ENTREPRENEURSHIP IN RETINA

A roundtable moderated by Namrata Saroj, OD; With Darius M. Moshfeghi, MD; Rishi P. Singh, MD; and Charles C. Wykoff, MD, PhD

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As Demonstrated in Phase 3 Clinical Trials

IMPORTANT SAFETY INFORMATION AND INDICATIONS

CONTRAINDICATIONS
• EYLEA is contraindicated in patients with ocular or periocular infections, active intraocular inflammation, or known hypersensitivity to aflibercept or to any of the excipients in EYLEA.

WARNINGS AND PRECAUTIONS
• Intravitreal injections, including those with EYLEA, have been associated with endophthalmitis and retinal detachments. Proper aseptic injection technique must always be used when administering EYLEA. Patients should be instructed to report any symptoms suggestive of endophthalmitis or retinal detachment without delay and should be managed appropriately. Intraocular inflammation has been reported with the use of EYLEA.
• Acute increases in intraocular pressure have been seen within 60 minutes of intravitreal injection, including with EYLEA. Sustained increases in intraocular pressure have also been reported after repeated intravitreal dosing with VEGF inhibitors. Intraocular pressure and the perfusion of the optic nerve head should be monitored and managed appropriately.
• There is a potential risk of arterial thromboembolic events (ATEs) following intravitreal use of VEGF inhibitors, including EYLEA. ATEs are defined as nonfatal stroke, nonfatal myocardial infarction, or vascular death (including deaths of unknown cause). The incidence of reported thromboembolic events in wet AMD studies during the first year was 1.8% (32 out of 1824) in the combined group of patients treated with EYLEA compared with 1.5% (9 out of 595) in patients treated with ranibizumab; through 96 weeks, the incidence was 3.3% (60 out of 1824) in the EYLEA group compared with 3.2% (19 out of 595) in the ranibizumab group. The incidence in the DME studies from baseline to week 52 was 3.3% (19 out of 578) in the combined group of patients treated with EYLEA compared with 2.8% (8 out of 287) in the control group; from baseline to week 100, the incidence was 6.4% (37 out of 578) in the combined group of patients treated with EYLEA compared with 4.2% (12 out of 287) in the control group. There were no reported thromboembolic events in the patients treated with EYLEA in the first six months of the RVO studies.
TRUST #8 YEARS of Extensive Clinical Experience and the Integrity of Data From Large, Well-Controlled Trials

EYLEA IS THE

#1 PRESCRIBED anti-VEGF
FDA approved for Wet AMD, DME, and MEfRVO

*IBM Truven MarketScan data: Number of injections administered from Q4 2017 through Q3 2018; data on file.

AN ESTIMATED

≈9 MILLION doses administered to ≈790,000 eyes since launch (and counting)

ACROSS ALL APPROVED INDICATIONS

8 PHASE 3 CLINICAL TRIALS including more than 3000 EYLEA–treated patients

START WITH EYLEA
Visit HCP.EYLEA.us to see our data.

ADVERSE REACTIONS

• Serious adverse reactions related to the injection procedure have occurred in <0.1% of intravitreal injections with EYLEA including endophthalmitis and retinal detachment.

• The most common adverse reactions (≥5%) reported in patients receiving EYLEA were conjunctival hemorrhage, eye pain, cataract, vitreous detachment, vitreous floaters, and intraocular pressure increased.

INDICATIONS

EYLEA® (aflibercept) Injection 2 mg (0.05 mL) is indicated for the treatment of patients with Neovascular (Wet) Age-related Macular Degeneration (AMD), Macular Edema following Retinal Vein Occlusion (RVO), Diabetic Macular Edema (DME), and Diabetic Retinopathy (DR).

Please see Brief Summary of Prescribing Information on the following page.

anti-VEGF = anti–vascular endothelial growth factor; AMD = Age-related Macular Degeneration; DME = Diabetic Macular Edema; MEfRVO = Macular Edema following Retinal Vein Occlusion.


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11/2019
EYL-19-10-0044-REGEYL431
EYLEA RS JA-BMC Retina Today - Business Matters_R1.indd   1-2
2/14/20   1:11 PM
Untitled-2   3
2/18/20   1:20 PM
EYLEA® (aflibercept) Injection
Full Prescribing Information
for Intravitreal Injection

BRIEF SUMMARY—Please see the EYLEA full Prescribing Information available on HCPYELEA.US for additional product information.

1 INDICATIONS AND USAGE
EYLEA is a vascular endothelial growth factor (VEGF) inhibitor indicated for the treatment of:

Neovascular (Wet) Age-Related Macular Degeneration (AMD); Macular Edema Following Retinal Vein Occlusion (RVO); Diabetic Macular Edema (DME); Diabetic Retinopathy (DR).

4 CONTRAINDICATIONS
4.1 Ocular or Periocular Infections
EYLEA is contraindicated in patients with ocular or periocular infections.

4.2 Active Intravitreal Inflammation
EYLEA is contraindicated in patients with active intravitreal inflammation.

4.3 Hypersensitivity
EYLEA is contraindicated in patients with known hypersensitivity to aflibercept or any of the excipients in EYLEA. Hypersensitivity reactions may manifest as rash, pruritus, urticaria, severe anaphylactic/anaphylactoid reactions, or severe intravitreal inflammation.

5 WARNINGS AND PRECAUTIONS
5.1 Endophthalmitis and Retinal Detachments.

Intraocular injections, including those with EYLEA, have been associated with endophthalmitis and retinal detachments [see Adverse Reactions (6.2)]. Proper aseptic injection technique must always be used when administering EYLEA. Patients should be instructed to report any symptoms suggestive of endophthalmitis or retinal detachment without delay and should be managed appropriately [see Patient Counseling Information (9.7)].

5.2 Increase in Intracocular Pressure.
Acute increases in intracocular pressure have been seen within 60 minutes of intravitreal injection, including with EYLEA [see Adverse Reactions (6.1)]. Sustained increases in intracocular pressure have also been reported after repeated intravitreal dosing with vascular endothelial growth factor (VEGF) inhibitors. Intracocular pressure and the optic nerve head should be monitored and managed appropriately.

5.3 Thromboembolic Events.
There is a potential risk of arterial thromboembolic events (ATEs) following intravitreal use of VEGF inhibitors, including EYLEA. ATEs are defined as nonfatal stroke, nonfatal myocardial infarction, or vascular death (including deaths of unknown cause). The incidence of reported thromboembolic events in 2 RVO studies during the first year was 1.8% (32 of 1924) in the combined group of patients treated with EYLEA compared with 1.5% (5 of 329) in patients treated with ranibizumab; through 96 weeks, the incidence was 1.3% (60 of 4624) in the EYLEA group compared with 0.9% (25 of 2563) in the ranibizumab group. The incidence in the DME studies from baseline to week 52 was 3.3% (19 out of 578) in the combined group of patients treated with EYLEA compared with 2.8% (14 out of 500) in the control group; from baseline to week 100, the incidence was 4.4% (14 out of 327) in the combined group of patients treated with EYLEA compared with 4.2% (12 out of 287) in the control group. There were no reported thromboembolic events in the patients treated with EYLEA in the first six months of the RVO studies.

6 ADVERSE REACTIONS
6.1 Clinical Trials Experience.

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in other clinical trials of the same or another drug and may not reflect the rates observed in practice.

A total of 2159 patients treated with EYLEA were selected in the safety population in 8 phase 3 studies. Among these, 2159 patients were treated with the recommended dose of 2 mg. Serious adverse reactions related to the injection procedure have occurred in ≤0.1% of intraocular injections with EYLEA including endophthalmitis and retinal detachment. The most common adverse reactions (≥5%) reported in patients receiving EYLEA were conjunctival hemorrhage, eye pain, cataract, vitreous detachment, vitreous floaters, and injection site pain.

Neovascular (Wet) Age-Related Macular Degeneration (AMD). The data described below reflect exposure to EYLEA in 1824 patients for 24 months (with active control in year 1).

The data described below reflect exposure to EYLEA in 29 patients with nonproliferative diabetic retinopathy (NPDR) through week 52 in the PANORAMA trial were consistent with those seen in the phase 3 VIVID and VISTA trials (see Table 1 above).

As with all therapeutic proteins, there is a potential for an immune response in patients treated with EYLEA. The immunogenicity of EYLEA was evaluated in serum samples. The immunogenicity data reflect the percentage of patients whose test results were considered positive for antibodies to EYLEA in immunoassay. The detection of an immune response is highly dependent on the sensitivity and specificity of the assays used, sample handling, timing of sample collection, concomitant medications, and underlying disease state. A comparison of the incidence of antibodies to other products may be misleading.

In the DME, RVO, and DME studies, the pre-treatment incidence of immunogenicity to EYLEA was approximately 1% to 2% across treatment groups. After dosing with EYLEA for 24-70 weeks, antibodies to EYLEA were detected in a similar percentage range of patients. There were no differences in efficacy or safety between patients with or without immunogenicity.

8 USE IN SPECIFIC POPULATIONS.
8.1 Pregnancy Risk Summary

Arteriovenous nullified and well-controlled studies with EYLEA have not been conducted in pregnant women. Aflibercept produced adverse embryofetal effects in rabbits, including external, visceral, and skeletal malformations. A full No Observed Adverse Effect Level (NOAEL) was not identified. At the lowest dose shown to produce adverse embryofetal effects, ocular exposures (based on AUC for the parent aflibercept) were approximately 6 times higher than AUC observed in humans after a single intravitreal treatment at the recommended clinical dose [see Animal Data].

Animal reproduction studies are not always predictive of human response, and it is not known whether EYLEA can cause fetal harm when administered to a pregnant woman. Based on the anti-VEGF mechanism of action for aflibercept treatment with EYLEA may pose a risk to human embryonic development. EYLEA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

There are no data on the background risk of birth defects, loss, or other adverse outcomes. The background risk of major birth defects and miscarriage for the indicated pregnant population is unknown. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2-4% and 15-20%, respectively.

Data

ART/RD

In two embryopathological development studies, aflibercept produced adverse embryofetal effects when administered every three days during organogenesis to pregnant rats at intravenous doses of 2 mg per kg, or every six days organogenesis to subcutaneous doses of 5 mg per kg.

Adverse embryofetal effects included increased incidences of postimplantation loss and fetal malformations, including exencephaly, umbilical hernia, diaphragmatic hernia, gastroschisis, short or absent thumbs, anencephaly, cyclopia, encephalocele, heart and major vascular defects, and skeletal malformations (closed vertebrae, sternum, and ribs; supraumbilical vertebral arch and ribs; and incompletely ossified). The maternal No Observed Adverse Effect Level (NOAEL) in these studies was 3 mg per kg.

Intraocular injection of aflibercept produced malformations at all doses assessed in rabbits and the fetal NOAEL was not identified. At the lowest dose shown to produce adverse embryofetal effects in rabbits (0.5 mg per kg), systemic exposure (AUC) of free aflibercept was approximately 6 times higher than systemic exposure (AUC) observed in humans after a single intravitreal dose of 2 mg.

8.2 Lactation

Risk Summary

There is no information regarding the presence of aflibercept in human milk, the effects of the drug on the breastfed infant, or the effects of the drug on milk production/secretion. Because many drugs are excreted in human milk, and because the potential for absorption and harm to infant growth and development exists, EYLEA is not recommended during breastfeeding.

In the developmental and health benefits of breastfeeding should be considered along with the mother’s clinical need for EYLEA and any potential adverse effects on the breastfeeding child from EYLEA.

8.3 Female and Male Subjects of Reproductive Potential

Contraception

Females of reproductive potential are advised to use effective contraception prior to the initial dose, during treatment, and for at least 3 months after the last intravitreal injection of EYLEA.

There are no data regarding the effects of EYLEA on human fertility. Aflibercept adversely affected female and male reproductive systems in cynomolgus monkeys when administered by intravenous injection at a dose approximately 500 times higher than the systemic level observed humans with an intravitreal dose of 2 mg. No Observed Adverse Effect Level (NOAEL) was not identified. These findings were reversible within 20 weeks after cessation of treatment.

8.4 Pediatric Use.

The safety and effectiveness of EYLEA in pediatric patients have not been established.

8.5 Geriatric Use.

In the clinical studies, approximately 76% (2049/2710) of patients randomized to treatment with EYLEA were ≥65 years of age and approximately 46% (1254/2710) were ≥75 years of age. No significant differences in efficacy or safety were seen with increasing age in these studies.

17 PATIENT COUNSELING INFORMATION

In the days following EYLEA administration, patients are at risk of developing endophthalmitis or retinal detachment. If the eye becomes red, sensitive to light, painful, or develops a change in vision, advise patients to seek immediate care from an ophthalmologist [see Warnings and Precautions (5.3)].

Patients may experience temporary visual disturbances after an intravitreal injection with EYLEA and the associated eye examinations. If the eye becomes red, sensitive to light, painful, or develops a change in vision, advise patients to seek immediate care from an ophthalmologist.

See Adverse Reactions (6). Advise patients not to drive or use machinery until visual function has recovered sufficiently.
There is something about the fabric of retina surgeons that attracts us to the field. We have a knack for surgery, a hunger for knowledge, a desire design and execute studies that answer questions that can further the field. For some of us, a passion for the clinic motivates us to learn the latest details of a specific study so that we can best help our patients. For others, however, there is a thirst to engage outside of the clinic and to expand our intellectual and professional horizons. The doctors who step outside of their comfort zones to explore research opportunities or inventions or business ventures or hospital-wide initiatives are the entrepreneurs who help keep retina on the forefront of innovation.

In this issue of Retina Today Business Matters, industry veteran Namrata Saroj, OD, interviews three surgical-entrepreneurial professionals— Darius M. Moshfeghi, MD; Rishi P. Singh, MD; and Charles C. Wykoff, MD, PhD—to find out how they arrived in their current positions. Dr. Saroj finds out what motivates them, how they bring an idea from concept to reality, and what advice they offer young surgeons seeking to enter the entrepreneurial sphere. It’s a conversation that is not to be missed.

Elsewhere in this issue, David B. Mandell, JD, MBA; and Jason O’Dell, MS, CWM, discuss long-term care planning for retina specialists in the Your Money column, and Joy Woodke, COE, OCS, OCIS, digs into the mailbag to answer reader questions in the Coding Advisor column.

Be sure to finish this issue’s cover story before heading to your next meeting. You never know what opportunity awaits there—and this issue can help prepare you for it.

ALAN RUBY, MD
SECTION EDITOR
GO AHEAD. BE A SHOWOFF!

Have a video of an innovative technique or interesting case?

Upload it to Eyetube.net/submit. It’s easy!

Videos should be **3-7 minutes** long.

**Accepted file formats** include mov, mpg, mp4, avi, and wmv.

Videos must be accompanied by an **English** narration. Narration should describe what the surgeon is doing and why. Explain subtle maneuvers, and name any instruments and/or devices that were pivotal to the case.

Files up to 2 GB are accepted. However, files larger than 1 GB may not transfer completely. Ensure you have a **good internet connection**, or contact us for an alternate upload method.

Include any relevant **financial disclosures**, either in the video or the video description.

**Avoid** background noise, music, movie clips, or animations that may distract viewers.

Companies may submit **educational or instructional videos** for consideration. Promotional material consisting of product advertisements, webinars, and/or symposia captures will not be accepted.

Questions? Contact Laura O’Connor, Digital Technologies Director • loconnor@bmctoday.com • 484.581.1860
STAYING INFORMED ABOUT THE NUANCES OF RETINA CODING CAN BE CHALLENGING. CPT AND ICD-10 CODES CHANGE, INSURANCE CARRIER POLICIES ARE UPDATED, AND UNUSUAL CASES MAY PRESENT. HERE ARE SEVERAL COMMON OR UNIQUE INQUIRIES I HAVE RECEIVED RECENTLY FROM RETINA PRACTICES.

SHOULD I BILL PLACE OF SERVICE 21, INPATIENT HOSPITAL, EVEN THOUGH THE PATIENT WITH INPATIENT STATUS IS SEEN IN THE OFFICE FOR AN INJECTION?

You must bill place of service (POS) 21 for a patient with inpatient status. CMS stated this in a transmittal:

“When a physician/practitioner furnishes services to a registered inpatient, payment is made under the PFS [ie, Physician Fee Schedule] at the facility rate. To that end, a physician/practitioner/supplier furnishing services to a patient who is a registered inpatient, shall, at a minimum, report the inpatient hospital POS code 21 irrespective of the setting where the patient actually receives the face-to-face encounter. In other words, reporting the inpatient hospital POS code 21 is a minimum requirement for purposes of triggering the facility payment under the PFS when services are provided to a registered inpatient.”

For more information, see bit.ly/RetinaToday1.

HOW DO WE BILL FOR TESTING SERVICES THAT INCLUDE “UNILATERAL OR BILATERAL” IN THEIR LANGUAGE?

When a code descriptor states “unilateral or bilateral,” such as CPT code 92250 (Fundus photography) or 92201 (Extended ophthalmoscopy with scleral depression of peripheral retinal disease), the code is considered inherently bilateral. Whether you test one or both eyes, you should submit the service only once. Modifiers -RT, -LT or -50 should not be appended and may cause denials.

I PERFORMED PNEUMATIC DISPLACEMENT TO ADDRESS A SUBMACULAR HEMORRHAGE. WHAT ARE THE APPROPRIATE CPT CODES?

Because there is no retinal detachment as seen with a pneumatic retinopexy (67110), the appropriate claim submission is CPT codes 67025 (Injection of vitreous substitute, pars plana or limbal approach, [fluid-gas exchange], with or without aspiration [separate procedure]) and 65800 (Paracentesis of anterior chamber of eye).

I PERFORMED AN Nd:YAG LASER PROCEDURE IN THE OFFICE TO TREAT VITREOUS OPAQUECES. THE PATIENT HAS NEVER UNDERGONE CATARACT SURGERY. WHAT CODE DO I USE?

There are reasons other than capsular haze for using an Nd:YAG laser. Submit CPT code 67031 (Severing of vitreous stands, vitreous face adhesions, sheets, membranes or opacities).
ties, laser surgery [-1 or more stages]). This is known as Nd:YAG vitreolysis.

Surgeon A performed cataract surgery 1 week ago. During the postoperative visit, the patient complained and displayed signs and symptoms of cystoid macular edema. The patient was referred to a retina specialist (Surgeon B) in the same group. Surgeon B performed an examination, ordered OCT imaging, and began treating the patient. From Surgeon B’s perspective, is this part of postoperative care or is this a billable examination?

Physicians of the same group share postoperative care. Only the retina OCT and treatment are billable. Billing the examination with modifier -24 (unrelated examination in the postop period) would not be appropriate, as the diagnosis is related or a complication of the cataract surgery.

Can we unbundle CPT codes 67036 (Pars plana vitrectomy) and 67145 (Prophylaxis of retinal detachment; photocoagulation) with modifier -59 if these procedures were performed during the same session?

CPT code 67145 has been bundled with 67036 since 1996. It is inappropriate to unbundle due to treatment of contiguous structures. Instead, bill CPT code 67039 (Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation).

When is it appropriate to unbundle CPT 67028 (Intravitreal injection) and 92201 (Extended ophthalmoscopy with scleral depression of peripheral retinal disease)?

It is appropriate to unbundle these two codes when the extended ophthalmoscopy with pathology is performed in the eye that did not receive an injection.

Can I bill for both CPT codes 92273 (Electroretinography [ERG], full field) and 92274 (ERG, multifocal) the same day?

There is no bundling edit for this situation. Physicians should clearly indicate why the two tests are medically necessary. Documentation may be requested. Payers do not expect to see this often.

If my office billed CPT code 67105 (Laser for detached retina) for a patient and that patient returned within the global period presenting with pathology that requires laser for detached retina, can our office bill for the laser again?

Even though the language “one or more sessions” was removed from the description for CPT code 67105, payers still expect to see only one laser billed during the 10-day global period.

I performed same-day bilateral repair of a retinal tear on a patient with Medicare coverage and used CPT code 67145 (Repair of retinal tear) for billing. The first claim I submitted was: 67145-RT, 67145-LT. When the payer denied it, I resubmitted: 67145-RT, 67145-LT-51. The payer also denied the second claim. What is the best way to submit this case?

Beginning in 2013, Medicare Part B has required all bilateral surgical procedures to be submitted as a single line, 67145-50 with a 1 in the unit field and double the charge. Medicare will pay 150% of the allowable. If this is not submitted properly, payment may be denied or may be at 100% of the allowable rather than at 150%. Commercial payers vary in their requirements. Some prefer two lines with -RT and -LT modifiers. There is no need to append modifier -51; most payers’ systems are sophisticated enough to recognize multiple procedures in the same setting.

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ENTREPRENEURSHIP IN RETINA

ENTREPRENEURSHIP IN RETINA: WHERE TO START

A roundtable of experts in entrepreneurship share their insights on the opportunities and challenges of launching a career outside the clinic.

MOTERATED BY NAMRATA SAROJ, OD; WITH DARIUS M. MOSHFEGHI, MD; RISHI P. SINGH, MD; AND CHARLES C. WYKOFF, MD, PhD

Chatter and cross-cutting advice can confuse young retina specialists who are considering expanding their professional contributions to areas outside the clinic. Whether one is considering entrepreneurship or an expanded role at an institution, understanding the experiences of others who recently went down the same path is helpful.

I asked Darius M. Moshfeghi, MD; Rishi P. Singh, MD; and Charles C. Wykoff, MD, PhD, to sit down for an extended discussion about how they got to where they are, what roadblocks they encountered, and what they would tell those whose ambitions tell them to fly higher.

—Namrata Saroj, OD

Namrata Saroj, OD: All three of you are involved in different aspects of entrepreneurship in retina. Is there a single entry point for those seeking to expand their professional scope?

Darius M. Moshfeghi, MD: Creating your own path is important. This way, you can prioritize what you think is important rather than collaborating with a company that will ask you to prioritize what they need. For me, starting various companies has worked.

Charles C. Wykoff, MD, PhD: I agree that creating your own path is key. But, if you want to "do more" but don’t yet
Meet the Roundtable

MODERATOR
Namrata Saroj, OD
All Eyes Consulting
After several years as a Medical Affairs professional at Genentech and Regeneron, Dr. Saroj founded a consulting service focused on assisting companies with drug development and healthcare technologies.

Darius M. Moshfeghi, MD
Stanford University
Dr. Moshfeghi is a Professor of Ophthalmology and the Chief of Retina at the Stanford University School of Medicine. He is a cofounder of Pr3vent, a platform that is developing deep learning to identify features associated with vision-threatening disease in babies.

Rishi P. Singh, MD
Center for Ophthalmic Bioinformatics, Cole Eye Institute, Cleveland Clinic
Dr. Singh is an Associate Professor of Ophthalmology at the Lerner College of Medicine. He is a surgeon at the Cole Eye Institute, Cleveland Clinic; serves as the Medical Director for Informatics at the Cleveland Clinic; and serves on the Board of Governors for Cleveland Clinic.

Charles C. Wykoff, MD, PhD
Retina Consultants of Houston
Dr. Wykoff is the Director of Research at the Greater Houston Retina Research Foundation, Retina Consultants of Houston & Retina Consultants of America. He is the Deputy Chair of Ophthalmology at the Blanton Eye Institute, Houston Methodist Hospital.

have your own idea, become a yes person and get engaged with others’ ideas and passions while remaining open to your own ideas. Regardless of where you are, mentors are important; experienced people can guide your vague idea toward something actionable and ultimately tangible. My mentors have been invaluable in guiding me and my thought processes in the space of drug and device development, something I have a passion for.

Rishi P. Singh, MD: My concepts of what I’ve wanted have changed as my career advanced. Helping design studies, contributing to scientific advisory boards, and educating ophthalmologists and optometrists has been a passion for a long time. As I grow as a physician, other opportunities have presented themselves.

Dr. Saroj: What shape do those opportunities take?

Dr. Singh: I’ve transitioned to focus on the larger healthcare landscape in a hospital system rather than only in ophthalmology. I am fortunate to have been in a physician-led organization at the Cleveland Clinic for 12 years. That means I can focus on areas such as improving OR efficiency for the ophthalmology department, and then move on to fields outside of my specialty such as facial plastics, ENT, and other surgical specialties. I’m now on the Board of Governors for the hospital system, which is the body that reviews the clinical, financial, and academic performance of each of our institutes.

Dr. Saroj: Does your experience as a clinician inform your role on the Board of Governors and vice versa?

Dr. Singh: I found that the frustrations and struggles of medicine—issues like patient access and streamlining and insurance problems—are not limited to ophthalmology. By being in the clinic and the OR, I can identify
problems in the hospital system. By working in leadership for the hospital, I can help implement solutions. Seeing how adjustments can be found and generalized to other fields has been very helpful to me.

**MENTORSHIP**

**Dr. Saroj:** You all had mentors who guided you toward success. But you’re also at the point in your careers where you’ll be the mentor for a young entrepreneur. What is your approach to selecting whom you will mentor and who is not the right fit?

**Dr. Wykoff:** When I was starting out, Dr. Moshfeghi gave me a piece of advice that has lingered in my thoughts: “Answer every email; return every phone call.” When someone wants an ear to share their idea with or comes looking for advice, I try to always take the time to listen. I enjoy hearing others’ insights—it can be really motivating. Plus, I’ve made a good number of mistakes along the way and like the concept of hopefully helping others over those hurdles.

**Dr. Moshfeghi:** In general, I’ll take a meeting with anyone who wants to meet with me. A lot of people flame out at the first meeting. They just want to meet and say hello, or they want an introduction to someone else. But if a person I meet with consistently follows up and shows consistent progress and isn’t asking you to do the work for them, then I feel it’s worth it to invest time and energy into their success.

I often tell young entrepreneurs that they need to help the people that they’re seeking help from. If you provide some assistance to the person whose mentorship you’re seeking, they’re likely to repay the favor. Sometimes it’s something simple like helping draft a paper; other times it’s something far more complex.

**Dr. Wykoff:** You can read someone, or at least someone’s dedication, pretty quickly. If you collaborate with them on a project and they are detail-oriented and put the time in, I tend to gravitate toward them. If they’re sloppy or lazy or inefficient, then I move away.

Time is finite and the opportunities many. The more productive collaborators and projects take precedence. It’s natural selection.

**Dr. Singh:** I always remind future entrepreneurs in the field that they need to be seen to be taken seriously. And by that I mean that they need to attend meetings, that they need to write papers, that they need to interact with people in the field. I wrote my first paper when I was an undergraduate student, so by the time I got to the stage when I needed mentorship, I had already interacted with some of the people who might potentially take an interest in me. When I brought up a question or asked for guidance, they listened and responded.

**Dr. Saroj:** Working on the industry side, I often engage with mentees who are under the wing of leaders in the field. I tend to continue with such collaborations only if the mentees show initiative.
Have any of you come across counterintuitive themes in mentorship?

Dr. Singh: There are two counterintuitive themes that jump out to me. It’s worth noting that there are good mentors and un-ideal mentors. Good mentors are people you look toward for guidance and information, and un-ideal mentors are people you look at and say, “I don’t want to be like this person at all.” Sometimes the good mentors can become un-ideal as you peel back their layers and find their deeper convictions. Finding a un-ideal mentor, in a way, can be good for development. It can help you hone your focus on what you actually want to do.

A piece of advice that might surprise some people looking for mentors: Look outside of your field for guidance. People who are adjacent to what you ultimately want to do—for example, a nonophthalmic MD or a medical entrepreneur—may have a fresh perspective on the field, a different attitude entirely. Their experiences are ones that people in this field may not have the chance to encounter.

ENRICHING PROFESSIONAL DEVELOPMENT

Dr. Saroj: How has entrepreneurship enriched your experience in retina?

Dr. Wykoff: My experiences have certainly enriched my entrepreneurship. But, in some ways, entrepreneurship creates problems. With each concept pursued, other ideas become visible, and the opportunities expand beyond available bandwidth.

Dr. Saroj: And that’s a problem?

Dr. Wykoff: In a way, yes. You have an idea and then a plan, and that leads to implementation and follow-through. On this road of planning and innovating, your network expands, and then you have more ideas because you’ve made new connections. It forces you to prioritize, because unfortunately we can’t do everything at once.

A phrase I use with my kids applies equally well to this situation: “You can do anything you want in life, you just can’t do them all at the same time.” Seeing short-term, medium-term, and long-term goals in your field of view at once is difficult, but it’s necessary as your experience expands your possibilities.

Dr. Singh: My experiences in this field have led to a more tested emotional intelligence. There are right things and wrong things to say in certain times of conflict; you can throw gasoline on a fire if you want to, or you can mediate a discussion and come out with a constructive outcome.

Take, for example, a situation in which one person wants to do something that everyone else on the team thinks is a bad idea. You can tell that person that their idea is stupid, or you can work to build insight in the group that the proposed course of action is not right at that time. The latter option builds bridges, and the former option burns them.

Dr. Moshfeghi: Creating a business venture gives you the opportunity to dictate the terms of your legacy. As an entrepreneur enters the field and spends time with other people in the space, you’ll inevitably start partnering with other projects. Some of them are fun; others you’ll slowly step away from. But for your own project—for the one you built—you’ll find that it gives you renewed energy.

For me, that project is Pr3vent. It drives multiple aspects of my life. Pr3vent is developing artificial intelligence to screen every newborn infant for features associated with vision-threatening disease. This is an unmet need. Approximately 5% of babies have referral-warranted disease, and screening each patient with unautomated methods won’t work.

Dr. Saroj: You mentioned collaborating with other people in the entrepreneurial space. Can you expand on that?

Dr. Moshfeghi: When you connect with other companies, you meet a diverse group of people who have similar motivations and have faced similar challenges. You’ve had your cash crunch. You’ve been halted by government barriers. You have failures. The people you meet are just like you, and they’ll encourage you when you hit those roadblocks.

With Pr3vent, we have just completed the Stanford accelerator, which is called StartX. When you collaborate with something like StartX, you start meeting people working in other areas of innovation. I’ve met inventors who are designing water-sparing showerheads that sense body movement, and I’ve met innovators who are creating technology to track cattle. It really runs the gamut. You start getting mentorship from people who are adjacent to what you’re doing, and it’s a real boost.

I love the burst of energy I get when I meet with government regulators or when I’m fundraising or when I’m brainstorming. I take that energy and bring it back to my clinic. It keeps me fresh.

Dr. Saroj: It’s easy to think that time spent with entrepreneurial commitments comes at the expense of clinical time. But Dr. Moshfeghi has indicated that they complement each other. Has that been your experience, Dr. Singh?

Dr. Singh: You have to be in the trenches in order to see the issues with patients to understand what your initiatives should be. I don’t think you need to be in clinic four days a week, though. I’m in clinic twice a week and in the OR once a week. The other two days are spent on administrative responsibili-
ties. The upshot is that you must cut your clinical workload in order to pursue other ventures.

**Dr. Moshfeghi:** The most valuable commodity is time. Years ago, I wanted to add more clinics to my workload and find more surgical time. My brother Andrew Moshfeghi, MD, MBA, told me that I was wasting my time, and that I should try to contract my schedule so I could find more time for entrepreneurial ventures that I have a passion for. It was the best advice I ever received.

**Dr. Wykoff:** I think setting aside a block of time in which nothing is scheduled is very important. I think of this as white space. It’s a time dedicated to sitting somewhere with a blank piece of paper, so to speak, so I can hash out my ideas and think of how to move them forward. No conference calls. No distractions. Just time to prioritize my goals and brainstorm.

**ADVICE TO YOUNG ENTREPRENEURS**

**Dr. Saroj:** What are one or two things that young entrepreneurs can do to get the ball rolling on their extra-clinical careers?

**Dr. Moshfeghi:** You need to work on your pitch. If you can’t get an investor to support your idea, go back to your pitch and rehearse it until you nail it down.

There was one particular investor whom I spoke with often. Each time I pitched him, he would tell me to leave. But there was one time when I wasn’t pitching him—I was just explaining my idea—and he asked me if he could invest. I had finally nailed it.

**Dr. Singh:** I have two pieces of advice. First figure out what your purpose is; research, education, and business development are examples. Second, remember that you can’t force progress. Opportunities will come with time. Keep your work effort up, keep your passion high, and eventually it will happen.

**Dr. Wykoff:** I often encounter people who want to do something meaningful, but they don’t quite know what shape it will take. For those people, I advise being a yes person. When people come to you with ideas for projects, an invitation to an advisory board, or the chance to develop new guidelines for something like an ASRS protocol for managing a particular disease, say yes.

Everyone thinks that they’re overloaded and too busy, and they’re probably right. But, if you want to explore entrepreneurial opportunities in retina, it helps to get exposure to how others think and how projects develop from inspiration to completion. You’ll meet potential mentors and be exposed to the challenges of concept development. Jump in!
What comes to mind when you consider the phrase long-term care? You may think of the services provided by a nursing home, assisted living facility, or in-home caregiver. In fact, long-term care can be any one or a combination of these services needed for yourself, your spouse, your parents, or in-laws.

One might think that retina specialists, as physicians, anticipate the medical, family, and financial challenges of long-term care and make proper planning decisions before the need for care creates a tension-filled issue. Unfortunately, this is often not the case.

In this article, we describe the background of long-term care planning and give an overview of some key issues all physicians should understand.

**THE CHALLENGE**

As physicians, retina specialists should be aware of the medical reasons people need long-term care services. Very simply, as we age, basic daily functions (called activities of daily living or ADLs in long-term care jargon) become difficult to perform without assistance. ADLs include eating, bathing, dressing, toileting, transferring, and continence.

Retina specialists should also be aware that assistance with such activities, whether in a nursing home, in a skilled nursing facility, or even at home, can be very expensive—and the need for assistance may last for years. In fact, the yearly cost for full nursing home care can be $100,000 or more. Thus, for both family and financial reasons, giving careful thought to these challenges in advance of a long-term care need is wise.

Looking at the macro statistics, 1 just a few numbers can tell the story:

1. **15 million**: The number of Americans expected to have a high long-term care need by 2050.
2. **52.3%**: The expected percentage of people turning 65 who will have a long-term care need during their lifetimes.
4. **$470 billion**: The dollar value of long-term care provided by unpaid caregivers, 2013.
5. **129,000**: Number of individual long-term care insurance policies sold, 2014.

**TIMELY IMPLEMENTATION OF LONG-TERM CARE PLANNING STRATEGIES CAN HAVE A POSITIVE EFFECT ON FAMILY DYNAMICS, WHILE HELPING TO PROTECT THE WEALTH A PHYSICIAN HAS WORKED HARD TO EARN.**

Generally, the government will pay for long-term care as part of the Medicaid program, but only after the care recipient meets certain state-specific income, asset, and physical minimums. In other words, you must be poor by state standards before the government will assist you under the Medicaid program, and the assistance will likely be provided in a nursing home.

For most retina specialists and their spouses, meeting these minimums would mean losing most of the assets they have worked hard to earn over their careers—an unacceptable proposition. However, for the parents and in-laws of some physicians, Medicaid qualification may be a suitable solution. With advance planning, the use...
of Medicaid trusts and other tools to qualify for benefits by moving assets to family members can be a viable option that should be explored.

**HAVING FAMILY MEMBERS PROVIDE CARE**

While siblings, children, grandchildren, and further-removed family members can play an important role in providing care, there are a myriad of issues to consider, including time management, geography, and funding. Think about how pressed for time most people are today, balancing the demands of their families and careers. Ponder also the challenges that could arise if some family members live near the person needing care and others do not. Will all geographically close relatives split duties equally? Will some be compensated for their time? At what rate? Can family members do a good job of providing care—or even adequate care? Even in the best of circumstances, these are issues that can build resentment, anger, and stress, and can often lead to serious repercussions throughout the family.

**PAYING OUT OF POCKET**

Certainly, many retina specialists can afford to pay out of pocket for months if not years of services for themselves and their spouses. But, is this a wise choice from an overall financial planning perspective? It may not be, especially when insurance coverage is considered (see below).

Even more problematic may be paying out of pocket for parents or in-laws, especially when other siblings do not have the ability or desire to pay their fair share. Anger, stress, and resentment among family members are common in these situations.

**INSURANCE COVERAGE**

Purchasing insurance to cover long-term care needs can be a sound part of a financial plan. Long-term care (LTC) insurance is an insurance product that pays for long-term care services in many settings, such as at home, in a nursing home, assisted living facility, or adult day care facility. Since there are many different LTC insurance plans and insurance carriers who offer them, it is important to make sure the plan you select will meet your foreseeable needs. Some plans cover facilities-only care, while others cover facilities care and home care. Some policies exist as stand-alone LTC policies and others can be hybrid life insurance/LTC policies.

When deciding on the best choice for you or a family member, it is essential to work with an experienced insurance advisor who is familiar with the products in the marketplace. Also, as with most insurance, costs typically increase with the age of the insured, so there can be a significant benefit in locking down favorable coverage sooner rather than later.

**THE BENEFITS OF BEING PROACTIVE**

Because long-term care planning will impact nearly every family in some way, it is wise to proactively examine options for you and family members before the need for care arises. Timely implementation of long-term care planning strategies can have a positive effect on family dynamics, while helping to protect the wealth a physician has worked hard to earn.


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Mr. Mandell is an attorney, consultant at the OJM Group, and author of more than a dozen books for doctors. To receive free print copies or e-book downloads of For Doctors Only: A Guide to Working Less and Building More and Wealth Management Made Simple, text RETINA to 555-888, or visit www.ojmbookstore.com and enter promotional code RETINA at checkout.

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