# OPTING OUT OF MEDICARE

Two surgeons' experiences.

## Why I Have Opted out for the Past Decade

**BY DANIEL DURRIE, MD**

The decision to opt in or out of Medicare affects all aspects of an ophthalmologist's practice. Without a doubt, it is one of the most serious business decisions of a physician's career. My practice opted out of Medicare almost a decade ago and no longer accepts insurance. It now operates on a private-pay–only business model.

### ADVANTAGES OF OPTING OUT

One of the major advantages of opting out of Medicare relates to fee structure. At Durrie Vision, our fees are dictated by the quality of our services, our reputation, and word-of-mouth referrals rather than insurance or Medicare programs. We provide patients with an extremely high level of care that produces a high volume of word-of-mouth referrals. We invest in equipment and diagnostics that some patients would not have access to with a general ophthalmic evaluation dictated by insurance.

We have also consciously limited the number of patients visiting the practice. When we are seeing new patients, we see 12 in half a day. In contrast, I used to see 40 to 50 patients in half a day when I was involved in private insurance and Medicare, just because the reimbursement was so low that we had no option but to increase volume.

### MAKING THE DECISION IN 2005

Ophthalmologists are fortunate to have a mix of patients. One group is disease based, including individuals with cataracts, glaucoma, retinal pathology, and dry eye disease that require evaluation and treatment. These patients represent the mainstay of ophthalmology and would be extremely hard to incorporate into a private-pay–only model. Refractive surgery, oculoplastics, and elective refractive lens exchange are not covered services, but individuals in this category can become life-long patients.

When we were deciding whether or not to continue with Medicare in 2005, about 20% of our procedures were reimbursed. The rest were already private pay only. Opting out of Medicare simplified our practice. It is now a very successful high-end boutique practice. The personnel previously dedicated to billing and collection were reassigned to customer service.


### THE PATIENT'S EXPERIENCE

We spend a great deal of time with every new patient to develop a lifetime vision plan. We meet and greet patients individually and immediately bring them into the back rooms; they never sit in the waiting room. The staff is not concentrating on how to code a particular procedure or whether a patient already had a specific diagnostic test in the previous calendar year. This flexibility allows us to offer patients the most comprehensive examinations we can. We perform optical coherence tomography retinal scans on and take endothelial photographs of every new patient.

Our patients feel that we are as thorough as possible and that our recommendations for their vision plan reflect this comprehensive approach.

### POINTS TO CONSIDER

Opting out is not always a good business decision. I do not recommend that anyone starting out in practice turn down patients. Private insurance and Medicare are where to find patients with a lot of the diseases ophthalmologists are trained to treat. Building a loyal patient base at the beginning of one's career often means accepting insurance. Yes, some surgeons opened LASIK-only practices and never got involved with insurance, but that happened when LASIK volume was substantially higher than it currently is. Large cataract practices with an optometric referral base and their own ambulatory service center are not likely to be successful candidates for my business model.

I should note that some services that are out-of-pocket expenditures for patients do not necessarily affect Medicare or insurance participation. Examples include a 45- to 65-year-old patient undergoing refractive lens exchange or a presbyopia-correcting procedure and younger patients who want laser vision correction.

The number ophthalmologists who are totally opting out of Medicare and insurance is extremely small. Those who are

interested in doing so should focus first on the private-pay part of their practice and attempt to grow it.

Finally, I should explain that the process of opting out has to be repeated every 2 years. Otherwise, Medicare automatically restores the physician/practice. At Durrie Vision, our chief financial officer is responsible for monitoring our eligibility. We have found it easiest if all of our physicians (optometrists included) opt out; that makes it less confusing for patients and staff.

## Why I Opted Back in

### BY MARGUERITE McDONALD, MD

In the year 2000, long before Hurricane Katrina, I had a single-surgeon cornea/refractive/anterior segment practice in New Orleans. My 6,000-square-foot office housed a clinical trials unit, a minor surgery suite, seven lanes, and my own refractive surgery center, where I performed LASIK, PRK, conductive keratoplasty, and astigmatic keratotomies.

During the heyday of LASIK, my office manager, Denise, came to me with spreadsheets to prove to me that it was no longer economically viable to spend so much time and effort performing penetrating keratoplasties and other Medicare procedures as reimbursements plummeted. In addition, the LASIK patients were being booked 4 months out, which they did not like; this situation was causing some of them to cancel. Denise felt strongly that I should consider dropping out of Medicare, and she provided convincing supporting data.

She and I spent a great deal of time researching the pros and cons of opting out as well as our responsibilities. I would have to identify all of my Medicare patients, notify them, and refer them—each with a complete case summary letter—to one of my colleagues (competitors) in town. We spent hours on the exact wording of the patient notification letter so that it was truthful, thoughtful, legal, and clear. We were aware that there would be no turning back for a minimum of 2 years, which is the length of each opt-out period.

For the first 6 months, life was wonderful. I was able to reduce my billing staff to one person (out of 16 employees) and switch over the rest of the billing staff to service-related activities. I was able to spend more money on marketing, and my LASIK volume soared. Ours had become a successful non-Medicare boutique practice. What happened?

#### SEPTEMBER 11, 2001

When the disasters of September 11, 2001, occurred, the office phone rang off the hook with LASIK cancellations. Because New Orleans is a tourist town, most of my patients were in the hospitality industry and were terrified that reduced tourism would cost them their jobs. Their fear was justified: half of my employees were married to hospitality workers who immediately lost their jobs.

Denise and I went into our "war room" with a bunker mentality. How would we survive 1 ½ more years—until we could opt back in to Medicare—with virtually no income? I was forced to let half of my employees go, and we came up with a plan by which to save the rest. Denise and a small team went through all of our patients' charts by hand (this was at a time when electronic health records were not in widespread use) to find non-Medicare patients with insurance who were due for office visits, a small percentage of whom had been contemplating surgery at their last visit. We called every one of my patients with keratoconus, with contact lenses, and with glaucoma as well as anyone overdue for his or her next examination. Bonuses disappeared. Every employee who had not already been cross-trained was taught to perform numerous other duties.

I wished that I could bring back my Medicare patients, but of course, I could not. I had sent them away, and they were now established in the practices of my local colleagues. The atmosphere in my office was grim, to say the least.

#### OPTING BACK IN

At the first opportunity, after 18 long months, I opted back in to Medicare. A few of my old patients came back when they heard through the grapevine that I was accepting Medicare again but not many. Despite my kindly worded letter, some had been offended by my opting out. Nevertheless, the practice began to be more profitable, and the "survivors" all heaved a cautious sigh of relief. In retrospect, perhaps I could have brought on a junior associate to share the burden of Medicare patients before I took the dramatic step of opting out.

My husband, Stephen Klyce, PhD, was a bit confused by all of this. He famously asked, "Let me get this straight: you opted out of Medicare because of declining reimbursements, and now, you are opting back in in spite of declining reimbursements?" That pretty much summed it up!

Turns out that Grandma was right: you never know what is around the corner, and you should never put all your eggs in one basket. ■

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