From MANAGER to LEADER

- Become a Master Coder
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- The Benefits of a Financial Advisor

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Now Approved for an expanded indication in Diabetic Retinopathy (DR)

EYLEA® (afibercept) Injection
For Intravitreal Injection

POWER AGAINST

In PANORAMA, EYLEA significantly improved DR severity scores at week 52†
Proportion of patients achieving a ≥2-step improvement in ETDRS-DRSS* score from baseline (primary endpoint)¶

![Graph showing data]

The recommended dose for EYLEA in DR is 2 mg (0.05 mL) administered by intravitreal injection every 4 weeks (approximately every 28 days, monthly) for the first 5 injections, followed by 2 mg (0.05 mL) via intravitreal injection once every 8 weeks (2 months). Although EYLEA may be dosed as frequently as 2 mg every 4 weeks (approximately every 25 days, monthly), additional efficacy was not demonstrated in most patients when EYLEA was dosed every 4 weeks compared to every 8 weeks. Some patients may need every-4-week (monthly) dosing after the first 20 weeks (5 months).

Efficacy and safety data of EYLEA in DR are also derived from VISTA and VIVID. The percentage of patients with a ≥2-step improvement on the ETDRS-DRSS from baseline at 100 weeks was 38%, 38%, and 16% in VISTA and 32%, 28%, and 7% in VIVID with EYLEA 2 mg every 8 weeks after 5 initial monthly doses, EYLEA 2 mg every 4 weeks, and control, respectively (secondary endpoint).

PANORAMA study design: Multicenter, double-masked, controlled study in which patients with moderately severe to severe NPDR (ETDRS-DRSS: 47 or 53) without central-involved DME (CI-DME) (N=402; age range: 25-85 years, with a mean of 56 years) were randomized to receive 1) 3 initial monthly EYLEA 2 mg injections, followed by 1 injection after 8 weeks and then 1 injection every 16 weeks; 2) 5 initial monthly EYLEA 2 mg injections, followed by 1 injection every 8 weeks; or 3) sham treatment. Protocol-specified visits occurred every 28±7 days for the first 5 visits, then every 8 weeks (56±7 days). The primary efficacy endpoint was the proportion of patients who improved by ≥2 steps on the ETDRS-DRSS from baseline to week 24 in the combined EYLEA groups vs sham and at week 52 in the EYLEA 2 mg every-16-week and EYLEA 2 mg every-8-week groups individually vs sham. A secondary endpoint was the proportion of patients developing the composite endpoint of proliferative DR (PDR) or anterior segment neovascularization.

VISTA and VIVID study design: 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, efficacy endpoints included the mean change from baseline in best-corrected visual acuity (BCVA), as measured by ETDRS letters, at 52 weeks (primary endpoint) and 100 weeks (secondary endpoint).

INDICATIONS AND IMPORTANT SAFETY INFORMATION

INDICATIONS

EYLEA 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).

CONTRAINDICATIONS

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

*Early Treatment Diabetic Retinopathy Study–Diabetic Retinopathy Severity Scale: An established grading scale for measuring the severity of DR.
†Full analysis set.
‡3 initial monthly injections, followed by 1 injection after 8 weeks and then 1 injection every 16 weeks.
§3 initial monthly injections, followed by 1 injection every 8 weeks.

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REGENERON

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777 Old Saw Mill River Road, Tarrytown, NY 10591
DISEASE PROGRESSION

EYLEA can help prevent DR vision-threatening complications that can lead to blindness

Significantly fewer patients developed PDR or ASNV with EYLEA at week 52

Composite endpoint of patients who developed PDR or ASNV at week 52 (event rates) (secondary endpoint)

Hazard ratio: 0.15

20.1%

Hazard ratio: 0.12

2.4%‡

4.0%‡

EYLEA 2 mg every 8 weeks (n=134)

EYLEA 2 mg every 16 weeks (n=135)

sham (n=133)

‡P<0.01 vs sham.

All patients were treatment-naïve to focal or grid laser photocoagulation, panretinal photocoagulation, and any anti–vascular endothelial growth factor (anti-VEGF) treatment. Composite endpoint of developing PDR or anterior segment neovascularization (ASNV) was diagnosed by either the reading center or investigator through week 52. Event rate was estimated using the Kaplan-Meier method.

WARNINGS AND PRECAUTIONS

• Intravitreal injections, including those with EYLEA, have been associated with endophthalmitis and retinal detachments. Proper aseptic injection technique must always be used when administering EYLEA. Patients should be instructed to report any symptoms suggestive of endophthalmitis or retinal detachment without delay and should be managed appropriately. Intraocular inflammation has been reported with the use of EYLEA.

• Acute increases in intraocular pressure have been seen within 60 minutes of intravitreal injection, including with EYLEA. Sustained increases in intraocular pressure have also been reported after repeated intravitreal dosing with VEGF inhibitors. Intraocular pressure and the perfusion of the optic nerve head should be monitored and managed appropriately.

• There is a potential risk of arterial thromboembolic events (ATEs) following intravitreal use of VEGF inhibitors, including EYLEA. ATEs are defined as nonfatal stroke, nonfatal myocardial infarction, or vascular death (including deaths of unknown cause). The incidence of reported thromboembolic events in wet AMD studies during the first year was 1.8% (32 out of 1824) in the combined group of patients treated with EYLEA compared with 1.5% (9 out of 595) in patients treated with ranibizumab; through 96 weeks, the incidence was 3.3% (60 out of 1824) in the EYLEA group compared with 3.2% (19 out of 595) in the ranibizumab group. The incidence in the DME studies from baseline to week 52 was 3.3% (19 out of 578) in the combined group of patients treated with EYLEA compared with 2.8% (8 out of 287) in the control group; from baseline to week 100, the incidence was 6.4% (37 out of 578) in the combined group of patients treated with EYLEA compared with 4.2% (12 out of 287) in the control group. There were no reported thromboembolic events in the patients treated with EYLEA in the first six months of the RVO studies.

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 of Prescribing Information on the following pages.

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

1 INDICATIONS AND USAGE
EYLEA is a vascular endothelial growth factor (VEGF) inhibitor indicated for the treatment of:
- Neovascular (Wet) Age-Related Macular Degeneration (AMD), Macular Edema Following Retinal Vein Occlusion (RVO), Diabetic Macular Edema (DME), Diabetic Retinopathy (DR).

2 CONTRAINDICATIONS
- Ocular or Periorificial Infections
- EYLEA is contraindicated in patients with ocular or periorificial infections.

3 WARNINGS AND PRECAUTIONS
5 Endophthalmitis and Retinal Detachments.

6 ADVERSE REACTIONS
The following potentially serious adverse reactions are described elsewhere in the labeling:
- Hyperosmolarity (see Contraindications [4.5])
- Endophthalmitis and retinal detachments (see Warnings and Precautions [5.1])
- Thromboembolic events (see Warnings and Precautions [5.2])

7.1 Clinical Trials Experience.

8.5 Geriatric Use.

8.6 Pregnancy.

8.7 Nursing Mothers.

9.1 Pregnancy Risk Category.

9.2 Pregnancy: Nonclinical Studies.

9.3 Pregnancy: Clinical Studies.

9.4 Nursing Mothers.

9.5 Reproduction Studies.

9.6 Contraception.

9.7 Breastfeeding.

10 USE IN SPECIFIC POPULATIONS.

10.1 Pregnancy.

10.2 Nursing Mothers.

10.3 Pediatric Use.

10.4 Geriatric Use.

11 ADVERSE REACTIONS

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

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

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

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Tarrytown, NY 10591
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Initial U.S. Approval: 2011
Based on the May 2019 EYLEA® (aflibercept) Injection full Prescribing Information.
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Nobody teaches us how to be a good manager, and it’s not necessarily a skill that can be taught. We can hone our management skills by being exposed to and mentored by people who have more experience than we do and who are willing to share the knowledge and skills they’ve gained.

Leadership, though, is a different beast. Being a good manager and being a good leader are two very different skills that are often conflated. Managers focus on people and tasks. Leaders focus on the bigger picture—on how to inspire staff to better the practice rather than on how to teach staff to perform the functions of their jobs. In this issue’s feature article, practice management experts Corinne Z. Wohl, MHSA, COE, and John B. Pinto answer questions about how managers can grow into leaders.

Other articles you’ll find in this issue are a detailed analysis of why hiring a financial adviser is an intelligent investment to make, an overview of how big data can be leveraged for effective practice management, and a broad look at the essential topics in retina coding that will help you become a master coder.

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

Have a video of an innovative technique or interesting case?

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

Videos should be 3-7 minutes long.

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

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

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

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

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

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

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eyetube
A accurate coding can reduce denials and ensure prompt and proper payment for services provided. Knowledge of key coding principles will contribute to successful reimbursement. This article presents an overview of a few of these key principles.

**BUNDLED CODES**

National Correct Coding Initiative (NCCI) edits are published periodically by CMS. NCCI edits bundle specific CPT codes when the procedures are performed by the same surgeon or group practice, in the same patient session, or at the same surgical site. CMS publishes quarterly NCCI edits to identify CPT codes that are considered bundled (not separately payable) when performed on the same day. A link to these edits can be found at aao.org/coding and in the AAO’s 2019 Retina Coding: Complete Reference Guide.

There are two types of bundled codes. 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 to do so they must meet the definition of modifier -59 per specific local coverage determinations (LCDs). Refer to Table 1 for examples of mutually exclusive and comprehensive bundled codes.

When procedures with multiple CPT codes are performed on the same patient on the same day, best practice is to review the NCCI edits related to those codes. Each CPT code combination should be reviewed for bundles. Some tests are bundled with other tests as well as with surgical procedures; some surgical procedures are bundled with other surgical procedures. These edits are updated quarterly (January 1, April 1, July 1, and October 1).

**When Is Unbundling Appropriate?**

Each bundling edit is identified with either a 1, indicating that unbundling is acceptable when certain criteria are met; a 0, indicating that the two codes involved are mutually exclusive and should never be unbundled unless an insurance payer policy allows under certain circumstances; or a 9, indicating that the bundling edit was made in error and has been reversed.

For bundled codes with an indicator of 1, it is appropriate to unbundle when the other bundled service is provided in the patient’s other eye. When unbundling is appropriate, modifier -59 would be appended to the appropriate CPT code.

To meet the criteria for unbundling, documentation must support either a different session, a different procedure or surgery, a different site or organ, a separate incision or excision, or a separate injury.

**AT A GLANCE**

- Knowledge of bundled codes, global periods, and the differences among insurance carriers’ policies can lead to receiving successful reimbursement.

- The author provides an overview of each of those key principles to help you master retina coding and optimize your practice’s reimbursement.
Example
Laser to repair a retinal lesion using photocoagulation (67210) and laser to repair progressive retinopathy using photocoagulation (67228) are bundled with modifier 1 because the different laser procedures are treating the same contiguous structures of the same organ. If these procedures were performed in contralateral eyes, then unbundling these two codes would be appropriate. To unbundle the two codes, modifier -59 is appended to the CPT code 67228.

When bundled codes are incorrectly submitted to an insurance carrier, the CPT code with the lower allowable is typically paid and the code or codes with higher allowables are typically denied. Creating a process to verify NCCI edits prior to claims submission will ensure maximum reimbursement.

Maintain Current Relative Value Unit per CPT Code
When two codes are bundled, the CPT code with the higher relative value unit (RVU) should be submitted. Maintaining a list of current RVUs per CPT code billed will allow you to best determine the appropriate coding. Note that each year the RVU value per CPT code may change.

For example, RVU for pars plana vitrectomy with endolaser panretinal photocoagulation (67040) and removal of preretal cellular membrane (67041) are bundled under NCCI. The RVU value of these two codes changed in 2015 (Table 2).

Previously, 67040 was the higher valued code, but in 2015 67041 became the code with the higher value. When these two codes are performed during the same surgical session, the CPT code 67041 should be billed. Incorrectly coding 67040 in this case could reduce reimbursement by approximately $109 per session.

Identify the Global Period per CPT Code
The global period for surgical procedures can change periodically. For example, in January 2017, the global period for laser to repair a retinal detachment (67105) was adjusted from 90 days to 10 days for Medicare carriers.

When such changes occur, some commercial or Medicaid payers may also update the global period, while others may remain at 90 days. Promptly identifying the global period per CPT code and insurance carrier is essential to proper coding and reimbursement.

A change in the global period affects how and when office visits are billed.

Incorrectly assigning a 90-day global period to a CPT code for which the insurance carrier recognizes a 10-day global period would result in a loss of revenue because visits from 10 days out to 90 days would be inappropriately coded as postoperative and not billed.

The assignment of the global period also defines whether a procedure is major (90-day global) or minor (0- or 10-day global). This is essential knowledge when one is considering the appropriate modifier for a same-day office visit for a procedure. The decision to perform major surgery the same day as an office visit would warrant appending the -57 modifier to the office visit code. For minor procedures performed on the same day as an office visit, the -25 modifier would be evaluated to determine if the documentation meets the definition of a significant, separately identifiable office visit.

Maintain Current Relative Value Unit per CPT Code

<table>
<thead>
<tr>
<th>TABLE 1. EXAMPLES OF MUTUALLY EXCLUSIVE AND COMPREHENSIVE CODES</th>
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<tbody>
<tr>
<td>Procedure 1</td>
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<td>92133</td>
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<td>67039</td>
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<th>TABLE 2. CHANGE IN RELATIVE VALUE UNIT DOLLAR VALUE OF CPT CODES 67040 AND 67041 BY YEAR</th>
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<tr>
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</tr>
<tr>
<td>67040</td>
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<tr>
<td>67041</td>
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Note: The higher RVU value per year is in green.

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<tr>
<th>TABLE 3. LASER PROCEDURES AND THEIR GLOBAL PERIODS (Continued on page 15)</th>
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<tbody>
<tr>
<td>CPT Code</td>
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<tr>
<td>66761 (Nd:YAG PI)</td>
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<tr>
<td>66823 (Nd:YAG PCO)</td>
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<tr>
<td>67105 (Laser repair RD)</td>
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<tr>
<td>67145 (Laser repair retinal tear, prophylaxis RD)</td>
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<tr>
<td>67210 (Focal laser)</td>
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<tr>
<td>67220 (Laser for choroidal lesion, CNV)</td>
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<tr>
<td>67228 (PRP laser)</td>
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Abbreviations: CNV, choroidal neovascularization; PCO, posterior capsular opacification; PI, peripheral iridotomy; PRP, panretinal photocoagulation; RD, retinal detachment.
Medicine, law, and engineering are learned professions. You learn a body of knowledge, take a test, become licensed to build a bridge or transplant a heart, and go on to practice your craft, albeit more skillfully over the years. Management is not a learned profession. One does not graduate from business school as an effective administrator on day 1. Management skills develop acratively. With an excellent mentor or coach and the personal desire to improve, management skills grow faster, but they are still dependent on the sheer number of challenges through which the manager has worked. In your first years as a manager, your focus is on managing people, learning to be numerate, and absorbing the details of the industry. Developing leadership skills occurs over time.

For this article, Retina Today Business Matters asked practice management experts John B. Pinto and Corinne Wohl, MHSA, COE, for advice on how managers grow to become leaders. An edited version of their answers follows.

Q: WHAT ARE THE PROMINENT DIFFERENCES BETWEEN A LEADER AND A MANAGER?

A: The descriptions of managers and leaders can be imagined by using a Venn diagram; there is an overlapping area with identifiers unique to each role (see Managers and Leaders). Managers prominently provide instruction to their staffs for task management. Leaders can be described as providing direction in the same way, but they do it in ways that inspire the staff to want to achieve more and excel professionally to benefit the practice. You could think about a leader as a manager plus.

The comparison is not unlike what occurs in medical training. When you start as a doctor in training, you mainly do what you are directed to do. Later in your career, you start managing the work of others such as nurses and administrative staff members. You are not only managing, and you are not only doing; there is a doing-managing-leading path that every professional progresses through on the way toward leadership.

Managers typically live in the moment. They may ask themselves, “Do I have the staff that I need this morning to see our patients? Does the staff know how to do a particular procedure?” They think operationally and in the short term. Leaders are typically more visionary. They are future-oriented and think strategically. They may ask themselves, “Are we going to have the right complement of staff and the right training programs by the end of this year to take on a new service?”

Managers usually have a short decision cycle. If an issue arises and they need to make a decision, it is usually regarding a problem occurring that day or that week. A leader makes decisions over a much longer time frame. The senior administrator in a practice might have a question posed to him or her
in the boardroom in January and quite reasonably not come back to the boardroom with an answer until April.

A manager follows goals predicated on the leader’s vision. Typically, managers are more about maintaining the status quo. They lean toward playing it safe and are sometimes even resistant to change. Leaders, by contrast, are more willing to take chances and have more authority and responsibility to take risks that are proportionate to potential gain. A leader might blow up the status quo and say, “Starting next week, we’re not going to do it that way any longer.” That can be a bit of a high-wire act because he or she could be wrong, but that is how leaders push their practices toward improvement and success.

Q: IS IT HELPFUL TO HAVE A FORMAL PROCESS IN PLACE TO FOSTER THE GROWTH OF MANAGERS INTO LEADERS?

A: Absolutely! Although it is great to have a definitive professional growth process in place, it can be influenced by the size of a practice and the resources that are reasonably devoted to continuing education. For example, we work with many large practice clients who hold quarterly educational sessions for their midlevel managers to help develop their management and leadership skills. Our small to medium-sized practices may not be able to expend that level of effort, but they can help to foster growth by providing written goals and feedback to managers as well as resources such as webinars, books, and management conference attendance.

We see examples at both ends of the enterprise scale. There are very small practices that do a superior job in formal leadership and management training for their staff and doctors and very large practices that do not allocate sufficient resources for training. Consider whether you are prioritizing efforts to help foster leadership growth and how your practice could benefit. (Editor’s note: More information about this topic may be found in Ms. Wohl and Mr. Pinto’s new book, Up: Taking Ophthalmic Administrators and Their Management Teams to the Next Level of Skill, Performance and Career Satisfaction.)

Q: WHAT IS THE ROLE OF CONTINUING EDUCATION IN GROWING MANAGERS INTO LEADERS? DOES IT INVOLVE HONING BASIC OFFICE SKILLS, LEARNING THE INS AND OUTS OF PROCEDURES, ETC.?

A: There are about 7,000 ophthalmology practices in the United States. It is common to see wide variation, from practice to practice, ranging from how staff members answer the phones, to how clinics are organized, to how the practice fosters growth among employees. In our experience, the role of continuing education in most practices is about 90% internal. Staff members learn from one another how to do certain tasks. The more technically formal and critical the subject areas are—for example, billing and coding—the more precise the training must be. In most practices, a subset of the staff goes to regional or national workshops, but the training must not stop there. It benefits the practice if those employees then pass the knowledge they have acquired on to others.

One potential downfall of having staff members train one another is that it could lead to a methodological echo chamber. For example, Mary at the front desk has a certain way of checking in a new patient, and, as she trains Bill, he may forget some steps of the process when he teaches the next person under him. About five staff members later, your employees could be performing important tasks differently from what was originally practiced. In all practices, you need to have performance consistency, developed by creating detailed documentation for all major tasks and then training to those standards.

We have observed that the top-performing 10% of our client base all have written documentation for departmental protocols. In even the smallest practices, operations manuals can be very lengthy to account for a tremendous level of detail.

Q: HOW DOES ONE IDENTIFY LEADERSHIP POTENTIAL IN AN EMPLOYEE?

A: Not all managers have the interest or desire to move their careers to the next level. Those who do will express definitive interest. They will be open to suggestions on how to improve their skills.

There may be hidden potential leaders in your practice beyond your existing managers. There are likely individuals who have earned the trust of others and toward whom employees gravitate for advice. These informal leaders may be providing suggestions and new ideas to the practice’s leaders. Other signs include working long hours to achieve goals and showing initiative or creativity to solve problems. When you recognize a potential leader, but that person does not yet see it in himself or herself, it may be due to a lack
of confidence. You can quickly tell whether some guidance and encouragement will help or whether he or she is really not interested.

In athletic terms, someone who is not a natural athlete can certainly be athletically trained, but he or she may not be as proficient at a given sport as a person who is a natural athlete. We can apply that analogy to leaders. You can see natural leadership shine by watching kids play in the sandbox. One might take the lead and say, “We are going to build a castle.” He or she could be a little CEO in the making.

The personal lives and career histories of your staff members can tell you a lot about how well they will take to leadership—the staff member who was not just a Boy Scout but became an Eagle Scout or the staff member who was not just a cheerleader but was the head of the squad. People who organize things and pull people together are the individuals who are natural leaders.

**Q: HOW DOES ONE DEFINE SUCCESS AS A LEADER?**

**A:** A leader defines goals, measures progress, is confident making midcourse corrections for better outcomes, and develops solid working relationships with doctors, managers, and staff. Leaders possess the skills to work through disagreements, challenges, and difficulties while maintaining respectful relationships. The term **servant leader** is often used to describe individuals who think of others’ needs first and of themselves last. A successful leader inspires those working with him or her to do their best work and focus on the success of the overall practice.

Another success factor that we cannot ignore is raw tenure. There is a well-understood honeymoon period for most people who assume a leadership position. At first, everyone loves you, but you start to lose popularity when you have to make potentially unpopular decisions. Even US presidents often have initially high approval ratings but, after 4 years of leadership, leave office with drastically lower ratings—perhaps lower than they deserve. We have met perfectly adept doctors and administrators who have moved on from one practice to another because they wore out their welcome at the first.

**Q: SHOULD A FORMAL MENTORSHIP PLAN PLAY A ROLE?**

**A:** Mentorship is an ideal way to help a manager become a leader. We believe that the benefits of mentoring go both ways: There is always something to be learned from both sides. When you have a mentor, you learn from someone else’s successes and failures, and this expedites personal and professional growth for the mentee. Mentors and mentees both benefit because you cannot teach without learning something yourself.

One of the first things taught in medical school is not to provide treatments that you do not know how to provide. In other words, when you get stumped by a patient’s condition, don’t guess—get a second opinion. It is important to understand your limits as a business leader as well.

There is no perfect administrator or CEO of a practice. Everybody has some hole in his or her skill set or experience, and it is important to know where those holes are and when to call on peers, attorneys, accountants, or consultants to back up your judgment.

**Q: WHAT ARE THE NECESSARY SKILLS AND ATTRIBUTES FOR A STRONG LEADER?**

**A:** Defining the attributes of strong practice leadership could fill a whole book, but the main areas include the ability to create and nurture working relationships with doctors, managers, staff, vendors, and patients; excellent communication skills; the ability to perform financial analysis; and a commitment to making data-driven decisions.

It is also important to have compassion. Cold-hearted leadership, especially in the health care field, tends to fail. Practice leaders who have compassion for their staff, their doctors, and their patients generate inspired work. Communication skills—writing, speaking, and listening—are vital. An effective leader is able to develop written goals, communicate those goals through protocols and policy, share progress, and express understanding and appreciation of staff efforts.

In addition, the value of raw intelligence must not be overlooked. If you are unable to stand toe-to-toe with your doctors and your board members at an intellectual level, they will not have confidence in you as a leader. That is true whether you are the administrator or the managing partner of a practice.

**CONCLUSION**

The professional growth discussed in this article starts with the manager. The manager must first have a desire to grow if he or she wants to evolve as a manager into a leader. It cannot happen without personal commitment and drive.

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- Financial disclosure: None
The term big data has been around since 2005, but the volume of data in health care has spiked significantly over the past few years as organizations have transitioned to electronic health records (EHR) and as the use of applications to support and store these data has grown. Health care organizations increasingly rely on analytics tools, cloud-based solutions, medical devices and wearables, medical imaging, and other health-related applications as the field continues on a path toward value-based care.

This article outlines some of the uses of big data in medicine and suggests ways that retina practices and others can take advantage of this type of information to improve health care delivery.

THE IMPACT OF BIG DATA

The benefit of acquiring, analyzing, and leveraging vast amounts of health care data is in the ability of the data to reveal patterns and trends that can lead to better understanding and prediction of human behavior. The effective use of these data can allow providers and retina practices to make more informed health care and financial decisions and provide better treatments. This can ultimately lead to a higher level of patient care.

With providers and payers generating and collecting data from a growing list of sources, the amount of overall data will continue to increase, requiring many health care organizations to increase their investments in big data analytics. In a poll of approximately 1,300 medical practices in March, 84% of respondents said they use benchmarking data to improve practice operations (Figure).1 Adopting the use of data analytics methods such as these can allow organizations to identify problems before it is too late and to increase efficiency by providing a clear view into financial operations, staffing, inventory, medical records, patient engagement, and so on.

POTENTIAL CHALLENGES AND BENEFITS

Challenges

The growth of data use in health care may occur more slowly than in other fields because of the challenges health care organizations will face as they strive to meet government-mandated HIPAA policies, find effective storage and security options, and learn how to effectively capture and utilize the vast amount of disorganized data that exists.

Benefits

There are several ways in which big data could transform the health care industry over the long term, potentially affecting the way patient care is delivered:

• Effective use of data analytics has the potential to reduce the costs of treatment by improving patient outcomes, as information on outcomes specific to treatments are analyzed through data-driven findings;
• The use of predictive analytics tools can improve the delivery of care through the gathering of EHR data. Physician decisions increasingly rely on evidence-based research and clinical data;
• Providers can assess methods and treatments faster, helping them develop a comprehensive picture of their patients. Treatment in early stages of a disease can reduce costs and improve overall outlook;
• Patients can have greater access to professional care through applications on their smartphones or tablets;
• The ability to easily share data among caregivers improves continuity of care, allowing more efficient treatment of patients while also potentially reducing costs;
• Effective use of data can increase practice efficiencies, help to track inventory, analyze payer reimbursements for future contract negotiations, and more; and
• Analyzing population-specific

AT A GLANCE

► Analyzing health care data can reveal patterns and trends and lead to a better understanding and prediction of human behavior.

► Data analytics can allow organizations to identify problems before it is too late and increase efficiencies.

► EHRs and other data solutions can help to create efficiencies in retina practices through benchmarking with key indicators.
health data could help to identify risk factors for certain diseases and patient behaviors.

**CREATING EFFICIENCIES**

The day-to-day operations of a retina practice require much time and patience to manage. From staffing and patient scheduling to technology infrastructure, there are many facets of operation to manage concurrently. Use of EHR and other data solutions can help to create efficiencies in a retina practice through benchmarking with key indicators, such as staffing ratios, financial performance, patient care, and patient satisfaction.

Through the practice’s information technology infrastructure, practice managers can implement patient reminders for follow-up appointments, create a patient portal for scheduling appointments, and institute a patient-accessible system for requesting refills. Other tools can allow managers to review staffing ratios, forecast visit rates, and see different staffing models, allowing them to ensure that clinics are staffed appropriately based on patient population and disease burden.

Improved efficiencies such as these can result in reduced patient wait times and more effective use of staff and office resources.

**TAKING ADVANTAGE OF BIG DATA**

Retina practices can benefit from the use of technologies such as EHRs, telemedicine, and the latest specialty-specific patient engagement applications. For example, retina practices can encourage their patients to use a patient portal, receive alerts from their EHR systems regarding lab results, and track prescriptions and possible drug interactions, all to improve the level of patient care.

Practice managers should educate and train staff members on the types of data to be gathered through EHR management software and other sources and explain to them the value of the data they are gathering.

Practice managers can also educate themselves on the variety of smartphone and tablet applications that are available to patients. Use of such apps may help to improve care. In ophthalmology, for example, a recently introduced risk calculator app, Retina Risk (Risk Medical Solutions; available for Apple and Android systems), allows patients with diabetes to assess their risk of developing diabetic retinopathy.

**EFFECTIVE IMPLEMENTATION OF BIG DATA SOLUTIONS**

Retina practices should have full visibility into what an effective EHR platform can do. Third-party vendors can help with enhancements that might help to gather specific data. Other steps practices can take include these:

- With management support, develop a clear vision of the objectives of implementing big data analytics;
- Assess organizational readiness for change and develop a plan for implementation;
- Determine data availability and quality. For data to be valuable, it must be the right data;
- Create an infrastructure plan that includes data storage, management, and security. Storing and analyzing massive amounts of data requires a comprehensive technological infrastructure, including redundancy plans, high-capacity servers, and powerful processors;
- Ensure that systems are secure by using analytics that can identify changes in network traffic or other behavior that might indicate a cyberattack;
- Research third-party vendors who can partner with you on big data solutions;
- Research compliance laws and regulations that govern individuals and communities’ privacy and security. Invest in human capital such as information technology experts, data scientists, data architects, and data engineers; and
- Educate staff on how and why data are needed and how they will be used.

**PREPARE FOR THE FUTURE**

With the volume of data expected to increase and the health care industry in constant flux, practices must be prepared for the future. One way a retina practice can do this is by staying current with trends and advances in big data. Staying current with health care initiatives, guidelines, and requirements that necessitate effective use and interpretation of data will also put you at an advantage.

There will be a growing need for individuals trained to interpret vast amounts of data, as well as for systems that can store and allow those data to be accessed and analyzed in meaningful ways. There is also much work to be done to educate patients and providers on the uses and benefits of data in improving health care overall.

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THE ADVISOR ADVANTAGE

Seven benefits your financial advisor should bring to your portfolio.

BY BOB PEELMAN, CFP; AND DAVID B. MANDELL, JD, MBA

Do I really need help, or can I handle wealth management on my own? What does an investment advisor do for the fee I pay? These are common questions that physicians often ask. We believe these questions are crucial, as the decision of whom you trust to manage your wealth will be one of the most important financial decisions you will ever make.

In this article, we address the value you should be getting if you decide to use an outside financial advisor. We focus on seven potential benefits of receiving sound advice, all of which can have quantifiable and qualitative consequences on your long-term financial success.

THE SEVEN BENEFITS OF A GOOD ADVISOR

1. A Portfolio That Evolves With You
   Does your advisor research funds to identify the best options in each asset category? Only with thorough data on a wide range of investment options can your advisor appropriately allocate funds for a custom-designed portfolio that evolves with you and your financial goals. Because asset values change, your advisor should regularly assess your portfolio to identify any drift from target allocations and take steps to rebalance as required.

2. A Portfolio Designed to Match Your Risk Tolerance
   Most physician investors initially provide their advisors with an idea of their tolerance for risk in their portfolios. Age, a shortening retirement horizon, and changes to career and family can dramatically affect an investor’s risk tolerance. Does your advisor periodically calculate the risk score of your current portfolio and compare it with your personal risk score? Nothing can take all the risk out of investing, but a thorough advisor will stress-test your portfolio in a variety of market scenarios and optimize asset allocation to match your risk tolerance, even as it changes over time.

3. Portfolio Management With an Eye on Taxes
   Many busy ophthalmologists focus primarily on portfolio performance, overlooking the impact of taxes on their investment returns. The cost of federal and state income and capital gains taxes on a portfolio depends on many factors, including the underlying investments, asset turnover, the structure in which the investments are held, the investor’s other income, and state of residence.
   An advisor who is well-versed in alternative investments can offer investors a broad menu of options, including real estate investment trusts, commodities, managed futures, and private equity, and review the risks and fees associated with each option. Some advisors can also provide access to vetted private nontraded alternatives to help investors maximize returns while reducing overall portfolio risk.

5. A Comprehensive Financial Plan
   Your advisor should work with you to develop a comprehensive financial plan that keeps your big picture in focus. A cash flow analysis, personal balance sheet, income projections, and goals for education and retirement are data that can be used to generate a dynamic plan, a road map to guide the financial decisions you make for you and your family. As part of your advisor’s wealth management services, he or she should periodically review your financial plan and update it to incorporate any changes to your income, family situation, goals, and time horizon.

6. A Clear Understanding of How You Are Doing
   If reports from your investment advisor don’t paint a clear picture of your portfolio’s performance, it is a problem. Your reports should track net contributions and withdrawals,
present a customized portfolio summary, and transparently show the performance of your portfolio net of all fees.

7. Total Wealth Management, Not Simply Investments

Does your advisor’s firm work only with investments, or is he or she backed by a solid wealth management team? A multidisciplinary wealth management firm includes specialists in areas of expertise affecting your overall financial well-being.

For example, attorneys can analyze each asset and make recommendations to reduce the asset’s level of exposure to lawsuits and other risks, certified public accountants can review tax returns and suggest ways to reduce or defer tax liability, and insurance experts can review existing policies and present options that could reduce premiums or improve coverage. An advisor who can offer these areas of expertise within his or her firm is well-equipped to become your financial quarterback, a resource to handle questions concerning any financial matter.

THE ADVISOR ADVANTAGE:

The best advisors deliver significant benefits that can add both quantifiable and qualitative value to their clients’ portfolios. This advisor advantage can help you achieve your long-term financial goals by aligning your portfolio with your personal risk tolerance, focusing on your net after-tax return, and developing a strategic wealth management plan that evolves with you and your family.

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(Continued from page 8)

(Continued from page 8)

visit. To illustrate this, Table 3 outlines the global periods associated with various laser procedures.

REVIEW INSURANCE POLICIES FREQUENTLY

Medicare Administrative Contractors (MACs) publish LCDs, and CMS publishes national coverage determinations, or NCDs, to provide policies and guidelines for correct coding for specific procedures. These policies designate medical necessity, approved diagnosis codes, diagnostic testing requirements, and frequency edits as applicable. Commercial insurance carriers may also publish their own policies for procedures, and these are often posted on their websites or included in provider manuals. LCDs may vary by region, and they are revised periodically. To review and maintain a current copy of published LCDs for each MAC, visit aao.org/lcds.

It is important not to apply one payer’s rule or perceived rule to all payers. Each insurance carrier may have unique policies that may differ from those of other carriers. Additionally, commercial payers may not recognize the same NCCI bundles published by CMS.

STAY SHARP

The protocols for coding retina procedures change at the margins from time to time, and these changes may have major downstream consequences if the new rules aren’t followed. By keeping up to date with developments in coding in the areas outlined in this article, you can maximize profitability for your practice and avoid costly audits.

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