CYBERSECURITY
KEEP YOUR PRACTICE’S DATA SECURE

ALSO IN THIS ISSUE
Guarding Your Practice Against Fraud
Retirement Planning Options
How to Properly Code for Uveitis
INDICATIONS AND IMPORTANT SAFETY INFORMATION

INDICATIONS
EYLEA® (aflibercept) Injection 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) in patients with DME.

CONTRAINDICATIONS
• EYLEA® (aflibercept) Injection 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.

EYLEA® (aflibercept) Injection
For Intravitreal Injection

EYLEA is a registered trademark of Regeneron Pharmaceuticals, Inc.

REGENERON
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777 Old Saw Mill River Road, Tarrytown, NY 10591
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.

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.

Please see Brief Summary on following pages.

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) in Patients with DME

4 CONTRAINDICATIONS

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

4.2 Active Intraocular Inflammation
EYLEA is contraindicated in patients with active intraocular 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 intraocular inflammation.

5 WARNINGS AND PRECAUTIONS

5.1 Endophthalmitis and Retinal Detachments.
Intravitreal injections, including those with EYLEA, have been associated with endophthalmitis and retinal detachments [see Adverse Reactions (6.1)]. 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 (17)].

5.2 Increase in Intraocular Pressure.
Acute increases in intraocular pressure have been seen within 60 minutes of intravitreal injection, including with EYLEA [see Adverse Reactions (6.1)]. Sustained increases in intraocular pressure have also been reported after repeated intravitreal dosing with vascular endothelial growth factor (VEGF) inhibitors. Intraocular pressure and the perfusion of 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 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.

6 ADVERSE REACTIONS

The following potentially serious adverse reactions are described elsewhere in the labeling:
- Hypersensitivity [see Contraindications (4.3)]
- Endophthalmitis and retinal detachments [see Warnings and Precautions (5.1)]
- Increase in intraocular pressure [see Warnings and Precautions (5.2)]
- Thromboembolic events [see Warnings and Precautions (5.3)]

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 2711 patients treated with EYLEA constituted the safety population in seven phase 3 studies. Among those, 2110 patients were treated with the recommended dose of 2 mg. 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.

Neovascular (Wet) Age-Related Macular Degeneration (AMD). The data described below reflect exposure to EYLEA in 1824 patients with wet AMD, including 1223 patients treated with the 2-mg dose, in 2 double-masked, controlled clinical studies (VIEW1 and VIEW2) for 24 months (with active control in year 1). Safety data observed in the EYLEA group in a 52-week, double-masked, Phase 2 study were consistent with these results.

Table 1: Most Common Adverse Reactions (≥1%) in Wet AMD Studies

<table>
<thead>
<tr>
<th>Adverse Reactions</th>
<th>Baseline to Week 52</th>
<th>Baseline to Week 96</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EYLEA (N=1824)</td>
<td>Active Control</td>
</tr>
<tr>
<td></td>
<td>(ranibizumab) (N=595)</td>
<td>EYLEA (N=1824)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Control (ranibizumab) (N=595)</td>
</tr>
<tr>
<td>Conjunctival hemorrhage</td>
<td>25%</td>
<td>28%</td>
</tr>
<tr>
<td>Eye pain</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Cataract</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Vitreous detachment</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td>Vitreous floaters</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>Intraocular pressure increased</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Ocular hypertension</td>
<td>4%</td>
<td>8%</td>
</tr>
<tr>
<td>Corneal epithelium defect</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Detachment of the retinal pigment epithelium</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Injection site pain</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Foreign body sensation in eyes</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>Laceration increased</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Vision blurred</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Intraocular inflammation</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>Retinal pigment epithelium tear</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Injection site hemorrhage</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Eyelid edema</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Retinal detachment</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

Less common serious adverse reactions reported in <1% of the patients treated with EYLEA were hypersensitivity, retinal tear, and endophthalmitis.

Macular Edema Following Retinal Vein Occlusion (RVO). The data described below reflect 6 months exposure to EYLEA with a monthly 2 mg dose in 218 patients following CRVO in 2 clinical studies (COPERNICUS and GALILEO) and 91 patients following BRVO in one clinical study (VIBRANT).

Table 2: Most Common Adverse Reactions (≥1%) in RVO Studies

<table>
<thead>
<tr>
<th>Adverse Reactions</th>
<th>CRVO</th>
<th>BRVO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye pain</td>
<td>13%</td>
<td>5%</td>
</tr>
<tr>
<td>Conjunctival hemorrhage</td>
<td>12%</td>
<td>11%</td>
</tr>
<tr>
<td>Intraocular pressure increased</td>
<td>8%</td>
<td>6%</td>
</tr>
<tr>
<td>Corneal epithelium defect</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Vitreous floaters</td>
<td>5%</td>
<td>1%</td>
</tr>
<tr>
<td>Ocular hypertension</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>Foreign body sensation in eyes</td>
<td>3%</td>
<td>5%</td>
</tr>
<tr>
<td>Vitreous detachment</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>Laceration increased</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>Vision blurred</td>
<td>1%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Intraocular inflammation</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Cataract</td>
<td>&lt;1%</td>
<td>1%</td>
</tr>
<tr>
<td>Eyelid edema</td>
<td>&lt;1%</td>
<td>1%</td>
</tr>
</tbody>
</table>
Less common adverse reactions reported in <1% of the patients treated with EYLEA in the CRVO studies were corneal edema, retinal tear, hypersensitivity, and endophthalmitis. **Diabetic Macular Edema (DME).** The data described below reflect exposure to EYLEA in 578 patients with DME treated with the 2-mg dose in 2 double-masked, controlled clinical studies (VIVID and VISTA) from baseline to week 52 and from baseline to week 100.

**Table 3: Most Common Adverse Reactions (≥1%) in DME Studies**

<table>
<thead>
<tr>
<th>Adverse Reactions</th>
<th>Baseline to Week 52 (N=578)</th>
<th>Control (N=287)</th>
<th>Baseline to Week 100 (N=578)</th>
<th>Control (N=287)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conjunctival hemorrhage</td>
<td>28%</td>
<td>17%</td>
<td>31%</td>
<td>21%</td>
</tr>
<tr>
<td>Eye pain</td>
<td>9%</td>
<td>6%</td>
<td>11%</td>
<td>9%</td>
</tr>
<tr>
<td>Cataract</td>
<td>8%</td>
<td>9%</td>
<td>19%</td>
<td>17%</td>
</tr>
<tr>
<td>Vitreous floaters</td>
<td>6%</td>
<td>3%</td>
<td>8%</td>
<td>6%</td>
</tr>
<tr>
<td>Corneal epithelium defect</td>
<td>5%</td>
<td>3%</td>
<td>7%</td>
<td>5%</td>
</tr>
<tr>
<td>Intraocular pressure increased</td>
<td>5%</td>
<td>3%</td>
<td>9%</td>
<td>5%</td>
</tr>
<tr>
<td>Ocular hyperemia</td>
<td>5%</td>
<td>6%</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Vitreous detachment</td>
<td>3%</td>
<td>3%</td>
<td>8%</td>
<td>6%</td>
</tr>
<tr>
<td>Foreign body sensation in eyes</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Lacrimation increased</td>
<td>3%</td>
<td>2%</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Vision blurred</td>
<td>2%</td>
<td>2%</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>Intraocular inflammation</td>
<td>2%</td>
<td>&lt;1%</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Injection site pain</td>
<td>2%</td>
<td>&lt;1%</td>
<td>2%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Eyelid edema</td>
<td>&lt;1%</td>
<td>1%</td>
<td>2%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Less common adverse reactions reported in <1% of the patients treated with EYLEA were hypersensitivity, retinal detachment, retinal tear, corneal edema, and injection site hemorrhage.

### 6.2 Immunogenicity

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 immunoassays. 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. For these reasons, comparison of the incidence of antibodies to EYLEA with the incidence of antibodies to other products may be misleading.

In the wet AMD, RVO, and DME studies, the pre-treatment incidence of immunoreactivity to EYLEA was approximately 1% to 3% across treatment groups. After dosing with EYLEA for 24-100 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 immunoreactivity.

### 8 USE IN SPECIFIC POPULATIONS

#### 8.1 Pregnancy

**Risk Summary**

Adequate 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 fetal No Observed Adverse Effect Level (NOAEL) was not identified. At the lowest dose shown to produce adverse embryofetal effects, systemic exposure (AUC) of free aflibercept was not identified. These findings were reversible within 20 weeks after cessation of treatment.

**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 embryofetal development. EYLEA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. All pregnancies have a background risk of birth defect, loss, or other adverse outcomes.

The background risk of major birth defects and miscarriage for the indicated 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**

Animal Data

In two embryofetal development studies, aflibercept produced adverse embryofetal effects when administered every three days during organogenesis to pregnant rabbits at intravenous doses ≥3 mg per kg, or every six days during organogenesis at subcutaneous doses ≥0.1 mg per kg. Adverse embryofetal effects included increased incidences of postimplantation loss and fetal malformations, including anasarca, umbilical hernia, diaphragmatic hernia, gastrochisis, cleft palate, ectrodactyly, intestinal atresia, spina bifida, encephalomeningocoele, heart and major vessel defects, and skeletal malformations (fused vertebrae, sternebrae, and ribs; supernumerary vertebral arches and ribs; and incomplete ossification). The maternal No Observed Adverse Effect Level (NOAEL) in these studies was 3 mg per kg. Aflibercept produced fetal 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 (0.1 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/excretion. 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. 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 breastfed child from EYLEA.

#### 8.3 Females and Males 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.

**Infertility**

There are no data regarding the effects of EYLEA on human fertility. Aflibercept adversely affected female and male reproductive systems in cynomolgous monkeys when administered by intravenous injection at a dose approximately 1500 times higher than the systemic level observed humans with an intravitreal dose of 2 mg. A 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% (2049/2701) of patients randomized to treatment with EYLEA were ≥65 years of age and approximately 46% (1250/2701) 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 (5.1)]. Patients may experience temporary visual disturbances after an intravitreal injection with EYLEA and the associated eye examinations [see Adverse Reactions (6)]. Advise patients not to drive or use machinery until visual function has recovered sufficiently.
BEWARE OF CYBERTHREATS

Cybersecurity has been a hot-button issue for several years now. As our reliance on the internet expands, we will see concomitant increases in the numbers of targeted attacks on and data breaches of companies that handle sensitive customer information. It seems every time we turn on the news there is another headline story about a data breach affecting millions of individuals. As Crawford Ifland points out in our feature story, Cybersecurity for the Ophthalmic Practice, between January 1, 2005, and April 18, 2018, there were 8,854 recorded cybersecurity breaches. As physicians, we are given the responsibility of handling our patients’ sensitive personal information—personal information that is highly sought after and highly valuable to internet ne’er-do-wells. It is also our responsibility to protect that information. You can learn about several methods of doing just that in Mr. Ifland’s article.

Also featured in this issue are articles on fraud prevention, ICD-10 coding for uveitis, and retirement planning options. Kenneth T. Hertz, FACMPE, provides an enlightening outline of the types of fraud that may be committed by and against health care facilities, as well as the systems you can put into place to protect yourself against them. Joy Woodke, COE, OCS, OCSR, teaches you the ins and outs of coding for uveitis, and Robert M. Beardsley, MD, provides two uveitis case examples and the proper coding for them. And David B. Mandell, JD, MBA, and Carole C. Foos, CPA, give you the lowdown on using qualified and nonqualified plans to help you achieve the retirement you want.

ALAN RUBY, MD
SECTION EDITOR

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ALAN RUBY, MD
SECTION EDITOR
Reviewing the principles of ICD-10 and the classifications of uveitis will help ensure correct coding. Here, Joy Woodke, COE, OCS, OCSR, outlines how to properly code for uveitis, and Robert M. Beardsley, MD, provides two real-world case examples.

**BACK TO BASICS**
When selecting the appropriate ICD-10, you should choose the code that accurately reflects the initial confirmed diagnosis. The best code is the actual disease. Without a confirmed diagnosis, the next best is a sign or symptom. After that, *other* is the best option. The least appropriate code is *unspecified*. Only use *unspecified* when there is not a more definitive code.

Code the diagnosis you know. Do not code probable, suspected, or questionable diagnoses, do not rule out conditions until they are confirmed.

These principles are relevant when coding for uveitis cases. Often, patients present with obvious symptoms and a diagnosis of anterior uveitis is clear. However, determining why the patient has uveitis and uncovering the underlying systemic disease may be possible with additional testing. As the results are reviewed and an etiology becomes apparent, a more definitive uveitis diagnosis and ICD-10 code will be assessed.

**CLASSIFYING UVEITIS**
Based on the anatomical involvement, uveitis can be classified as anterior, affecting the anterior chamber/iris; intermediate, affecting the vitreous/pars plana; posterior, affecting the retina and choroid; or panuveitis, affecting the anterior chamber, vitreous, and retina/choroid.

Based on these classifications, we can determine the appropriate ICD-10 code and start the diagnostic process. If the initial diagnosis is anterior uveitis, the next step is to specify the condition as primary acute, recurrent acute, or chronic. See Table 1 for an outline of the ICD-10 codes for anterior uveitis.

**Panuveitis and Endophthalmitis**
Refer to Table 2 when a diagnosis of intermediate or posterior uveitis is made to determine appropriate coding for the specific diagnosis. Table 3 can be used when determining appropriate coding for the various panuveitis diagnoses.

**Secondary, Noninfectious Anterior Uveitis**
After an initial diagnosis of anterior uveitis, additional laboratory testing and an extended history may be obtained. Once received, the underlying cause and a more specific diagnosis can be applied. If anterior uveitis is secondary to a systemic disease, first determine if the diagnosis is infectious or noninfectious. Next, add the systemic disease as a secondary code. The ICD-10 codes for

**AT A GLANCE**
- When selecting the appropriate ICD-10 code, you should choose the code that accurately reflects the initial confirmed diagnosis.
- Code the diagnosis you know and do not code probable, suspected, or questionable diagnoses, and do not rule out conditions until they are confirmed.
- The least appropriate code is unspecified. Only use unspecified when there is not a more definitive code.
Secondary, noninfectious anterior uveitis can be found in Table 4.

Secondary, Infectious Anterior Uveitis

A patient with infectious secondary anterior uveitis may be diagnosed with, for example, herpes simplex virus or tuberculosis. These cases are coded with a primary diagnosis of H20.03—secondary, infectious anterior uveitis, and a secondary code for the systemic disease. Refer to Table 5 for the appropriate ICD-10 codes for secondary infectious anterior uveitis and to Table 6 for the appropriate ICD-10 codes for a few examples of systemic diseases that have caused secondary infectious anterior uveitis.

The Diagnostic Process

The process of diagnosing anterior uveitis and determining the most specific code is outlined in Figure 1. The initial diagnosis of anterior uveitis (primary acute, recurrent acute, and chronic) is used when waiting for a confirmed diagnosis.

When the results are obtained, a more definitive diagnosis may be used. If anterior uveitis is secondary to an underlying disease, the next step is determining if that systemic disease is infectious or noninfectious. The initial ICD-10 codes are replaced with the secondary anterior uveitis code, as appropriate, and the systemic disease is coded as a secondary ICD-10 code. There may be cases where the underlying cause is not identified, and the diagnosis will remain anterior uveitis.

For patients presenting with panuveitis, there may be an initial diagnosis, followed by a confirmed diagnosis following additional workup. Endophthalmitis, sympathetic uveitis, secondary anterior uveitis (infectious or noninfectious), or panuveitis.
ICD-10 Coding for Anterior Uveitis

*Initial diagnosis = Best confirmed diagnosis*

Anterior Uveitis
- Primary, Acute: H20.01-
- Recurrent, Acute: H20.02-
- Chronic: H20.1-

Lab Tests Ordered
- HLA-B27 Testing
- Extended History Obtained

Diagnosis confirmed: possible ICD-10 change

Secondary, Anterior Uveitis, Infectious: H20.03-
- Add: System Disease (eg, Herpes simplex virus)

Secondary, Anterior Uveitis, Noninfectious: H20.04-
- Add: System Disease (eg, Psoriatic arthritis, inflammatory bowel disease)

Primary, Acute: H20.01-
- Recurrent, Acute: H20.02-
- Chronic: H20.1-

Figure 1. As test results are returned, a more precise diagnosis may be present. Figure adapted from: American Academy of Ophthalmology.

ICD-10 Coding for Panuveitis

*Initial diagnosis = Best confirmed diagnosis*

Panuveitis: H44.11

Lab Tests Ordered
- Vitreous Tap

Endophthalmitis
- Purulent: H44.00-
- Chronic: H44.02-
- Parasitic: H44.11

Sympathetic Uveitis: H44.13-

Secondary Uveitis, Infectious: H20.03-
- Add: System Disease (eg, Herpes simplex virus), Panuveitis

Secondary Uveitis, Noninfectious: H20.04-
- Add: System Disease (eg, Vogt-Koyangi syndrome H20.82-), Panuveitis

Panuveitis: H44.11-
- (postinjection, inflammatory, or undifferentiated)

Figure 2. Panuveitis diagnosis becomes more precise after evaluation. Figure adapted from: American Academy of Ophthalmology.
(Continued from page 8)
(post-injection, inflammatory, or undifferentiated) may be the confirmed diagnosis. Figure 2 follows this process. There are no specific ICD-10 codes for panuveitis secondary to a systemic disease. For these conditions, use the secondary anterior uveitis code in addition to the panuveitis code. By definition, panuveitis includes anterior uveitis, so this coding is anatomically correct.

**TEST YOUR KNOWLEDGE: CODE THIS CASE**

Using the resources outlined above, the following cases can be reviewed, and the appropriate ICD-10 codes selected.

**Case 1**

A 67-year-old Indian man presented with a 3-month history of bilateral redness, mild irritation, photophobia, and blurry vision. His pertinent history included no medications, multiple trips to India within the past 5 years, and no systemic illnesses. He was seen previously in an urgent care clinic that prescribed antibiotic drops 1 month prior to presentation with little effect on his symptoms. Examination revealed 1+ injection bilaterally, 1+ cell with 1+ flare in each eye, fine keratic precipitate OU, no obvious posterior synechiae, and no vitreous cell, chorioretinal lesions, or optic nerve head edema. VA was 20/50 OU and IOP was 17 OD and 19 OS.

The patient was diagnosed with primary chronic anterior uveitis based on the duration and location of the inflammation. He was started on prednisolone acetate 1% to be taken 6 times daily OU. Labs and imaging were ordered, and the patient returned 1 week later.

**Initial diagnosis:** Primary chronic anterior uveitis, OU. ICD-10 code: H20.13

The patient’s laboratory work was unremarkable except for a positive QuantiFERON-TB Gold test and a chest x-ray demonstrating multiple focal granulomatous scars. HLA-B27 and RPR/FTA were both negative. At this point, the patient’s diagnosis was adjusted to chronic anterior uveitis secondary to tuberculosis. He was evaluated by the infectious disease department and, given the active inflammation with positive x-ray findings and QuantiFERON-TB Gold testing, the patient was started on quad therapy for antituberculous medication. Sputum cultures were negative. He was changed to difluprednate topical (Durezol, Alcon) QID OU. The inflammation resolved after 2 to 3 weeks, and he was tapered off of difluprednate over the course of 8 weeks. His IOP remained stable throughout the course of therapy. His vision improved to 20/25 and his symptoms resolved. Upon completion of the antituberculous therapy, he maintained quiescence for 12 months.

**Confirmed diagnosis:** Infectious chronic anterior uveitis, secondary to tuberculosis, OU. ICD-10 codes: H20.033, A18.54.

**Case 2**

A 24-year-old man presented to the clinic with the complaint of bilateral floaters for the past 6 months. He noted no redness, irritation, or blurriness in either eye. Review of systems testing was negative for infection, neurological symptoms, tick bites, joint pains, rashes, or difficulty breathing. He had not sought care prior to presentation.

Examination revealed a quiet anterior chamber, clear cornea and lenses, moderate cell in the vitreous with inferior snowballs, and snowbanking OU. The optic nerves were flat and there was a good foveal reflex. VA was 20/25 OU and IOP was normal OU. Fluorescein angiography revealed peripheral vascular leakage and minimal angiographic edema (Figure 3). He was diagnosed with primary chronic intermediate uveitis and started on difluprednate OU BID. Laboratory work and imaging were ordered, and he returned in 2 weeks.

**Initial diagnosis:** Primary chronic intermediate uveitis, OU; cystoid macular edema, OU. ICD-10 codes: H43.89, H35.353.

His workup was unrevealing with a negative RPR/FTA, Quantiferon-TB Gold test, and lyme titers. HLA-B27 testing was negative. Imaging showed a clear chest x-ray and an MRI scan of his brain showed no evidence of multiple sclerosis. His examination had improved with decreased symptoms and slightly fewer vitreous cells and fewer apparent snowballs.

Given that no systemic disease was found on workup, his diagnosis was maintained as primary chronic intermediate uveitis (also known as pars planitis). Given a lack of central edema, he was maintained on topical therapy. We plan to repeat the MRI in 4 years to determine if there is interval change.

**Follow-up diagnosis:** Primary chronic intermediate uveitis, OU; cystoid macular edema, OU. ICD-10 codes: H43.89, H35.353.

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Cybersecurity seems to be in the news on a weekly basis, from breaches, to identity theft, to massive settlements from companies who have misused or mishandled customer data. Cybersecurity is a hot topic today for good reason: between January 1, 2005, and April 18, 2018, there were 8,854 recorded breaches.¹

Anyone who handles sensitive data is living in an increasingly dangerous world. This is all the more true for medical practitioners, for whom extensive compliance, regulation, and penalties for mishandling sensitive patient information have never been greater. According to Reuters, patient records can be 10 to 20 times more valuable than credit card information, so there is an obvious incentive for cybercriminals to target medical practices.² After all, credit card numbers can be changed overnight, but addresses, employers, insurance documents, and diseases cannot.

What practical steps can retina specialists take to secure their practices in the age of daily attacks and

### AT A GLANCE

- Patient records can be 10 to 20 times more valuable than credit card information.
- Basic in-office necessities for cybersecurity include antivirus software, separate Wi-Fi networks for staff and for patients, and a virtual private network.
- Helping employees and vendors understand why certain cybersecurity tools are in use is the best way to ensure compliance and foster a security-minded culture.
extensive regulatory compliance? This article explores how to increase cybersecurity and mitigate risks associated with running a modern ophthalmic practice.

IN YOUR OFFICE
Antivirus Software
The no-brainer: antivirus software can recognize threats, malicious files, and the like. Whenever multiple computers are connected to the internet (and to each other) in a business environment, antivirus software is a must. Many ophthalmic practices run on Windows PCs, which means they are particularly vulnerable. There are hundreds of thousands of known viruses for Windows, with more surfacing every day. For practices running on Macintosh computers, good antivirus software is still important.

Separate Wi-Fi Networks
Another recommended measure is creating separate Wi-Fi networks for staff and for patients and their families or caretakers. This is a must when dealing with sensitive health information. Separating your Wi-Fi networks (or not offering in-office Wi-Fi to patients and their families or caretakers at all) is especially important if any of your diagnostic tools connect to the internet. It is estimated that one out of four medical devices is connected to a network, so this is a huge potential liability.

Virtual Private Network
Beyond having separate public and private Wi-Fi networks, it is also recommended that each computer in your physical office obtain and use a virtual private network (VPN) to further secure network communications (Figure 1). Have you ever used the public Wi-Fi in your local Starbucks to send an email or to access your online banking? Unless you were using a VPN to encrypt your data, anyone else on that Wi-Fi network could theoretically see the information your device was sending and receiving. Say goodbye to that online banking password.

A VPN stops other users from being able to “sniff” your network traffic. Think of it as a tunnel: data are passing through, but they are obscured to anyone trying to look in from the outside. Even if someone were to crack the Wi-Fi password for your main network, he or she wouldn’t be able to see any information coming through that network. VPNs encrypt all data, making them useless and unreadable to anyone sniffing traffic on your network.

Password Managers
So you’ve separated your public Wi-Fi and the private network that your office staff uses for billing, electronic health records, and diagnostic devices. But what if your office is broken into or physically compromised? One of the most practical security measures the average person can take is to strengthen passwords. Password management software is an incredibly easy way to store all of the passwords you use and reset your current passwords to random, virtually uncrackable alphanumeric strings. A shared team account is an easy way for office staff to share passwords for your practice’s most frequently used online services, including your website, social media accounts, and billing applications. You can delegate access to everyone in your organization or create separate “vaults” for different teams, giving access only to those who truly need it.

ON THE WEB
Secure Sockets Layer
If you are serious about securing your practice from data breaches, you also need to consider the security of your website. Although implementation of website security measures can easily escalate to complex solutions, the easiest way to cover your bases is to install a Secure Sockets Layer (SSL) certificate on your website.

SSL certificates encrypt all data sent to and from your website. So, even if someone were able to intercept any data sent to or from your website (eg, appointment requests with sensitive patient information), the data would be unreadable. Most SSL certificates cost less than $100 per year, so, if you collect any sort of personal or health-related information on your website, this step is easy to implement.

Content Distribution Network
When handling sensitive patient information, security is the primary goal. But what about business goals? What if your website is attacked or goes down unexpectedly? What could the downtime cost your practice in terms of lost efficiency, time, and revenue?

Using a content distribution network such as Cloudflare (cloudflare.com) can help mitigate this risk. Cloudflare has servers and data centers around the world that can increase uptime for your website and help handle the load, should your website receive lots of traffic or fall prey to a distributed denial-of-service attack.
attack. Cloudflare’s servers can also help serve your content to users faster and make your website safer and more secure, minimizing the potential for loss due to downtime or attacks.

Two-Factor Authentication
Two-factor authentication is a verification process by which online services require not only a password but also something that you have physical access to, such as your cell phone. Have you ever tried to log into Facebook and been prompted for a six-digit passcode that was texted to your cell phone? That’s two-factor authentication at work, and it’s much more secure than a traditional password alone.

IN YOUR COMMUNICATIONS

Encrypted Email
How can you ensure your email communications are secure? There are plenty of HIPAA rules about what a medical practice may and may not communicate via email, but, if you’re concerned about emails getting intercepted, I recommend using secure, encrypted email services such as Pretty Good Privacy (PGP).

PGP relies on a technology called public-key cryptography to encrypt and secure emails. Think of it as a mailbox with two keys (Figure 2). One key is used to deposit mail in the mailbox. This is known as your public key, and you can give it out to anyone. Tweet it to the whole world, if you want, or post it on a billboard. It doesn’t matter. Anyone in possession of your public key will be able to send encrypted email to you that only you can read. The other key is known as your private key. You—and only you—should have access to this private key, or else anyone will be able to read your emails.

Secure File Upload Sites
If patients or business associates need to send sensitive documents to you but don’t want to rely on PGP, consider using secure file upload sites such as ShareFile (sharefile.com). These file sharing applications use bank-level encryption and security, so they are incredibly secure ways to share sensitive documents you wouldn’t want to fall into the wrong hands.

SECURITY CULTURE
It is worth mentioning that the most sophisticated tools in the world won’t help if you don’t use them. Your chance of getting struck by lightning is one in 960,000. According to the Ponemon Institute, the chances of your business’ experiencing a data breach are as high as one in four. What’s worse, the average cost of a data breach exceeds $3.5 million.³

The first step in implementing a security practice is to create and foster a security-minded culture. It comes down to your people, your vendors, and the way you conduct business. Although I strongly recommend implementing some or all of the security tactics mentioned in this article, you must walk through the proper use of these tools with your staff. Helping employees and vendors understand why these tools are in use is the best way to ensure compliance and foster a security-minded culture.

Although the suggestions outlined in this article are certainly not an exhaustive list, their careful and successful implementation will place you well on your way to having a more secure ophthalmic practice and extra peace of mind.

Disclaimer: Messenger does not claim to be an expert on HIPAA compliance and cannot be held responsible for misuse of this information. Always consult a cybersecurity expert when installing or implementing cybersecurity measures.


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Every year, health care–related fraud, waste, and abuse drain millions of dollars from the health care industry. According to the Office of the Inspector General’s (OIG’s) 2018 National Health Care Fraud Takedown report, the fraud and abuse offenses committed by the individuals charged in the takedown cost our nation’s health care programs about $2 billion.¹

Fraud, waste, and abuse come in many forms, from submitting false claims, billing for unnecessary medical services or charging excessive amounts for medical services, to the financial mismanagement of a medical practice by its employees. All of these drain the health care ecosystem, increasing costs to government, health care providers, medical practices, and patients through higher premiums, higher payroll taxes, and higher operating costs. Financial losses aren’t the only negative consequence of health care fraud; it can also physically harm patients who receive inadequate care or unnecessary services.

Health care fraud, waste, and abuse can be committed by providers, insurance companies, patients, and organized crime groups alike. Although committed by a very small percentage of people, these activities can wreak havoc on a health care operation and all of the parties involved in it. Schemes to commit fraud are constantly evolving as people seek out new ways to cheat the system and take advantage of opportunities.

### Common Forms of Health Care Fraud, Waste, and Abuse

**Falsifying a Diagnosis**

A health care provider purposefully submits an incorrect claim or payment.

**Submitting Claims for Waived Charges**

This method of fraud involves waiving patient deductibles or copayments on a regular basis but submitting claims for the money anyway.

### At a Glance

- There are many methods of committing fraud in medical practice, including submitting false claims, billing for unnecessary medical services, and charging excessive amounts for medical services.
- Fraud can be committed by anyone, from health care providers, patients, and insurance companies, to organized crime groups.
- Being aware of the potential areas of weakness in your practice and implementing guidelines and procedures to address them will help protect your practice and your patients from fraud, waste, and abuse.
Kickbacks
An individual or entity receives benefits—financial or otherwise—in exchange for doing a favor.

Unnecessary Prescriptions and False Claims
A medical professionalprescribes medications to patients who do not need them and submits falsified claims for those unnecessary medications.

Medical Identity Theft
An individual gains access to someone else’s personal information without consent, in order to submit a false medical claim.

THINK BROADLY
Health care administrators should think about fraud, waste, and abuse broadly in their day-to-day operations. Taking the time to look closely at the activities and people at the core of their financial operations may help prevent fraudulent activity and protect their practices in the long term.

Fraud, waste, and abuse occur on the financial and operations sides of a medical practice. More often than not, these illicit activities involve mismanagement of a practice’s finances, theft, and, in worst-case scenarios, embezzlement.

EIGHT BARRIERS TO FRAUD
Medical practices, regardless of their size, can take a few simple business operational steps to build barriers against fraud, waste, and abuse.

No. 1: Financial Background Checks
Conduct background checks on the individuals within the practice who handle money, billing processes, and any other aspect of your practice’s finances. This is a simple way to ensure that your practice’s financial operations are being managed by responsible, honest, and financially fit individuals. Your practice’s certified public accountant or legal counsel can direct your practice administrator to companies who specialize in conducting employee background checks, which can uncover the educational background, criminal record, credit score, and employment history of an employee, among other things.

No. 2: Zero Tolerance Policy
Create a policy of zero tolerance for fraudulent and dishonest activities in your practice and be up front about your high expectations with new employees. Meeting with all staff on a quarterly basis is an effective way of reminding your employees of your expectations.

No. 3: Protect Your Assets
Create a healthy workplace with an open-door policy and an environment in which employees feel empowered to discuss questionable activities. Ensure that all staff members are bonded and covered by fidelity bonds so that your practice is protected in the event that an employee commits fraud. Your practice administrator can use resources available on the internet to educate himself or herself about fidelity and surety bonds.

Before purchasing a bond, speak to a commercial insurance agent who can point you in the right direction, instruct your practice administrator to speak to your practice’s certified public accountant about the available resources in your area, or contact your local professional association for assistance.

No. 4: Create Checks and Balances
Be sure that more than one individual is responsible for conducting your practice’s financial- and billing-related operations.

No. 5: Implement Daily and Monthly Reconciliations
Reconcile cash receipts daily and review your monthly bank reconciliations every month to ensure that the cash received on a daily or monthly basis matches the cash receipts on the practice management system.

ADDITIONAL SUPPORT
• State associations for medical practice managers can be a valuable resource.
• Retired certified public accountants in your area may serve as community volunteers who can lend expertise.
• A consultant can create a full compliance plan and/or conduct compliance training for you and your employees.
• National organizations such as Medical Group Management Association or American Medical Group Association can offer additional assistance and information.
• The Centers for Medicare and Medicaid Services has several resources on its website: cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/providercompliance.html or bit.ly/Hertz0519.
• The Office of the Inspector General is another online resource that can be accessed here: https://oig.hhs.gov/compliance/ or bit.ly/OIG0519.
• Many law firms that specialize in health care offer assistance for developing compliance plans on their websites.

(Continued on page 19)
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Questions? Contact Laura O’Connor, Digital Technologies Director • loconnor@bmctoday.com • 484.581.1860
In our work with more than 1,000 physicians across the country, we have observed that the No. 1 financial goal for nearly all physicians is to achieve a financially secure retirement on their own terms, including each doctor’s unique timeline and lifestyle goals. It is not surprising that data from national physician surveys confirm this as the top financial objective.

What is surprising (to us anyway) is how many physicians attempt to reach this goal using only one of the tools at their disposal—a qualified retirement plan (QRP)—and how many are unaware of another tool they could be using—a nonqualified plan (non-Q plan).

In this article, we briefly describe these two types of plans, each of which can have significant impacts on physician retirement.

**Basics of Qualified Plans**

The designation QRP means that a plan meets the definition of a retirement plan under US Department of Labor and Internal Revenue Service rules created under the Employee Retirement and Income Security Act. A QRP may be in the form of a defined benefit plan, profit sharing plan, money purchase plan, 401(k), or 403(b).

Properly structured plans offer a variety of benefits: You can fully deduct contributions to a traditional QRP, funds within the QRP grow tax-deferred, and (if nonowner employees participate) the funds within a QRP enjoy superior asset protection.

Although traditional QRPs can offer numerous benefits, there are also a host of disadvantages that physicians should understand:

- Mandated maximum annual contributions for defined contribution plans;
- Mandatory participation by employees;
- Potential liability for management of employee funds in the plan;
- Controlled group and affiliated service group restrictions;
- Penalties for withdrawal prior to age 59.5;
- Required distributions beginning at age 70.5;
- Full ordinary income taxation of distributions from the plan; and
- Full ordinary income taxation and estate taxation of plan balances upon death. (Combined tax rates on these balances can be more than 70%).

Despite these numerous disadvantages, nearly all US physicians participate in traditional QRPs. The tax deduction is a strong lure that often cannot be resisted. For many doctors, however, the cost of contributions for employees, potential liability for mismanagement of employee funds, and the ultimate tax costs on distributions may outweigh the current tax savings offered by QRPs. If not giving pause, these drawbacks at least suggest that it would make sense to investigate another type of plan that hedges the QRP as an additional savings vehicle.

This is especially true if you believe that income tax rates, especially the higher marginal rates, will go up over the coming decades. When you use a traditional QRP, you trade today’s tax rates on your contribution for the tax rates in the future when you withdraw the money from the plan. If rates rise in the future, the QRP might prove not to be a good deal at all. Although none of us knows what the future will bring, we do know that, historically, tax rates were much higher than they are today. Thus, the QRP tax rate bet is one that should be hedged against by using retirement savings alternatives.

**Using Qualified and Nonqualified Plans to Reach Retirement Goals**

Many physicians should use both.

**By David B. Mandell, JD, MBA; and Carole C. Foos, CPA**

**AT A GLANCE**

- In the authors’ experience, the No. 1 financial goal of nearly every physician is retirement on his or her own terms.
- A qualified retirement plan (QRP) may be in the form of a defined benefit plan, profit sharing plan, money purchase plan, 401(k), or 403(b). A nonqualified plan can be an ideal long-term tax hedge against a QRP.
Roth QRP

One alternative to consider is a Roth QRP. Many practices sponsor 401(k) plans that give participants the option of making salary deferrals into either a traditional 401(k) or a Roth 401(k). Although traditional contributions, as mentioned above, are tax deductions today and will be taxed upon distribution at the tax rates in effect at that time, their Roth counterparts are after-tax contributions today. Thus, the participant pays tax at today’s rates, but the funds grow on a tax-deferred basis and are tax-free upon withdrawal, assuming the funds stay in the Roth account for at least 5 years after the account is opened. Only the salary deferral portion of a contribution can go into a Roth plan. Any profit-sharing or match must go into a traditional account.

SEP-IRAs

Simplified Employee Pension Individual Retirement Accounts (SEP-IRAs) are not officially QRPs. They are custodial accounts that are similar to QRPs in many ways. Both SEP-IRAs and QRPs have the same tax restrictions on annual contribution amounts, penalties for early withdrawals, mandatory withdrawal rules, and taxation on distributions and plan balances at death. One big difference is that a SEP-IRA may not have the same level of asset protection under state law that a QRP enjoys.

Many physicians who use traditional QRPs, Roth QRPs, or SEP-IRAs as a substantial part of their retirement planning should understand that such plans alone may not be enough to achieve their retirement goals. Whether because of annual contribution limits or the taxation of distributions as ordinary income, most doctors will need another savings vehicle to reach their retirement goals. This is where non-Q plans could play a significant role.

Basics of Non-Q Plans

Non-Q plans are not used by physicians nearly as much as by corporate executives. This is unfortunate, as they could be valuable retirement tools for many doctors. Because these plans are not subject to QRP rules, non-Q plans do not have to be offered to any employees. Further, even among the physician-owners, there is total flexibility. For example, one doctor can contribute a maximum amount, the next partner could contribute much less, and a third physician could opt out completely.

The main drawback of non-Q plans is that contributions are never tax deductible. However, they can be structured for tax-free growth and tax-free access in retirement, like a Roth IRA. Ask yourself: How much would you put in a Roth IRA if there were not funding limitations? If you think you would fund such a vehicle, then a non-Q plan could be very attractive to you.

In fact, a non-Q plan can be an ideal long-term tax hedge against a QRP. Beyond these general ground rules, there is tremendous flexibility and variation with non-Q plan designs. Consider that they have the following attributes:

- No tax deduction on contributions, but funds can grow tax-free and be accessed tax-free upon withdrawal; and
- Top asset protection in many states.

Retirement on Your Terms

As noted at the outset, we have observed that the No. 1 financial goal of nearly every physician is retirement on his or her own terms. Both QRPs and non-Q plans can play important roles in achieving this goal. If building your retirement wealth is an important goal for you, we highly recommend that you work with an experienced advisor to investigate both types of retirement plan for your practice.

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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 Far 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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PERFECTING YOUR PRACTICE

No. 6: Create Safe Data Storage Options
Design and implement a plan for effective health care data storage in your practice. Consider all of the data storage options available to you, including onsite and cloud options, to ensure that all patient data are stored safely and securely. You should also train employees who are responsible for handling patient data and payment information on how to safely store data. Be clear about possible repercussions from a data breach. Read this issue’s feature story, Cybersecurity for the Ophthalmic Practice, on page 11 for more information on this topic.

No. 7: Conduct Surprise Employee Checks
Regularly perform unscheduled checks of your employees to ensure they are performing their duties as required. Just because you implement new guidelines and procedures doesn’t mean all of your employees are adhering to these rules. Never let your guard down. By conducting surprise checks, you can avoid large mistakes in the future.

No. 8: Audit
Practices that have the financial resources to do so should have an external party perform a thorough audit every few years. For example, if you’ve had the same person managing financial operations for 10 years, it’s likely time to have an audit.

MEET YOUR FRAUD PREVENTION GOALS
Taking the steps I have outlined will help you identify potential security risks in your practice and mitigate the potential fallout from dishonest or fraudulent activities that may be taking place. The goal of putting these procedures in place is to discourage people from taking advantage of your systems in the future. Implementing all of these steps at once could be overwhelming for a small medical practice. Start by taking some simple steps to scale these procedures up based on your staff availability and internal business objectives and priorities.

If you are looking for assistance from experts on fraud prevention within the health care industry and community, see Additional Support for a list of options.


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