment, or retinal vasculitis without delay and should be managed appropriately. (5.1)
- Increases in intraocular pressure have been seen within 60 minutes of an intravitreal injection. (5.2)
- There is a potential risk of arterial thromboembolic events following intravitreal use of VEGF inhibitors. (5.3)

ADVERSE REACTIONS
The most common adverse reactions (≥5%) reported in patients treated with EYLEA HD were cataract, conjunctival hemorrhage, intraocular pressure increased, ocular discomfort/eye pain/eye irritation, vision blurred, vitreous floaters, vitreous detachment, corneal epithelium defect, and retinal hemorrhage. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Regeneron at 1-855-393-3240 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

See 17 for PATIENT COUNSELING INFORMATION.

Revised: 10/2024

FDA Label

https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=BasicSearch.process

11

What is the appropriate next step

A. You know for certain that Eylea HD is FDA approved for the diagnosis of NVAMD, therefore you grab a drug from the fridge and perform the intravitreal injection.

B. You pause and decide to give the chart to your manager to verify that insurance will pay prior to treatment.

12

Policy Changes and Lack of Transparency

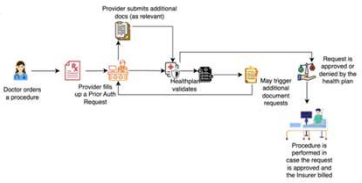
Private payers may not actively communicate changes to their policies or guidelines to providers in a clear and timely manner, making it difficult for providers to stay updated.

This lack of transparency can lead to situations where providers perform procedures or prescribe treatments that are later denied coverage due to a policy change, they were unaware of.

13

Prior Authorization

- Under medical and prescription drug plans, some treatments and medications may need approval from your health insurance carrier before you receive care



14

Step therapy

Step Therapy Criteria

Eylea

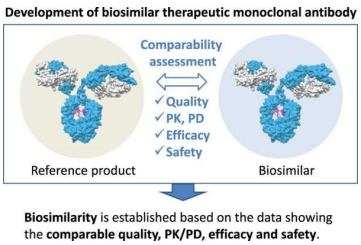
Eylea, when prescribed for Neovascular (Wet) Age-Related Macular Degeneration, may be covered when any of the criteria listed below are satisfied:

- History of a trial of at least 3 consecutive doses given monthly, resulting in minimal clinical response to compounded Avastin (bevacizumab); **or**
- History of contraindication or adverse event(s) to compounded Avastin (bevacizumab); **or**
- Continuation of prior therapy within the past 365 days.

15

Biosimilars

- Ishii-Watabe A, Kuwabara T. Biosimilarity assessment of biosimilar therapeutic monoclonal antibodies. *Drug Metab Pharmacokinet*. 2019;34(1):64-70. doi:10.1016/j.dmpk.2018.11.004



16

Out Of Pocket Costs Matter!

- Copay - A copay is a fixed amount you pay for a covered health care service, usually at the time you receive the service. Copays are a shared cost between you and your insurance company
- Deductible - A deductible is the amount of money you pay before your insurance covers the rest of a claim

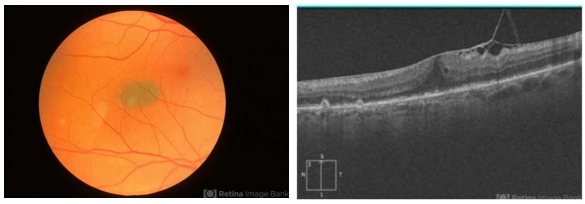
17

How Payers Impact Clinical Care

- Authorization requirements may affect the timeliness of care
- Payers may restrict or narrow treatment options

18

Case: 65-year-old male



19

Bundled Codes and Mutually Exclusive Codes

- The National Correct Coding Initiative (NCCI) edits, which are used by Medicare and many commercial payers, often bundle certain procedures together, meaning they are considered to be part of the same service and only one code should be billed.
- In some cases, the procedures are considered mutually exclusive, meaning that one procedure is generally considered to provide the same information as the other, and therefore, both should not be billed.

20

Local Coverage Determination (LCD):

Scanning Computerized Ophthalmic Diagnostic Imaging

L35038 Expand All | Collapse All

* Note: Please see next bullet if undergoing active treatment.

- No more than one (1) exam per month will be considered medically reasonable and necessary to manage the patient with retinal conditions undergoing active treatment, or in conditions suggestive of rapid deterioration. These conditions include wet AMD, choroidal neovascularization, macular edema, diabetic retinopathy (proliferative and non-proliferative), branch retinal vein occlusion, central retinal vein occlusion, and cystoid macular edema.

Frequency of allowable diagnostic services

https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=35038

21

What is the appropriate management of patients in this uncertain environment?

- Do what's right for the patient
- Follow established protocols for obtaining authorization
- Take guidance from your administrative support staff
- Talk to the patient in advance about possible out of pocket costs

22

Thank you!

Alex Melamud MD, MA
Retina Group of Washington

23

1

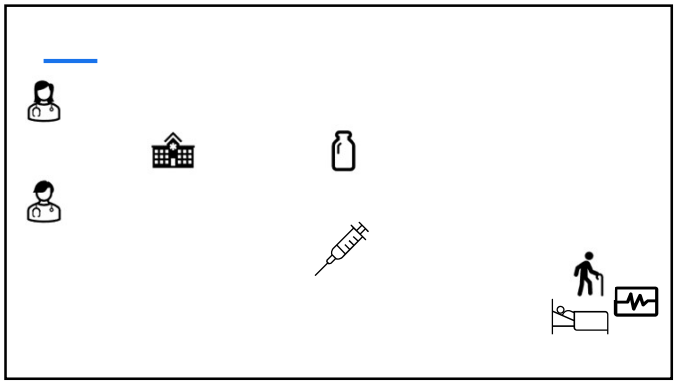
Objectives

- Understand buy-and-bill drug purchasing of retina specialty drugs
- Appreciate the general idea of what is required for retina specialty drugs to be administered in the office
- Learn about a variety of insurances which patients who we care for in the office, what the insurances cover and what patient out-of-pocket expense are for retina injections.

Descriptor: So many choices when it comes to retina injectable drugs, but when it comes to our patients, do we know what their insurance covers? How much should they expect to pay out-of-pocket? We will learn about this and more!

2

3



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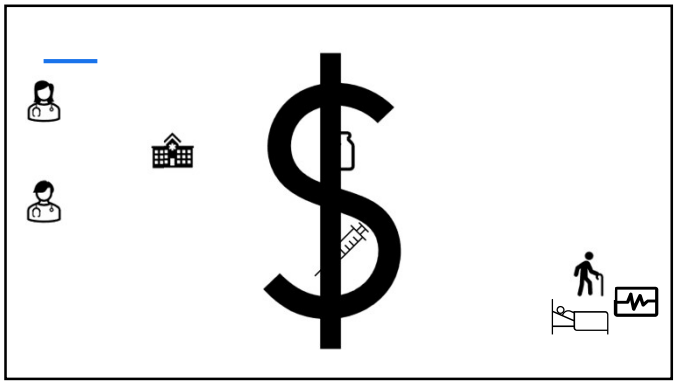


5

Why does this matter.

Bill and Dispense: Pharmacies do.

MD writes Rx

Rx goes to Pharmacy

Pharmacy dispense Rx to Pt.

6

Why does this matter.

Buy and Bill: Retina Practices

MD purchase Rx (before billing insurance/patients) in bulk

Not patient specific

Obtained from Distributors: AmerisourceBergen (Con***), Cardinal, McKesson

Wholesale negotiated prices

Drug now is owned by the Doctor.

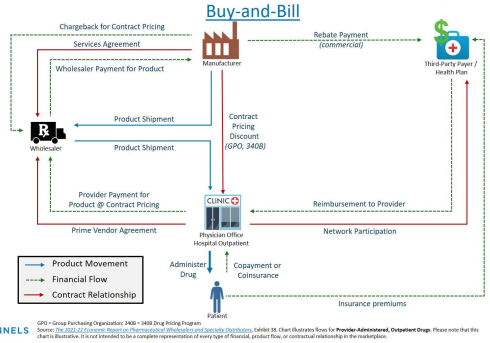
7

Drug now owned by Doc

- Drug is now owned, stored, and administered
  - Inventory management
  - Administered to patient
    - Insurance will cover none, some or all of the cost of the medication.
    - Whatever insurance does not cover, the patient has to pay.

8

Distribution and Reimbursement of Provider-Administered Outpatient Drugs: Buy-and-Bill

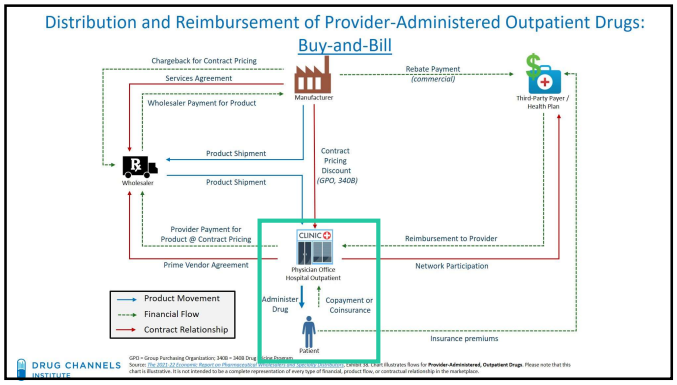


DRUG CHANNELS INSTITUTE

GPO = Group Purchasing Organization; 340B = 340B Drug Pricing Program

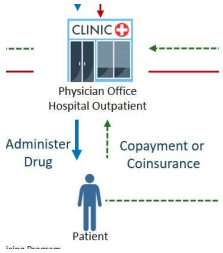
Source: The 2021-22 Economic Report on Pharmaceutical Wholesaling and Specialty Distribution, Exhibit 38. Chart illustrates flows for **Provider-Administered, Outpatient Drugs**. Please note that this chart is illustrative. It is not intended to be a complete representation of every type of financial, product flow, or contractual relationship in the marketplace.

9



10

Buy and Bill



- buy-and-bill process:

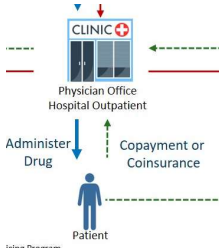
1. Doctor
   1. Purchases
   2. Stores
   3. Administers
2. Doctor bills out claim for reimbursement to third-party payer
   Buy *then* **Bill**

97% of all anti-VEGFs are through Buy-and-Bill

11

This is different than specialty pharmacies (Highmark Federal) which ships the drug to Doctor specifically for patient.

Buy and Bill



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   Buy *then* **Bill**

12

Doctor Responsibility in Buy-and-Bill

- Ordering and purchasing the drug (*Forecasting*)
- Managing drug inventory at the practice (*Inventory*)
- Prescribing and administering the drug to a patient (*Medicine*)
- Submitting reimbursement claims for a drug and related professional services (*Billing*)
- Collecting a patient's coinsurance or copayment for all services (*Collections)*

13

Doctor Responsibility in Buy-and-Bill

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- Managing drug inventory at the practice (*Inventory*)
- Prescribing and administering the drug to a patient (*Medicine*)
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- Collecting a patient's coinsurance or copayment for all services (*Collections)*

14

If a patient has insurance, how much out of pocket expense do they have for their anti-VEGF drug?

A. All of it, insurance covers none of their drug costs
B. Some of it, depends on their insurance
C. None of it, if they have insurance they are set!
D. None of the above

15

Out of Pocket
Expenses for
Injectable Therapies

16

Young
<65

Old
>65

17

Younger Patients Insurance Options

- Commercial PPOs, HMO, HDHP (66%)
- Medicaid or State directed department Assistance (18%)
- Veterans Affairs/Tricare (3.5%)

18

Younger Patients Insurance Options

- Commercial PPOs, HMO, HDHP (66%)
  - Copay assistance via Pharmaceutical Company (i.e. Eylea4U, Genentech Ophthalmology Program)
- Medicaid or State directed department Assistance (18%)
  - ***
- Veterans Affairs/Tricare (3.5%)
  - Can be covered up to 100%--(Means testing)

19

Older Patients Insurance Options

- Commercial Insurance
  - If spouse or patient works
- Medicare A+B
- Medicare C (Medicare Advantage Plan)

20

Anti-VEGF Breakdown Insurance

- Medicare FFS -46%
- Medicare Advantage-26%
- Commercial-20%
- Federal (VA/DOD) -3%
- Medicaid-3%

21

Medicare

- 65+
- People of any age with certain disabilities
- People of any age with end stage renal disease

22

Parts A, B, C & D

- A: (HOSPITAL) Inpatient hospital, SNFs, hospice, home healthcare
- B: (Medical): Physician services, outpatient care, Durbale medical equipiment, Home Health, Preventative
- C: (Advantage): Alternative to A&B, Private companies execute
- D: (Drug) Companies offer retail drug coverage to Medicare beneficiaries
- F/G (Medigap)

23

Older Patients Insurance Options

- Commercial Insurance
  - If spouse or patient works
    Drug company assistance
- Medicare A+B
  - *Medicare benefit: Administered in office/clinic, Buy & Bill*
- Medicare C (Medicare Advantage Plan)

24

Out of Pocket	Part B	Part C
Premium	>174.70 (2024)	Varies
Deductible	240	Varies
Copays		Varies,
Coinsurance	20% of the Medicare-approved amount for the covered services you use	Varies, may set for some coinsurances
Out-of-Pocket Max	No limit unless Medicare Supplement Insurance/Medigap/Part F	8,850 limit in 2024

25

Case Examples

- 1. 30 year old male with DME you are planning to do an injection of Eylea HD on, he wants to know how much out of pocket should he expect. His insurance is through:
  - VA
  - Commercial PPO
  - Medicaid

26

- Your parents are calling you on the phone and want to know if you can help them determine which insurance they should choose. Your dad gets Vabysmo for wet macular degeneration. What would you say their out of pocket would be for his vabysmo if he gets:
  - Medicare A+B
  - Medicare part C (Medicare advantage plan)
  - Medicare A+B+ F/G

27

Foundations

- **What is a Chronic Disease Fund (CDF)?**
- A financial assistance program for patients with chronic conditions like **wet macular degeneration (wAMD).**
- Helps cover out-of-pocket costs such as **co-pays, deductibles, and medication expenses.**
- Funded by **charitable donations, grants, and pharmaceutical companies.**

28

Why does it matter for MA patients

- Medicare Advantage plans often have **high out-of-pocket costs** for wAMD treatments.
- **Anti-VEGF injections** can be expensive.
- CDFs help make treatment **more affordable** and accessible.

29

What Kind of Insurance Do I Need?

Fellow Seminar

Robert Wang MD

TEXAS RETINA

1

ALUMNUS BOB WANG, MD GIVING BACK

Robert Wang, MD

Dr. Wang is a Buckeye through and through having completed his undergraduate, medical school and residency at Ohio State. As an undergraduate, he earned the coveted Evans Scholarship which provided him with full tuition and housing for four years and was a motivation for giving back. His four year scholarship made a difference in his life and inspired him to want to give other students a chance to attend college. So, in 2020, Dr. Wang created the George & Shirley Wang Fund for Student Excellence in Medicine which provides a scholarship each year for a medical student who is hoping to pursue a career in ophthalmology.

Dr. Wang lives in Dallas and practices at Texas Retina Associates, where he provides a full range of vitreoretinal care and sub-specializes in the treatment of uveitis.

"I feel lucky to have gone to Ohio State, and I'm at a point in my life where I feel it is nice to give back. I bleed scarlet and grey**!"**
- Dr. Robert Wang

Dr. Wang on Mount Everest (right)

Alyson Kishi with ARVO poster

WANG SCHOLARSHIP WINNER

The George and Shirley Wang Endowed Fund for Student Excellence in Medicine was established in 2020 by Dr. Wang to honor his parents. The annual award provides a scholarship to a student enrolled in the College of Medicine who shows interest in pursuing a medical career in ophthalmology. The Department recently announced Alyson Kishi as the 2024-2025 academic year recipient. Alyson is pursuing her medical degree at the Ohio State University College of Medicine. She presented a poster titled, "Detecting hypertensive vascular features in retinal images in preeclampsia" at the Association for Research in Vision and Ophthalmology (ARVO) meeting in Seattle, WA.

2

3

Insurance?

Its a way to protect against loss in exchange for a fee
*required
*optional

4

Insurance

From medical school to attending…

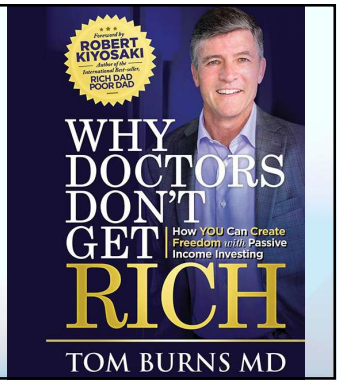
- Auto
- Home
- Disability
- Umbrella
- Whole life/Term
- LTC

5

Insurance

Fellow

- Salary net $50,000



6

Insurance

Auto

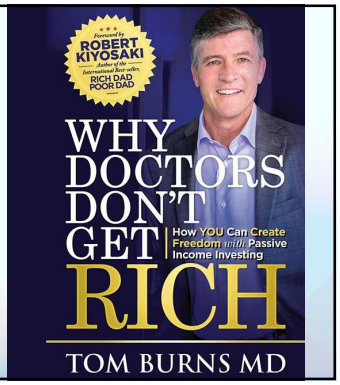
- Three numbers: 250/500/100 etc.
- Policy limits
  - Bodily injury per person
  - Bodily injury per accident
  - Property damage per accident
- Collision: deductible
- Comprehensive: deductible

7

Insurance

Fellow

- Salary net $50,000
  - $50000-$24,000=$26000(🚗)

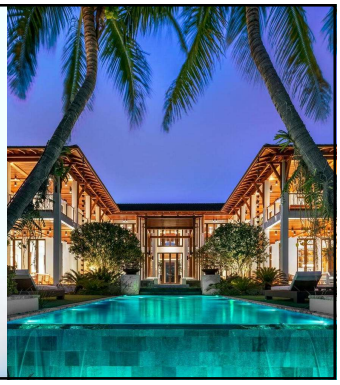


8

Insurance

Home

- Liability limits: Deductible
- Riders
  - Jewelry, watches



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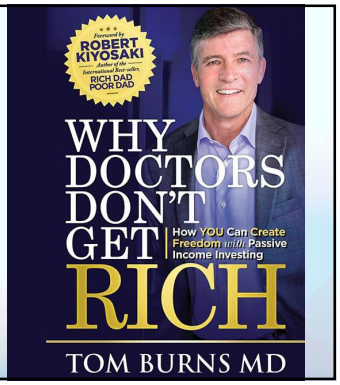

11

Insurance

Disability

- Short term
- Long term
- Work offers some form, limited
  - Income replacement ~60%
  - Medical Coverage etc
- Personal
  - Stackable
  - Own occupation
  - Definition of disability
  - Length of waiting period
  - Your income
  - Length of benefits

12

Insurance

Disability

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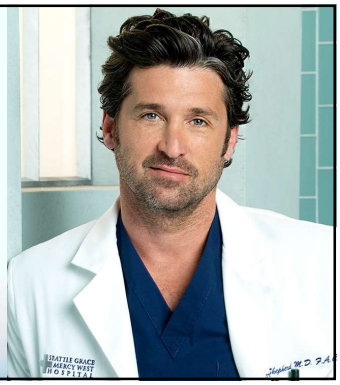

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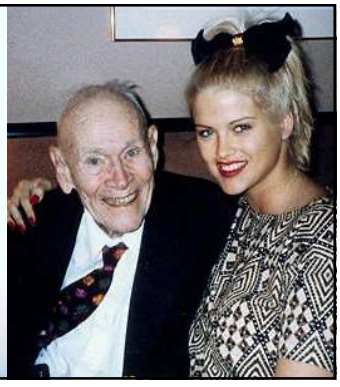
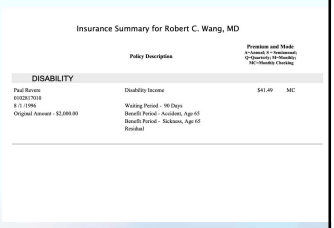


15

Insurance

Disability

- Some can't increase the premiums…locked in
  - Paul revere from residency $2,000
  - MassMutual $1,505 180 day waiting period.
  - Metlife $15,000 90 day waiting period
  - If I became disabled. Would be living off of $18,505 a month or $222,060 a year 👍
  - Premiums $350 a year MM, $500 for PR, $11,000 for Metlife



Insurance Summary for Robert C. Wang, MD

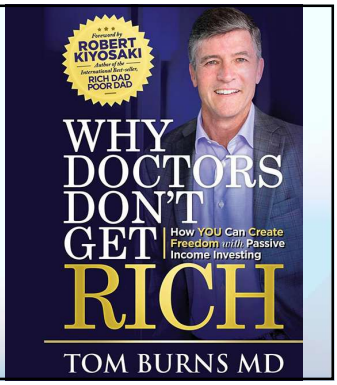
Policy Description		Premium and Mode (A=Annual, S = Semiannual) Q=Quarterly M=Monthly MC=Monthly Checking
DISABILITY		
Paul Revere 0102817010 E/I: /1996 Original Amount - $2,000.00	Disability Income Waiting Period - 90 Days Benefit Period - Accident, Age 65 Benefit Period - Sickness, Age 65 Residual	$41.49 MC

16

Insurance

Fellow

- Salary net $50,000
  - $50000-$24,000=$26000 (🚗)
  - $26,000-$8,000=$18,000 (🏠)
  - $18000-$11,850=$6,150 (🚵)



17

Insurance

Umbrella

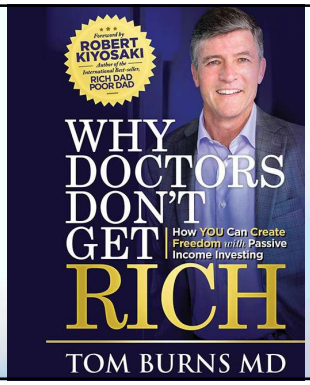
- Excess liability coverage (safety net)
- My is bundled with my Allstate (home, auto, umbrella)
  - Cheap
  - Remember the auto liability? Slip and falls etc.
  - Bodily injury and Property damage Annual
    - $1 mil each occurrence
    - $2 mil for policy period
  - Personal injury
    - $500,000 each occurrence
    - $1 mil for policy period
  - Additional dwelling rented to others..didnt get
  - $270 a year

18

Insurance

Fellow

- Salary net $50,000
  - $50000-$24,000=$26000 (🚗)
  - $26,000-$8,000=$18,000 (🏠)
  - $18000-$11,850=$6,150 (🚴)
  - $6,150-$270=$5,880 (☂️)



19

Insurance

Life policies

- Whole Life and Term
- In case of the death of the breadwinner….what if?

20

Insurance

Term

- Affordable
- For a certain time period or "term"
- Good for growing family
- Problems
  - Time frame not fit everyone
  - Lose that value
  - Health issues may keep from getting new policy
  - Can convert to whole but usually at a set time and costly

21

Insurance

Term

- Term life
  - Principal expires March 31, 2065
    - Born 1969, 96yo!
    - $3755 a year
    - 10 year term…

22

Insurance

Term

- Whole life
  - Guaranteed death benefit
  - Access to cash
  - Tax free death benefits
  - Tax free growth
  - Guaranteed growth
  - Policy keeps going as long as you keep paying
  - Cash value, interest and premiums go there to grow, living benefit

23

Insurance

Term

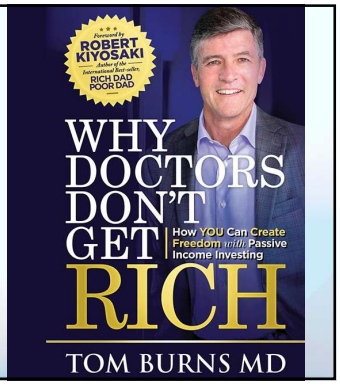
- Whole life
  - Payment
    - Level payment
    - Single payment
    - Limited payment
    - Modified whole life
  - Why insurance agents like it
  - Commission of 50-100% or first year premiums, smaller renewal commissions

24

Insurance

Fellow

- Salary net $50,000
  - $50000-$24,000=$26000 (🚗)
  - $26,000-$8,000=$18,000 (🏠)
  - $18000-$850=$17,150 (🚴)
  - $6,150-$270=$5,880 (☂️)
  - $5,880-$3,755=$2,125(🛟)



25

Insurance

Longterm Care

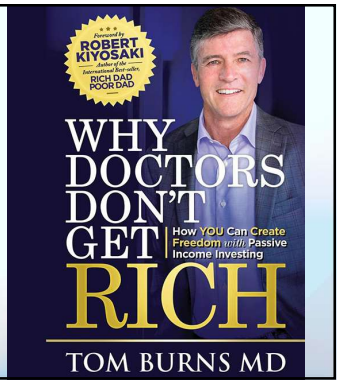
- LTC
  - Pay for cost associated with LTC not covered under Medicare/Medicaid
    - Not sick, but unable to perform 2 out of the 6 ADL's
      - Dressing, bathing, eating, toileting, continence, transferring, walking
    - Home coverage, private nurses, adult daycare etc.
    - New when I started CFP class
    - Genworth, premiums suppose to be fixed, had to raise, got sued. Now has a fixed options
    - $3700 premium

26

Insurance

Fellow

- Salary net $50,000
  - $50000-$24,000=$26000 (🚗)
  - $26,000-$8,000=$18,000 (🏠)
  - $18000-$850=$17,150 (🚴)
  - $6,150-$270=$5,880 (☂️)
  - $5,880-$3,755=$2,125(🛟)
  - $2,125-$3,700= -$1,575 (🎯)



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28

29

Physician Employment Contracts

2025 Business of Retina Meeting

Presented by: Caroline Patterson, Esq.

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SAUL EWING

1

Caroline Patterson, Esq.

Parnter | Healthcare Group

Chesterbrook, PA and
Princeton, NJ
Caroline.Patterson@saul.com
(610) 251-5066

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

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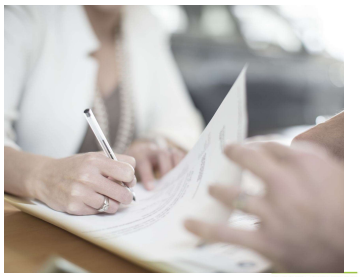
2

The Process

- Letter of Intent
- Negotiations
- Formal Agreement
- Engaging a Lawyer



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3

Term & Termination

Term

- Start Date
- Length of Term
- Expiration
- Automatic Renewal v. Agreement to Renew or Extend
- Relevance to Partnership

Termination

- Right of Termination at Any Time upon Required Notice – i.e., "Without Cause"
  - Required Notice Period
- Immediate – i.e., "For Cause"
- Termination issues

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4

Compensation

Basics

- Base Salary
- Annual Raises (Or Not)
- Relocation Allowances
- Signing Bonuses
- Net Collections Transition

Incentive Bonuses

- Individual vs. Group Profitability
- Mechanics
- Likelihood of Achievement
  - Reason for Hire
    - Adding Physician
    - Replacing Physician
    - Entering New Market
    - Incorporating Specialist

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5

Expenses

Business Expenses

- Malpractice Insurance
  - *Occurrence vs. Claims Made*
  - *"Tail" Upon Termination*
- State License; DEA; Hospital Fees
- Dues; Subscriptions; Journals
- CME Allowance
- Cell Phone
- Automobile Allowance
- Board Certification

Fringe Benefits

- Health Insurance (family)
- Dental Coverage
- Disability Insurance
- Group Term Life Insurance
- Retirement Plans
- Time Off
  - Vacation
  - Education Leave
  - Sick Leave
  - Materinity Leave

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6

Restricive Covanants

Non-Competition

- Non-Compete Restrictions
  - Enforceability
    - Geographic Scope and Duration
    - Public Interest
  - Liquidated Damages or Buy-Out Clauses
- Negotiating Options
  - Limit Geography
  - Limit to Termination For Cause
  - Limit if Part-Time or Employed Less Than a Year

Non-Solicitation

- Non-Solicitation Restriction
  - Enforceable
  - Less Negotiable
  - Patients
  - Referring Sources and Contractual Relations
  - Employees
  - General Advertisements

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7

Partnership

- Commencement Date
- Ownership Interest Sold
- Purchase Price
  - Tangible Assets
  - Accounts Receivable
  - Goodwill
- Structure
- Timing

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8

Questions?

SAUL EWING

9

Retinal Coding Essentials

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

RETINA CONSULTANTS OF AMERICA

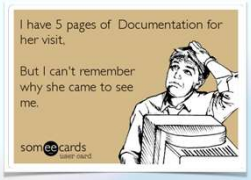
Retina Consultants of Texas

1

Outline

Retinal Coding Essentials

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



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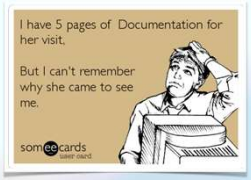
Coding Goals

- 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



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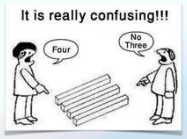
Coding Modifiers

- 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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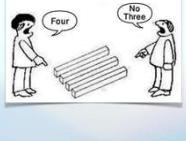
Coding Modifiers

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



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Coding Modifiers

6

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)

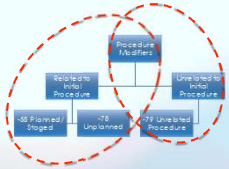
7

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



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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 1week 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

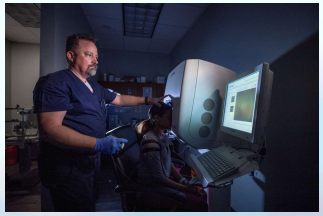
17

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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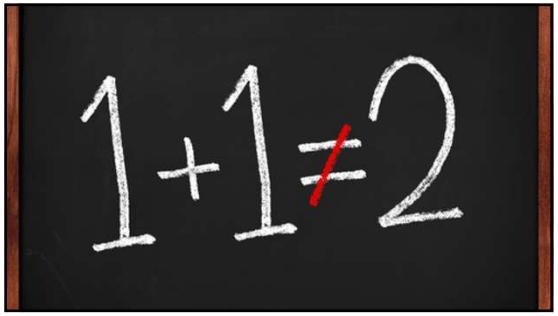

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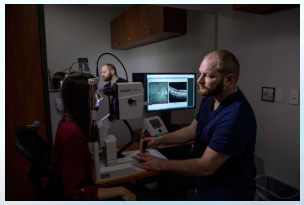
OCT/OCTA

- 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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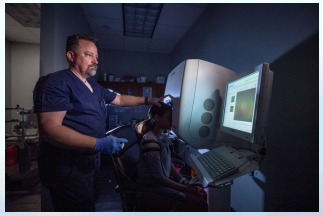
Fundus Photography

- 92250
- Bilateral code
- Includes Autofluorescence photos



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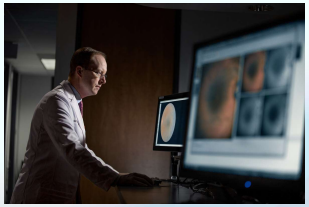
IVFA

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



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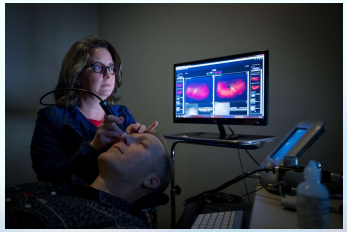
ICG

- 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

26

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 (Straightforward)	• 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

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E/M vs Eye

E/M Coding

99203/99213
No Treatment

99204/99214
Rx, Procedure

99205/99215
ER, Emergency

Eye Coding

92002/92012
Undilated Exam

92004/92014
Dilated Exam

32

Short Cuts

- PVD, Dry AMD, othe
  no treatment – Leve
- Wet AMD, RVO, DME
  with prescription dr
  or need for surgery
- Some Oncology, an
  Endopthalmitis, Ma
  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

Tax Advantages of owning a Private Practice

Business of Retina 2025
Atlanta, GA.

Keith A. Warren, M.D.
Founder and President Warren Retina Associates
Member, Board of Directors, American Board of Ophthalmology
Clinical Professor & Chair Emeritus, KU Ophthalmology

1

Financial Disclosures

- I do not have any financial interests to disclose related to this presentation

2

Objectives

- To discuss the tax advantages of owning a private practice
- Upon completion of this presentation the audience should:
  - Understand the different types of business structures and implications
  - Know some of the tax deductions that are available to business owners
  - Understand the differences of tax liabilities between employer/employees
  - Understand the advantages of being an employee

3

Disclaimer

- I AM NOT A TAX ATTORNEY OR CERTIFIED TAX ACCOUNTANT!!!!!

4

Acknowledgement

- I am current in ALL of my tax liabilities
- 12 years in academia(Department Chair)
- 20 year solo private practice(Expert in Retina)
- Advised by certified Tax Accountant and Wealth Advisor(Expert in Business Taxes)
- Still learning about tax implications

5

PLEASE CONSULT YOUR ACCOUNTANT OR TAX ATTORNEY FOR ANY QUESTIONS ABOUT YOUR TAX LIABILITIES!!!

6

Owning a Business "The American Way"

- Embodies the core values and culture of the United States
- Anyone can create a business and succeed is the American dream
- Encourages Innovation, Risk taking, and self–reliance ("eat what you kill")
- Independence, control of own success and wealth
- Government supports through legislation, funding, tax incentives

7

Personal Taxes vs. Business Taxes

- Most employees are "W-2" wage earners
- Taxed on basis of W-2 earnings
- Use Standard Form 1040 to assess tax liability

- Business are taxed based on the type of business structure
- Variety of tax forms required(Accountant/ Tax attorney)

8

Business Structures

Taxation depends on the business structure

- Sole Proprietorship – income on owner's personal return(Business and self-employment tax)
- Partnership - Business income passes to partner to personal return(No Business tax, but does have Self-employment tax)
- Corporations (C Corp or S Corp)- C Corp-Tax at corporate/personal level

S Corp – Business income passes through to personal return
(No Business or self employment tax)

- LLC –Limited Liability Company – Business income passes to owner +/- self-employment tax

9

Deductions

Employee Deduction

- Mortgage interest
- Retirement contributions
- Charitable contributions
- Dependents and Child tax credits
- HSA

Bus. Owner Deduction

- Mortgage interest
- Retirement contributions
- Charitable contributions
- Dependents and Child tax credits
- HSA

Bus. Owner Deduction + Bus. Expenses

- Mortgage interest
- Retirement contributions
- Charitable contributions
- Dependents and Child tax credits
- HSA
- Equipment/depreciation
- Salaries
- Self employment tax
- Business travel
- Office mortgage/rent
- Business use of home
- Defined Benefit Plan(CBP)

10

DEDUCTION EXAMPLES

11

Deductions
Business use of Home

- The space must be used exclusively and regularly for business purposes
- Home should be principal place of business, except if there is no other fixed location and regular administrative and managerial activities are performed there.*
- Calculate actual expenses incurred for the business portion of your home
- Exclusive use(storage room/bedroom… NOT!!!)
- Regular use
- Principal place of business*

12

Deductions
Business use of Home (Example)

Home area (4650 sf) Office space 18 x 24 (432sf) Office 432/4650 = 0.0929 or 9.3%

Direct expenses

- Painting $700
- Office furniture $2,100
- Router $695

Total $3,495

Indirect expenses (9.3%)

- Mortgage Int. payment $49,200
- Insurance $3,750
- Property tax $8,450
- Repairs/ Replacement* $6,250
- Utilities $6,150

Total $73,800 x 0.093 $6863

Business use of home – Deductions = $10,358

13

Deductions
Business related travel

- Allows for deduction of business-related travel expenses.
- Must be away from tax "home" and for business purposes
- Allowable expenses include, transportation, lodging, meals(50%)
- Must keep receipts and written record to substantiate travel
- Good benefit for employees(Retention and education)
- AAO and Business retreat

14

Deductions
Business related travel (Example)

- Local Ophthalmologic Society Meeting
  Expenses - Employee salary(+)
  Meeting Registration
  Meals(50%)
- Chicago AAO Meeting
  Expenses-Employee salary(+)
  Meeting registration
  Meals(50%)
  Transportation
  Housing

Added Benefits
Improves staff education and performance
Interactions with peers from around the country
Builds staff moral and loyalty

All of these expenses tax deductible. Greater reduction in tax liability with out-of-town Meeting

15

Deductions
Defined Benefit Plan (Cash Balance Plan)

- Type of defined benefit plan(Traditional plan and contribution plan)
  - Benefit separate from traditional 401(k) plan
  - Participants receives set percentage of yearly compensation + interest
  - Must comply with federal regulations (All employees/guaranteed)
  - Attractive employee benefit (recruitment and retention)
  - *Significant salary difference owner/employee. Up to $380k!!!
    - Owners can contribute significantly more towards retirement*

16

Deductions
Defined Benefit Plan/CBP (Example)

- 10 employee practice
- 8 employees (3% of salary/employee(24%)
- Physician owner/Administrator(51% of salary/25% of salary(76%)
- Business contributes/Plan guaranteed
- MD salary $300,000 = $153,000 Contribution to retirement plan

These significant contributions are ALL tax deductible as business expense

17

Summary

- Business ownership is the "American Way'
- Entrepreneurship promotes innovation, risk taking, and self-reliance
- Practice owners have more control over income
- Private practices have a wider range of deductions and retirement contribution options
- Practice owners have greater administrative complexity and responsibility for management and health of practice(People/equipment/office space, etc.)HEADACHE!
- Practice owners at greater overall financial risk

18

Summary

- Employees have fixed salaries with possibility of incentives(Guaranteed!!)
- Employees have fewer business deduction available to them
- Employees enjoy simpler tax filings and employer-provided benefits(PTO/Retirement, etc.)
- Employee avoid the headache of administrative and management responsibility
- Employees avoid significant financial risk and responsibility for health/success of business

19

Closing Thoughts

NO bad Choice!

There are advantages to being either a practice owner or employee

What you choose depends on your financial situation, long term goals, need for independence, risk tolerance/adversion and a willingness to shoulder the responsibility of owning a practice

The stability and simplicity of being an employee carries much less risk and has many benefits including one's overall health and well-being

20

Thank You!!!!!!

- I AM NOT A TAX ATTORNEY OR CERTIFIED TAX ACCOUNTANT!!!!!
- PLEASE CONSULT YOUR ACCOUNTANT OR TAX ATTORNEY FOR ANY QUESTIONS ABOUT YOUR TAX LIABILITIES!!!

21

Finances for Early Career

Arjun B. Sood, MD
Vitreoretinal Surgery and Uveitis
Retina Associates of Western NY, P.C.

1

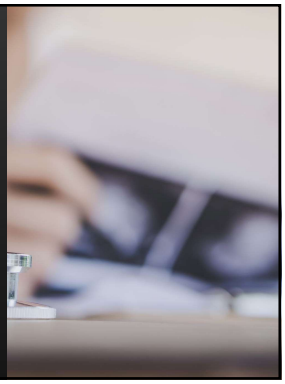
Outline:

- General Personal Finance Principles
- General Personal Finance steps
  - Protect against financial catastrophe
  - Estate Planning
  - Emergency fund
  - Student Loans & Debt management
  - Retirement

2

Personal Finance Principles

- As a physician, you have a tried and true pathway to wealth and financial independence
- Resist the urge to inflate spending too quickly with new attending salary
- Do NOT deprive yourself. Physician burnout is real. Delaying gratification will add to that.



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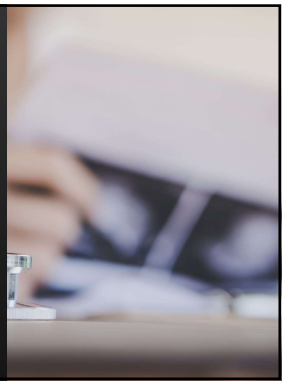
Personal Finance Principles

- Pay yourself first – set aside salary towards retirement and other savings
- Learn about basic personal finances (even if you have a financial advisor)



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Personal Finance Steps

5

Protect against financial catastrophe

- What's my plan to support myself (and family) if I can't earn money due to disability?
  - Disability Insurance
- What's my plan to support loved ones if I pass away?
  - Life Insurance
- Asset Protection
  - Umbrella Policy
  - Health, Auto, Homeowners/Rental, Malpractice

6

Disability Insurance

- "Own occupation" – if you're unable to perform the occupation for which you're trained, you are considered disabled
- Individually-owned (Priority)
  - Non-cancellable with guaranteed, fixed premiums
  - Policies are portable – can take them even if you depart your employer
  - Benefits are non-taxable since premiums are paid with after-tax dollars
  - Policy Riders – cost of living adjustment (COLA), future increase option (FIO), Student Loan Protection
- Employer – offered by some employers. Benefits are often taxable

7

Life Insurance

- Individually-owned
  - Term Insurance (Priority)
  - Permanent Insurance (Variable, Universal, Whole Life)
- How much Term Insurance do I need?
  - 3 Million coverage for 30 years
  - Can "ladder" your policies
    - 1 million for 10 years
    - 1 million for 20 year
    - 1 million for 30 years

8

Asset Protection

- You are a physician, and you will always have a target on your back
- Health, Auto, Homeowners, Malpractice
- Umbrella Policy (extra personal lability to cover home and auto)

9

Estate Planning – Why?

- Provides a plan for how you want your finances, health and property managed when you are unable due to illness, disability or death.
- Provides a guardianship plan for minor children

10

Basic Estate Plan:

- Financial power of attorney
- Healthcare Proxy
- Living will (advanced directive) – covers preferences for end-of-life care
- Will – provides instructions to transfer assets, appoint guardianship for minor children, and name an executor to oversee the estate of the deceased.

11

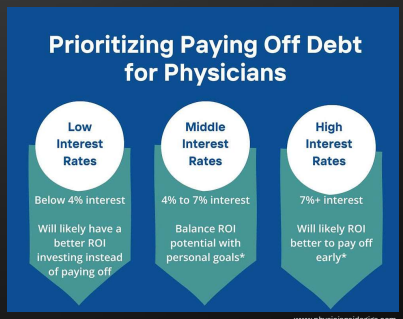
Emergency Fund

- Why?
  - Unexpected expenses: medical emergency, car/home repair
  - Loss of job/period of unemployment

How?
- Create a budget
- Set aside 3-6 months of your expenses
- High-yield savings account is a good for money you need to keep liquid

12

Debt management



13

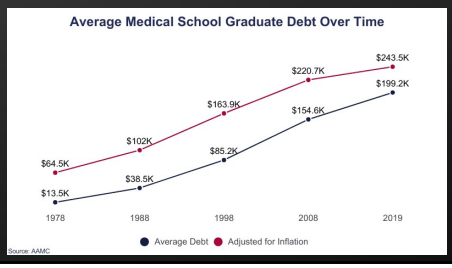
Debt management

- Eliminate High Interest Debt (credit card, car loan)
- Home ownership (plan for it) – if new to the area, better off doing a lease prior to buying.
- Wait to buy the "doctor" home
- "Lifestyle Creep" – while you can afford a newer car, luxury items etc. it is wise not to increase spending in proportion to income

14

Student Loans:

- 2023-2024: Average debt medical school graduates $264K



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Student Loans

- Standard repayment plan for federal loans is a fixed monthly payment plan that lasts up to 10 years
- Public Student Loan Forgiveness: Program that forgives debt issued by Federal Gov't after 120 payments
  - To be eligible, physicians must be employed by a non-profit, tax exempt 501(c)3 (i.e., university hospitals & community hospitals, VA, military)
  - The borrower must be enrolled in an income driven repayment plan

16

Not eligible for PSLF

- Refinance your government education loans to private student loans (SoFi, Laurel Road etc.)
- Once you go private, you can't go back to federal loans and take advantage of associated programs (PSLF)

17

18

Retirement – Employer Sponsored

- Tax advantaged accounts
  - 401K – for private, for-profit institutions
  - 403B– for non-profit, schools, hospitals, etc.
  - 457B – for government entities
- Many employers offer a "match" – should at least make minimum contributions to qualify for match
- Roth vs Traditional (some plans offer both)
  - Traditional – contributions funded with pre-tax dollars → grow tax-deferred → pay taxes when you withdraw
  - Roth – contributions funded with post-tax dollars → grow tax-deferred → tax-free withdrawal

19

Health Savings Account (HSA)

- HSA
  - "Triple Tax Advantage"
    - pre-tax dollars
    - tax-free growth
    - not taxed when used for qualifying healthcare expenses

20

Other Considerations:

- 529 – state sponsored plan designed to save for and invest in educational expenses (children)
- Cash Balance Plan – offered by some private practices
- Taxable accounts for excess savings

21

Should you DIY or hire a Financial Advisor?

- Financial Advisor fees can vary:
  - Pay set annual fee
  - Pay hourly rates
  - Fee based on Assets Under Management (usually breakpoints)
    - 0-2 Million has 0.85% fee
    - 2-5 million 0.75% fee
    - 5+ million 0.5% fee

22

Resources

- White Coat Investor
  - https://www.whitecoatinvestor.com/
  - Book and Online Course
- Physician Side Gigs
  - https://www.physiciansidegigs.com/

Fire Your Financial Advisor: ATTENDING

23

Questions / Thank you!

- arjunbsood@gmail.com

24

Getting Involved in Advocacy

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

1

Financial Disclosure

- EyePoint – public stock

2

It's a Great Time to Get Involved!

3

No, Really. It is.

- Fellows and early career physicians represent the future of the profession
  - You'll be taking care of today's leaders someday
- Make connections and relationships now to help you throughout your career
- **Make sure your patients' needs don't get lost in the political debate**

ASRS

4

Why is Advocacy Important?

- Medicine is one of the most-highly regulated professions
  - Federal policy sets Medicare payment rates and quality metrics
  - The FDA regulates drugs, devices, and outsourcing facilities
  - State agencies regulate licensure, scope of practice, and liability
  - Federal and state entities oversee insurance coverage and payer decisions
- If you don't have a say in these issues, someone else will

ASRS

5

Why is Advocacy Important for Retina Specialists?

- High percentage of Medicare-eligible patients
- Anti-VEGFs for retinal disease are some of the top Medicare expenditures for Part B drugs
  - #2 Eylea, #8 Lucentis – in 2022
- Medicare Advantage and commercial payers routinely require step therapy and/or prior authorization for anti-VEGF
- The supply chain for repackaged Avastin is fragile
- ODs and other non-physicians seek to expand their scope of practice

ASRS

6

What Does ASRS Do?

- Advocates to Congress and the executive branch on key issues:
  - Ensuring adequate Medicare physician reimbursement
  - Maintaining physician and patient choice of treatments
  - Limiting payer utilization management practices of prior authorization and step therapy

ASRS

7

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

8

How Does ASRS Advocate?

- ASRS speaks with one voice for all retina specialists
  - Meeting with policymakers and payers
  - Submitting comments, statements, etc.
  - Engaging with coalitions – Alliance of Specialty Medicine, Surgical Coalition, AMA, other ophthalmic organizations

- Educate members on key policy developments
  - **We let you know when to act!**

ASRS

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Advocacy Works: ASRS Wins

- ✓**Reduced MIPS Penalties** by advocating for CMS to exclude retina specialists from the diabetes cost measure
- ✓**Expanded retina specialists' ability to succeed** in MIPS by developing three new quality measures
- ✓**Protected patients from under-dosing** by achieving an exemption for a discarded drug rebate program for small volume single-use injectable drugs

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How Can I Make a Difference?

- Lawmakers want to hear from the people they represent and how they are affected by the policies enacted in Washington
- Only you can tell your story
  - Use your experiences to demonstrate how policies impact patients, the care you provide, and the way your practice runs
- Let politicians know how many of their voters you treat!

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Why Now?

- Political issues change and volatility fluctuates
- Today's hot button issues may be forgotten tomorrow
- **But you have to start somewhere**

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How Do I Get Started?

- Sign-up to be an ASRS Grassroots Contact
- **Respond to ASRS calls to action**
  - Instant, pre-written messages
- Visit asrs.org/grassroots for tips and resources
- Find out who your legislators are and learn about them
  - House.gov & senate.gov
- Make sure you're registered to vote – even if you don't plan on staying where you are for long
  - Re-register when you move

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How Do I Learn About the Issues?

- Visit ASRS.org and read the weekly newsletter *Advocacy and Practice News* on Tuesday afternoon
  - Keep an eye out for additional timely alerts to take action

- Read the newspaper
  - National ones – NYT, WaPo, WSJ, LA Times
  - Local news
  - Sign up for legislator newsletters

- **Don't worry – ASRS will give you talking points!**

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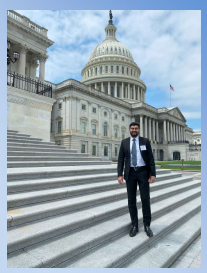
Want to Get More Involved?

- Represent ASRS at the annual Alliance of Specialty Medicine Advocacy Conference in Washington, D.C.
  - July 14-16, 2025
- Meet with your legislator back home, or invite them to your practice
  - ASRS can help facilitate



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THANK YOU!

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