MAKING THE LEAP TO PRIVATE EQUITY
YOUR PATIENTS WITH DME ARE READY FOR A CHANGE

The power of EYLEA improved and sustained outcomes in the largest phase 3 anti-VEGF clinical trials completed to date in DME (N=862), with improved visual acuity at 52 and 100 weeks.¹

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 with 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.

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777 Old Saw Mill River Road, Tarrytown, NY 10591

*Primary endpoint.  †Prespecified exploratory endpoint.  ‡Last observation carried forward; full analysis set.

MEAN CHANGE IN BCVA

52 WEEKS, 100 WEEKS

PROPORTION GAINED ≥15 LETTERS

EVERY 4 WEEKS

EVERY 8 WEEKS

EYLEA 2 MG
EYLEA IMPROVED AND SUSTAINED VISION GAINS THROUGH 52 AND 100 WEEKS IN DME\(^1\)\(^2\)\(^3\)

<table>
<thead>
<tr>
<th></th>
<th>EYLEA 2 MG EVERY 4 WEEKS(^\text{a})</th>
<th>EYLEA 2 MG EVERY 8 WEEKS(^\text{b})</th>
<th>CONTROL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VISTA</strong></td>
<td>(n=154)</td>
<td>(n=151)</td>
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</tr>
<tr>
<td>Mean change in BCVA</td>
<td>+12.5, +11.5 LETTERS</td>
<td>+10.7, +11.1 LETTERS</td>
<td>+0.2, +0.9 LETTERS</td>
</tr>
<tr>
<td>≥15 letters</td>
<td>41.6%, 38.3%</td>
<td>31.1%, 33.1%</td>
<td>7.8%, 13.0%</td>
</tr>
<tr>
<td>(52 weeks(^1), 100 weeks(^1))</td>
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| **VIVID**            | (n=136)                               | (n=135)                               | (n=132) |
| Mean change in BCVA  | +10.5, +11.4 LETTERS                  | +10.7, +9.4 LETTERS                   | +1.2, +0.7 LETTERS |
| ≥15 letters          | 32.4%, 38.2%                          | 33.3%, 31.1%                          | 9.1%, 12.1% |
| (52 weeks\(^1\), 100 weeks\(^1\)) |                         |                                      |         |

VISTA and VIVID study designs: Two randomized, multicenter, double-masked, controlled studies in which patients with DME (N=862; age range: 23-87 years, with a mean of 63 years) were randomized and received 1) EYLEA 2 mg administered every 8 weeks following 5 initial monthly doses; 2) EYLEA 2 mg administered every 4 weeks; or 3) macular laser photocoagulation (control) at baseline and then as needed. Protocol-specified visits occurred every 28 (±7) days. In both studies, the primary efficacy endpoint was the mean change from baseline in BCVA at week 52, as measured by ETDRS letter score. Efficacy of both EYLEA groups was statistically superior vs control at 52 and 100 weeks (P<0.01).

\(^{\text{a}}\)Prespecified exploratory endpoint.

\(^{\text{b}}\)Secondary endpoint.

\(^{\text{1}}\)Last observation carried forward; full analysis set.

\(^{\text{2}}\)Following 5 initial monthly doses.

The results of exploratory endpoints require cautious interpretation and could represent chance findings, as a multiplicity adjustment has not been applied.

See more at HCP.EYLEA.US

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\(^{\text{®}}\) (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.
Lacrimation increased 3% 2% 4% 4%
Detachment of the retinal pigment epithelium 3% 4% 2% 0%
Vitreous detachment 3% 3% 5% 5%
Intraocular pressure increased 8% 6% 2% 0%
Conjunctival hyperemia 5% 4% 2% 0%
Visual field defect 9% 6% 2% 2%
Glaucoma 5% 2% 2% 2%
Vitreous hemorrhage 5% 1% 1% 1%
Intraocular inflammation 1% 1% 1% 1%
Von Hippel disease Eylea<1% 1% 1% 1%
Less common adverse reactions reported in <1% of the patients treated with EYLEA in the CRVO studies were hypersensitivity, retinal tear, and endophthalmitis.

Diabetic Macular Edema (DME) and Diabetic Retinopathy (DR). The data described below reflect exposure to EYLEA in 578 patients with DME treated with the 2-mg dose in a double-masked, controlled clinical studies (VIVID and VISTA) from baseline week 52 and from baseline to week 100.

Table 3: Most Common Adverse Reactions (≥7%) in DME Studies

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Welcome to the first issue of Retina Today Business Matters for 2021. Hopefully the trials of 2020 are behind us, although face masks, face shields, and disinfecting wipes may be permanent line items in our budgets now.

Unfortunately, 2020 put a lot of emotional and financial strain on practice owners. It had a lot of us asking, “Is it time to get out?”

Many, like this month’s featured author, decided it was time to hand over their practice management responsibilities to a private equity (PE) firm and shift their focus back to patient care. In his article, “Making the Leap to Private Equity,” David F. Williams, MD, MBA, details the pros and cons of the decision to sell to PE, and why merging with a firm consisting only of retina practices made all the difference for him and his partners.

It’s a big decision, and one many practice owners are still leery about. As PE investors continue to consolidate ophthalmology practices, now is a good time to revisit the subject and see how the landscape has changed, and why it may—or may not—be the right move for your practice.

For those of you who aren’t interested in PE, this issue also includes articles geared toward growing your practice and improving your revenue streams. You can learn about a four-step process for embracing growth opportunities safely, how to capitalize on today’s historically low interest rates, and how to improve your reimbursements for same-session procedures.

Regardless of whether you are looking for an escape route in 2021 or are looking for ways to make this your practice’s best year yet, we’ve got you covered.

ALAN RUBY, MD
SECTION EDITOR

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WHEN MULTIPLE PROCEDURES ARE PERFORMED IN THE SAME SESSION

A checklist of 10 steps for correct coding.

BY JOY WOODKE, COE, OCS, OCSR

Many retina surgical cases involve multiple procedures. In these cases, it is crucial to identify the correct coding in order to reduce denials and maximize reimbursement. Use the 10 steps outlined in this article to ensure accuracy.

**Step No. 1: Identify all CPT codes performed, and read the full CPT descriptor.**

From the operative report, confirm each procedure performed, select the appropriate CPT code, and review the full CPT code descriptor. Many retina procedures use the same techniques and may appear similar for coding purposes. The CPT code descriptor may provide additional details, however, including the reason for the surgery.

For example, a pars plana vitrectomy is frequently performed during a retina surgical case, but the diagnosis will confirm the correct CPT code based on the definition. Coding for a vitrectomy for endophthalmitis (CPT code 67036, vitrectomy, mechanical, pars plana approach) is much different from coding for a vitrectomy performed during a retinal detachment repair (CPT code 67108, repair of retinal detachment; with vitrectomy, any method including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique).

Explore more on CPT code selection based on the reason for surgery in the previous *Retina Today* article "Properly Coding Retina Surgeries."³

**Step No. 2: Confirm that prior authorization was obtained when required prior to surgery.**

For insurance payers that require prior authorization (PA), request and confirm that the approval is on file. Additionally, review that the CPT and ICD-10-CM code or codes, place of service, and surgeon are accurate. If the PA was not obtained or the CPT codes authorized are not correct, a retroactive request should be initiated promptly.

**Step No. 3: Meet the specific payer’s preoperative documentation guidelines.**

Medicare Administrative Contractors (MACs) provide local coverage determinations (LCDs) and local coverage articles (LCAs) for specific services including testing services, injections, and surgeries. Additionally, CMS provides national coverage determinations (NCDs) that apply to all jurisdictions. Current NCDs relevant to retina cover procedures including vitrectomy and photodynamic therapy (PDT) laser. The policy for PDT laser includes specific documentation and testing service requirements to establish medical necessity. A checklist of these requirements can be found at aao.org/retinapm.

Review all current LCD and NCD policies for all multiple procedures performed, and confirm that documentation, frequency limitations, required testing services, and supporting ICD-10-CM codes are met per policy. These policies are available at aao.org/lcds.

Commercial, Medicaid, and other payers may have unique policies and documentation requirements. If they have been published, they may be available on the payer website or...
Step No. 4: Identify the global period of each CPT code and whether procedures were performed during a global period.

First, confirm the global period of each CPT code selected to identify the procedures as major (90-day global period) or minor (0 or 10-day global period). This would be relevant if an examination was performed the same day as the surgery. Also consider whether modifiers -25 (significant separately, identifiable evaluation and management code the same day as minor surgery) or -57 (decision to perform major surgery) would be appropriate for this case.

Next, determine if the surgery was performed during the postoperative period of another surgery; if so, additional surgical modifiers will be required.

Step No. 5: List the CPT codes in order from highest to lowest relative value unit and/or allowable for that payer.

When multiple procedures are performed during the same session, standard payment adjustment rules apply. This is defined as the multiple procedure indicator of “2” per CPT code, and it results in payment of 100% of the allowable for the first procedure and 50% for the subsequent procedures, regardless of whether performed in the same or both eyes.

Because of the multiple procedure reduction, rank the eligible CPT codes from highest to lowest based on their relative value units (RVUs) or the payer’s fee schedule. This will ensure that the full reimbursement will be received for the primary procedure with the highest value.

Step No. 6: Consider any site of service differential in RVU and/or allowable.

Some surgical CPT codes have different allowables depending on the place of service (POS): that is, whether they are performed in a facility or nonfacility setting. Facility sites of service would include surgery performed in an ambulatory surgery center (POS 24), outpatient hospital (POS 22), or inpatient hospital (POS 21). Nonfacility reimbursement is paid for procedures performed in the office setting (POS 11). Surgeries that are primarily performed only in a facility do not have a site of service differential.

Table 1 provides examples of retina procedures and their corresponding nonfacility and facility reimbursements. It is important to consider the POS and any site of service differential when ranking procedures as primary and subsequent codes based on fee schedules. The examples in Table 1 outline the differences in allowables for CPT codes 67028 and 67228 when performed in a facility or nonfacility POS. Also note that CPT code 67036 does not have a site of service differential.

Step No. 7: Review NCCI edits and commercial payer edits.

For all CPT codes identified, review the National Correct Coding Initiative (NCCI) edits for all codes. Check each code in every combination. For example, is the first code bundled with the second and/or third? Is the second bundled with the first or third?

If codes are bundled and it is not appropriate to unbundle, eliminate the lowest paying code or codes.

NCCI indicators can be defined as mutually exclusive or comprehensive:

- Mutually exclusive codes can never be unbundled and have an indicator of 0.
- Comprehensive codes with an indicator of 1 may be paid separately under limited circumstances and must meet the definition of modifier -59 or per specific LCDs. The most common instances are when two procedures are performed in contralateral eyes or defined as separate structures.

When pars plana vitrectomy (CPT 67036) is performed along with reposisioning of an IOL (CPT 66825) and sutured IOL (66682), confirm any NCCI bundles. Table 2 illustrates the NCCI bundles of 66825 and 66682 with an indicator of 1. Because these two codes are bundled when performed the same day and based on RVU value, the case would be billed as 67036 and 66825.

To explore more on NCCI edits and the criteria for unbundling, review the Retina Today article “Become a Master of Retina Coding.”

Many commercial payers follow the NCCI edits released by CMS. However, some may create their own bundling rules. Prior to submitting multiple procedures to these payers, confirm any unique bundling rules per insurance carrier.

Step No. 8: Append the appropriate modifier(s).

Appropriate anatomic modifiers (-RT, -LT, or -50 for a bilateral procedure) should be appended to surgical codes. In addition, if the surgery is performed during a global period, consider the need for adding the following surgical modifiers preceding the eye modifier:

-58 modifier: a staged or related procedure or service by the same physician during the postoperative period.

(Continued on page 10)
Making the Leap to Private Equity

One practice’s experience shows that savvy negotiations at the outset can help to ensure a successful partnership.

By David F. Williams, MD, MBA

Of recent trends in retina, the entry of private equity (PE) investment is perhaps the most impactful, generating intense interest among retina practices and angst among young retina specialists and fellows. PE firms use capital raised from investors to buy companies, with the goal of eventually selling those companies for a profit.

Make no mistake, the goal of the PE firm is to make money. However, the perception that PE firms routinely make decisions that are detrimental to practices to maximize profits is not so. Such actions would be antithetical to the profit motive. Profits are best generated by working constructively with the company’s management to improve operations. Such an approach is currently the rule, not the exception and is in the best interest of all stakeholders.

Our group in Minnesota, VitreoRetinal Surgery (VRS), completed a transaction with a PE firm in September 2020. We had declined previous opportunities to partner with PE but unanimously agreed to join Retina Consultants of America (RCA), a PE-backed national horizontal aggregation of retina practices. Horizontal, in this context, refers to the all-retina nature of the consortium, as opposed to the more typical vertical grouping of optometry, general ophthalmology, and subspecialties.

At a Glance

- Negative perceptions of private equity (PE) include the potential for loss of personal and clinical autonomy, adverse effects on quality of care, constraints on future personal income, and the uncertainty of future transactions.
- A carefully constructed legal agreement is critical for any retina group considering PE. You must negotiate detailed protections into the contract to safeguard important aspects of your personal and practice autonomy.
- All physicians in a practice can have equity in the PE-backed entity, which has the potential to be quite valuable over time and has the possibility to make up for, or exceed, whatever speculative future income is forgone.
We chose this path because we believe that RCA will become an impactful organization of retina specialists, with initiatives that will benefit members in terms of education, patient care, clinical research, contract negotiations, operations, finances, and practice growth. We believe that this national organization including more than 100 retina specialists will lead to greater future success for our practices and for each of us individually.

Negative perceptions of PE include the potential for:
- loss of clinical and personal autonomy,
- adverse effects on quality of care,
- constraints on future personal income, and
- the uncertainty of future transactions.

My partners and I at VRS share these concerns, but we found comfort and optimism as we researched the opportunity with RCA. I have no insights about other PE-backed platforms, but let me explain why my partners and I chose to align with RCA.

**AUTONOMY**

Most retina specialists, particularly those in private practice, value and jealously guard their autonomy. With RCA, the principals at the PE firm understand that they are engaging with retina practices that are successful because of the characteristics of the physicians and that interfering with their autonomy would be counterproductive and harmful to the value of the investment.

Thus, personal and clinical autonomy are enshrined in our legal agreements, and so far no one from RCA or the PE firm has joined our offices; in fact, we continue to operate as we did prior to the transaction.

A carefully constructed legal agreement is critical for any retina group considering a partnership with PE. You must negotiate detailed protections into the contract to safeguard important aspects of your personal and practice autonomy. VRS has control over schedules, personnel, hiring, and growth decisions. Costly decisions warrant justification and discussion, but there are no barriers if we are operating consistent with past business practice; plus, new initiatives are good for VRS.

**QUALITY OF CARE**

Commitment to high-quality patient care is a measure of the character of each physician, with or without a PE partnership, and this remains a priority for VRS physicians, partner physicians at other RCA practices, and our PE partner. Our success depends on our service to patients and referring doctors. A decline in the quality of care would be bad for our patients, reputations, practices, business, and the PE investment.

At VRS, in our first few months under RCA, we have not seen a decline in our commitment to quality, nor do we anticipate one.

**FINANCIAL CONSIDERATIONS**

A practice must have financial characteristics that are both acceptable to a PE firm and sufficient to structure a deal that provides attractive upfront and ongoing compensation to the physicians. The basic structure of a PE merger is to calculate the practice’s earnings before interest, taxes, depreciation, and amortization (EBITDA) and then to sell a portion of that EBITDA to the PE firm at a market multiple. The residual EBITDA is retained by the physicians as initial compensation.

Ongoing physician compensation can still grow as practice profitability increases over time, which is a major goal. This structure necessarily results in a decrease in initial annual income after the deal, which for us was more than offset by the upfront financial consideration (including cash and equity).

This trade-off may be perceived differently by early-, mid-, and late-career physicians and especially by retina fellows considering job placement options. The simplistic—and incorrect—interpretation is that seasoned physicians are getting their money upfront and will retire soon, leaving the younger physicians in the practice to deal with the aftermath of the PE deal, saddling them with lower annual incomes in the future. However, this ignores important factors, including the time value of money, the characteristics of an organization such as RCA, and the increasing risk to traditional private retina practice.

Because of the effects of compounding interest, young physician partners who invest their transaction proceeds wisely have an opportunity to be financially wealthier than their more seasoned physician partners when they approach the same age. With smart investment over the long term, given the average equity market return over the last 100 years, one can expect assets to double every 10 years, ad infinitum. Investors must maintain a long-term perspective, as returns over 1 year, or even 10, are highly unpredictable. However, over 10- to 20-year rolling periods, equity market returns have historically been very good.

Older physicians’ financial wealth has typically been painstakingly accumulated over a long period of time. They don’t have the same amount of time for their PE transaction proceeds to compound as do their younger partners.

Nonpartner physicians are in a different position. They don’t own equity in the practice, but they also haven’t spent decades investing in the practice. However, they can negotiate favorable considerations that can place them in a beneficial financial position, and, again, they can take advantage of the time value of money.

Future physician hires in RCA practices will generally start at higher incomes and will become full partners in their RCA-affiliated practices sooner than those who are hired at non-RCA practices. They will also benefit from the economies of scale and the greater career stability we expect RCA to provide.

Finally, all physicians in a practice (both current and future) can have equity in the PE-backed entity, which has...
the potential to be quite valuable over time and has the possibility to make up for, or exceed, whatever speculative future income is foregone.

**CHANGE IS IN THE AIR**

Some of the risks and benefits associated with partnering with PE are based on whether and how much the practice of retina will change over the next 30 years. Unfortunately, the future is not likely to be as favorable for the field of retina as the past. Significant and unfavorable changes in practice, and especially in reimbursement structures, are likely.

Retina has been lucky, but over the past 20 years we have seen one high-powered medical specialty after another brought to heel by a changing health care system. For example, in our region of Minnesota there are few independent physicians in specialties other than ophthalmology and cosmetic surgery; most are employed by large health care systems. Perhaps retina can avoid this fate for a while, but at some point trends against independent retina practices are likely to become overwhelming.

For me, the horizontal nature of RCA, as a pure aggregation of retina specialists, gives us an edge over vertical aggregations that include optometry, ophthalmology, and subspecialties. My personal interests are more closely aligned with fellow retina specialists than they are with a more diverse collection of eye care providers. I am confident that our uniform, committed, and cohesive group of physicians will be able to preserve and protect our prerogatives and our success in future relationships.

After long days at professional conferences in years past, I remember talking over dinner and drinks with my friends and colleagues from around the country, each of us extolling the attributes of our independent, successful retina practices. It occurred to many of us then that if we could combine into a national retina “supergroup” we would be able to respond more effectively to the growing challenges that face all of us. During those times, we couldn’t conceive of a mechanism or structure to accomplish that goal, and we all went home to our individual silos.

Now, RCA has provided us with an opportunity to create some form of that retina supergroup. I am proud to be a part of this new concept, and I’m incredibly optimistic about my own future and the future of all of my colleagues around the country who choose to join us.

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**10 STEPS TO ENSURE CORRECT CODING OF MULTIPLE PROCEDURES**

1. Read the full CPT code descriptor
2. Confirm prior authorization
3. Meet payer policy documentation guidelines
4. Identify global periods
5. Order CPT codes from highest to lowest RVU
6. Consider site of service differential
7. Review NCCI edits
8. Append appropriate modifier(s)
9. Link appropriate ICD-10-CM codes
10. Submit claim and confirm proper payment

- **-78 modifier:** unplanned return to the OR or procedure room by the same physician following an initial procedure for a related procedure during the postoperative period.
- **-79 modifier:** unrelated procedure or service by the same physician during the postoperative period.

**Step No. 9: Link the appropriate ICD-10-CM codes to CPT codes.**

On form CMS 1500 (Health Insurance Claim Form), link the appropriate ICD-10-CM code to each CPT code that supports medical necessity. Each CPT code may have multiple ICD-10-CM codes linked or different diagnosis codes per CPT code on the claim. Confirming that the diagnosis link is accurately completed on the claim form will reduce denials.

**Step No. 10: Submit the claim and watch the remittance advice to ensure that proper payment is received.**

The final step is to submit the claim and monitor for correct reimbursement. When the remittance advice is received, verify that the multiple procedure reduction is appropriate (ie, 100% for primary procedure, 50% for subsequent procedures) and that full reimbursement has been received for the entire claim per the payer fee schedule.

**MAKE IT A HABIT**

Whenever multiple procedures are performed during the same surgical session, use the checklist of 10 steps outlined in this article to ensure proper coding, reduce denials, and appropriately maximize your practice’s reimbursement.

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In times of slowdown, practices often ask themselves, “What do we need to grow?” Conversely, practices with strong and steady growth ask, “What do we need to do to continue to grow?” For both, the thinking may be to recruit new providers, add new technologies or service lines, or expand to new locations. To avoid making a hasty—and likely an ill-advised—decision, practices entertaining growth opportunities should base such decisions on analysis and research, followed by planning, before launching. Let’s explore each of these decision-making processes to ensure that thoughtful, well-reasoned business decisions are made during these challenging times.

STEP 1: ANALYZE
Before offering something new, practice leaders should ask themselves a broad range of questions and then analyze their answers and the resulting data. Topics—and related questions—to consider are:

- **Procedures.** What are the most frequently asked-for “foundational” procedures within the practice? Consider the marketplace and if practice providers are at maximum capacity for those foundational procedures. Are schedules full, and what is the timeline for the next available appointment? What practice procedures are the most profitable? If unsure, a procedure value per hour analysis (see “Procedure Value Per Hour Explained”) may help to determine this. Growing the practice’s patient base for its most profitable procedures or maxing out its most profitable procedures is a logical first step before investing in something new.

- **Patients.** Are the practice’s patients loyal? Analyze whether they are coming in regularly and at a recommended frequency. Are patients going somewhere else for services that the practice does or could easily offer, and if so, why? This requires some thoughtful listening, discussion, and maybe even a survey of the practice’s best patients.

- **Internal motivation.** Is the desire to grow or add to the service menu based on current financial health and opportunity, or is it reactionary to outside influences, whether the general economy; the desire to be the first; or the attractiveness of something new that’s either unproven, too good to be true, or a lookalike (ie, the “shiny new penny”)? This will illuminate whether leadership is reacting to some external force rather than driving action based on internal direction and what makes sense to leverage.

- **Leverage.** What can the practice afford to invest or borrow to fund growth? Is that amount enough to successfully launch the desired growth opportunity? This is the most vital aspect of the analysis—it’s not what the practice can afford to spend; it’s what it cannot afford to lose, and the fiscal responsibility to successfully invest in a solid launch.

- **Feasibility.** What additional resources are needed to support the proposed new offering? Consider whether more physical space, providers, support staff, or office supplies and equipment are needed. All of these resource considerations are part of an internal break-even feasibility analysis designed to help set goals and strive for the art of the possible.

### PROCEDURE VALUE PER HOUR EXPLAINED
Practices often ask, “What is the profit on a procedure?” thinking that profit defines profitability. The reality is that there are two variables to take into account for valuing any procedure: time and money. Consider these two equations:

- **Profit:**
  
  \[
  \text{Profit} = \text{Cost to the patient} - \text{Cost of goods}
  \]

- **Profitability:**
  
  \[
  \text{Profitability} = \frac{\text{Gross profit} (\text{Cost to the patient} - \text{Cost of goods})}{\text{Time}} = \text{Procedure value per hour}
  \]

Putting these equations into numbers, let’s consider a $1,000 procedure cost to the patient and a $480 cost of goods. The gross profit is $520 for the procedure alone. Now consider if that procedure takes 30 minutes to complete. Taking that $520 gross profit and dividing it by the 30 minutes for the procedure, the procedure value per hour is now $1,040 ($1,000–$480 = $520/0.5 hour = $1,040).

Time can also extend to include the time to perform the procedure consultation and the actual successful conversion rate for a more finite value.

The concept of procedure value per hour is a sensitive analysis, and incremental changes in any variable can result in a dramatic change.
**STEP 2: RESEARCH**

Do not limit research to one dimension. Research requires both internal information—like that gathered in Step 1—and external information, with its source being a key consideration. Knowing that, below are some areas practice leadership should focus on in their research efforts when considering growth opportunities.

- **Market trends.** Avoid considering what is popular in the media today—because a short-term spike doesn’t necessarily equate to genuine opportunity. Rather, focus on where inquiries and their traction are strong and steady. It’s easy to do a general and localized keyword internet search to get a sense of market trends.
- **Patient interest.** Are patients repeatedly inquiring or asking for a specific offering? If so, it may be time to conduct a patient survey to gauge broad interest. While survey results are subjective, that external data is a factor—though not the sole basis—for a decision.
- **Industry review.** Innovation is often a subject of industry review, whether in the form of pamphlets, articles, or discussions. While peer interest or support of a new technology or treatment may seem like the right reason to make a decision, it is only valid when one’s own practice analysis aligns with the opportunity in terms of patient support and financial feasibility.
- **Advisor input.** Seek expert advice. Engage the trusted consultants, accountants, and other professionals who know the practice and can objectively advise leadership before a final decision is made. If all research is conducted by practice leadership, advisor review will likely consist of minimal time but maximum value, helping leadership make an educated and fully vetted decision.

**STEP 3: PLAN**

Once the practice leaders have conducted all of the necessary research and analysis, and only if the opportunity still looks promising, should they take the next step: planning. This is the most often over-looked element when considering launching a growth opportunity. Questions to ask to flesh out a rollout plan include:

- Who are the target patients (good candidates and/or good loyal practice advocates)?
- What is the marketing plan to reach that audience, and what resources will the practice need to invest in to create awareness, interest, and engagement—in other words, valid inquiries?
- What is the return on investment related to retaining that internal patient/annuity or gaining a new patient who can become an annuity?
- What’s the best pricing model for patients?
- What is the timeline to marketable launch?
- What investment is needed for the first 6 months of operations?
- What is needed in addition to marketing, staffing, time, and resources to fully support the new opportunity?
- What is the expected return on investment for both the internal and external market, and what is the internal break-even amount and timeline?

A well-thought-out, comprehensive plan is needed to properly target and attract patients and create a positive patient experience to make the contemplated growth opportunity viable. Only then can leadership believe in the opportunity, embrace it into the practice culture, and offer it to patients with confidence.

**STEP 4: LAUNCH**

With a solid plan in place, backed by research and analysis, now is the time for action—to launch. Some practices will execute a soft launch with staff, family, and friends, while others will do a mass launch. No matter the type of launch the practice chooses to move forward with, in this phase it is still essential to ask questions and collect data (daily), including the following:

- **Reception.** Who is trying the new offering?
- **Testimonials.** Of those patients, what is their input on the experience and the resulting referral generation?
- **Results.** What is the practice thinking, feeling, and seeing in terms of actual results?

Keeping tabs on these metrics is key to measuring short-term success, adjusting where necessary, and planning long-term growth strategies. A new practice offering that soars and then flattens or falls is the shiny new penny; a new offering that continues on a strong and steady growth path is one that will take the practice to the next level. If practice leaders have done their due diligence, then they should be confident that the new offering will be an asset, complementing and enriching the practice.

**DECIDING FACTORS**

Ultimately, only the practice and its leadership can decide what is the right new offering to launch. While the motivations to pursue a growth opportunity may vary among practices—eg, address patient wants or needs, invite new patient populations, or be a market leader—the best business approach to vet an opportunity is to analyze internal factors, research external considerations, and create a thoughtful rollout plan and responsive launch strategy.

Take the time to properly assess potential growth opportunities, and, with that, be confident in the great likelihood of success no matter the times.

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CHOROIDAL MASS: WADING THROUGH THE DIFFERENTIALS
By Sham Talati, MBBS, DO; Manish Nagpal, MBBS, MS, FRCS; and Navneet Mehrotra, MBBS, DNB, FRF
As we continue to live through COVID-19, much of the US economy is hurting. However, a few opportunities have emerged, such as interest rates that—ultimately controlled by the Federal Reserve—are now at an all-time low. This government policy is intended to stimulate the economy and give businesses and individuals easier access to capital, and government officials have indicated that the policy will continue for the foreseeable future.

A near-0% interest loan policy benefits big banks, which can borrow at close to 0% and lend profitably, even at low rates. It also benefits big businesses, which can expand their operations with a near-0% cost of capital.

And ultra-low rates can significantly benefit ophthalmologists and their families. Here, we outline three ways they can take advantage of this situation, starting with the most obvious and popular, then moving to the more complex.

1. **Refinance Debt**

As mortgage rates have now reached all-time lows, most homeowners have already refinanced their home mortgage or are considering doing so. A simple financial model can calculate the long-term benefit of refinancing. Many websites have easy-to-understand mortgage comparison calculators, or a mortgage broker can provide this analysis.

The essence of this analysis is to compare an existing mortgage with a new mortgage at a lower interest rate. A thorough knowledge of the current loan terms (eg, prepayment penalties) and potential closing costs to secure the new mortgage is essential. The goal is to calculate the break-even point—the length of time at which paying the new lower-interest mortgage makes up for the one-time additional costs of changing the mortgage. Bottom line: If the loan terms are the same and you intend to remain in the home well past the break-even point, refinancing may be a good idea.

The same concept of refinancing can be applied to loans as varied as practice real estate mortgages, rental property mortgages, practice lines of credit, practice equipment financing, and even student loans.

Knowledge of your current loan terms, closing costs, and an accurate financial model are required to make these important financial decisions.

2. **Use Premium-Financed Life Insurance**

In our books and previous articles, we have explored the relative strengths and weaknesses of term and permanent life insurance (whole life, universal life, equity-indexed life, etc.). Bottom line: Significant tax, retirement, and estate benefits are offered by permanent life insurance.

Nonetheless, to build up large permanent policies that generate six-figure annual tax-free retirement income, ophthalmologists generally need to make significant investments into these policies for at least a few years while they work. Many physicians would like the tax-free retirement income but are averse to paying large insurance premiums.

This is where premium financing comes in. One can finance these policies during the funding phase, only paying a few percentage points in interest, rather than the entire premium. Then, typically 10 to 15 years into the plan, when cash values have grown, the cash value can be used to pay off the loan principal. What remains is a large debt-free permanent policy that can be used to generate tax-free income throughout the physician’s retirement.

Although this brief description glosses over a complex and significant transaction with a number of risks and success factors, the essence of it remains arbitrage; that is, growing the policy cash values at rates generally around 5% to 7% annually, which is higher than typical premium financing interest rates.

Today, those rates have plummeted, and some banks are offering rates below 3%, often with long-term lock options. As such, there has never been a better time to engage in this transaction since it became mainstream more than 25 years ago.
**YOUR MONEY**

**3 Leverage Intra-Family Loans for Gift and Estate Planning**

Often, a core element of sophisticated estate and gift tax planning is making loans between family members. Unlike loans between unrelated parties, intra-family loans must charge a minimum interest rate specified by the US Internal Revenue Service (IRS) to make the loan legitimate. This applicable federal rate (AFR) is issued by the IRS each month so that taxpayers and their advisors can know exactly how much interest must be charged in these scenarios. In fact, the IRS issues three specific AFRs: a short-term rate (maturities of 3 years or less), medium-term rate (3 to 9 years), and long-term rate (maturities greater than 9 years). In January, these rates were 0.14%, 0.52%, and 1.35%, respectively.¹

Although the specifics go beyond the scope of this article, there are myriad ways physicians can transfer wealth tax efficiently among family members, trusts, and partnerships when the interest rate on long-term loans is so low. Such loans can provide tremendous flexibility for physicians who want to transfer wealth to younger family members (or to trusts for their benefit) but want a safety valve to bring the funds back to them in case they need it. A loan to the individual or trust can provide that flexibility. If the physician eventually decides that he or she does not need a portion of the loaned assets back, he or she can forgive the loan using gift or estate tax exemptions. If the physician does want the assets back, the loan can be kept in force. Either way, by making a loan while interest rates are so low, the family has built flexibility into its plans at the cost of a tiny interest rate dictated by the IRS.

**CONCLUSION**

All retina specialists should determine how they can best capitalize on today’s historically low interest rates. For many, one or more of these tactics may be beneficial. As always, when implementing any of these options, be sure to work with a trusted and experienced professional advisor.


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