# Increasing Your Level of Success With Premium IOLs

Learn from the experiences at three practices with happy patients.

**By Mark Rosenberg**

The question of how to run a successful premium IOL practice has been addressed in almost every ophthalmic publication and symposium. As an industry, we seem to be seeking a magic spell that will instantly elevate our conversion rates for upgraded lenses. The questions we must all ask ourselves, however, are (1) what constitutes a premium lens? and (2) who defines success?

## WHAT'S IN A NAME?

The terminology used and its definition have yet to be accepted. *Premium IOLs* remains the go-to phrase (see this very issue of *Cataract & Refractive Surgery Today*), but many worry it emphasizes cost rather than quality. *Presbyopia-correcting IOLs* defines a technology, but the term has no sizzle. Moreover, many, including myself, would argue that the premium IOL category (there is that word again) includes toric lenses. Other terms in use include *specialty lenses*, *lifestyle lenses*, and my current favorite, *advanced-technology lenses*. At Barnet Dulaney Perkins Eye Center in Phoenix, where I am the executive director, I consider any lens for which the patient chooses to pay to be advanced technology (ie, a presbyopia-correcting or toric IOL but not a monofocal lens).

## WHAT CONSTITUTES SUCCESS?

Every practice has a different culture, as defined by the physician's style, demographics, and the psychographics of the patients that the practice serves. Moreover, the internal structure of a practice where the surgeon performs all general eye examinations will contrast greatly with that of a practice that relies on optometrists for this care. Although we can all learn something from practices that have another style, we must factor such differences into our application of their experiences to our own businesses.

The 70% to 80% conversion rate to presbyopia-correcting IOLs claimed by a doctor at the podium will not be realistic for all practices. Defining our own level of success as hitting others' conversion rates is not a useful approach. We are attempting to hit a mythical bar promoted by industry to meet the projections of Wall Street investors. Each of us must define success with premium IOLs by what we know about our own practices and patients.

I will share a story to elucidate this dichotomy in perspectives and agendas. Several years ago, I was on a panel at a professional meeting. One of the industry leaders on the panel with me told our audience of leading ophthalmologists that, as a group, we are not meeting market expectations for premium IOLs. He said there was a 7% penetration rate of premium IOLs to the number of cataract procedures performed. He stated that the goal (expectation) should be more like 20%. I agreed with the 20% figure but made several stipulations. First, I noted that all toric lenses implanted should be included in the calculation of penetration. Second, I argued for excluding from this figure the cohort of cataract procedures performed at Veterans Administration Hospitals, by the Indian Health Services, or under Medicaid—government institutions/programs in which only medically necessary operations are performed. With these stipulations, I argued, the penetration level of premium IOLs was about 20%. Then, the fight began.

## PEARLS

At Barnet Dulaney Perkins Eye Center, optometrists see the general patient base. When diagnosed with a cataract, patients speak with a surgery scheduler and possibly a lens counselor. Patients are then are scheduled for a history, physical, and further diagnostic testing.

By the time patients saw a surgeon for their preoperative examination, they usually had decided that a premium IOL was not for them, generally due to its cost. For the optome-

trists to do all of the “selling” had challenges. Certainly, these professionals are recommending solutions, but in addition to the available IOLs, our optometrists have to promote our optical as well as hearing services. It proved unrealistic to expect them to devote the time necessary for discussing IOLs. Now, delivering this education is a priority of our frontline surgery schedulers. They receive real sales training and a script focusing on lens replacement, not cataract surgery. They share with patients a story about how the eye is like a camera and say, “Let’s talk about what lens you would like for your replacement.”

In my experience, the key is for someone the patient views as credible to deliver this message—someone who is not threatening and whom patients feel has no financial incentive, just caring concern. When we implemented these changes, our conversion rate increased by 42% from our previous level.

## CONCLUSION

Let’s all define our success rates with premium IOLs by the quality of our outcomes, our patients’ level of satisfaction, and our own unique expectations—not industry’s or our peers’ standards. The number of products and choices for treatment for which patients will be paying out of pocket is only going to increase. Now is the time to define which business model is a comfortable fit for our doctors, our patients, and our practices.

*Mark Rosenberg may be reached at (602) 508-4808; mrosenberg@bdpec.com.*

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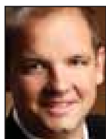

**By Matt Jensen, MBA**

Early in 2005 at Vance Thompson Vision in Sioux Falls, South Dakota, we faced the challenge of counseling our very first patient for the Crystalens (Bausch + Lomb). The process turned out to be more complicated than we had anticipated. The patient was a Medicare beneficiary, and the Centers for Medicare & Medicaid Services had not yet approved unbundling the fee as a pathway to charge for the noncovered service of presbyopic correction. Since the agency’s landmark decision, growth in the category of presbyopia-correcting IOLs has remained steady, constant, and exciting.

What I believe has made our practice successful in this arena for the past 6 years is our focus—on patients and their education, on communication, and on the doctors and their recommendations.

## EDUCATION

Never before have we had to communicate our offerings for cataract surgery to such a savvy population. Patients interested in presbyopia-correcting and toric IOLs desire a specific refractive outcome. Because it is their cloudy vision that prompts them to call us, however, it is highly unlikely that they will be prepared to pay for one of these lenses if they are not given the time to consider the technology’s potential pros and cons. Most of these patients are seeking a solution to their cataract, not to their presbyopia or astigmatism, largely because they do not know that the last two can be addressed at the time of cataract surgery. For this reason, we make every effort to begin educating patients about the important decisions surrounding their cataract removal and selection of an IOL days to weeks prior to their scheduled visit.

## COMMUNICATION

The type and number of options for an IOL will overwhelm most patients, so the need for education and guidance is high. That requirement combined with the complexities of billing and coding as well as of comanaging patients’ after-care represents a challenge for any ophthalmic practice. We therefore make communication a priority at our practice.

Our team explains to patients that the purpose of their visit is threefold. First, we want to determine whether or not their cloudy vision warrants surgery. Second, we will assess their current visual function in order to recommend an IOL that will provide them with the best opportunity of attaining high-level visual function at the distances that they articulate are important to them. How the patient communicates these needs and the IOL chosen influences the decision of which methodology will be used for nuclear fragmentation.

## RECOMMENDATION

Patients undergoing cataract surgery need to understand the benefits and risks associated with the proposed and alternative methods of correcting their vision. We discuss all of the options with patients regardless of their age or finances. After a thorough education, however, patients want the surgeon’s professional recommendation.

Our ophthalmologists state whether they believe the patients’ cataract (or other condition) is operable. Having listened attentively to the patient’s description of how he or she uses vision on a daily basis and his or her hobbies and activities, they describe the available options and then make a recommendation based on the patient’s specific situation and desired outcome. We have found that there simply is no substitute for the doctor’s guidance delivered directly.

*Matt Jensen, MBA, is the executive director of Vance Thompson Vision in Sioux Falls, South Dakota, and he is a certified Experience Economy expert. He acknowledged no*

*financial interest in the product or company mentioned herein. Mr. Jensen may be reached at (605) 328-3903; matt.jensen@sanfordhealth.org.*

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**By Kerry D. Solomon, MD**

The definition of success with premium IOLs (accommodating, multifocal, and toric) is going to vary, depending on what practices charge. To me, however, the true measure of success is the degree of satisfaction among patients. Happy patients build a business regardless of the conversion rate.

Not everything we tried at our practice worked. The main secret, we found, is educating patients so that they can make informed decisions about what they want.

## WHAT CRASHED AND BURNED

Our initial approach of adopting premium IOLs without changing much in our practice was a failure. So, too, was simply suggesting that virtually everyone is a candidate for these lenses. A third strategy that did not pan out was our trying to predict who would be interested in a premium IOL and only offering the technology to those individuals. We had patients return to our office, tell us that they would have liked to have considered a premium IOL, and ask why they were not given the opportunity.

## WHAT WORKS

### Equal Opportunity

Today, my staff and I discuss premium IOLs with all of our cataract patients. That requires us to spend more time with patients, so we see fewer of them in a day. I am continually amazed, however, that people I did not think would have the ability find a way to pay for premium IOLs, whereas others whom I am sure will have the means and desire for this technology turn out not to be interested. I learned it is impossible to make consistently accurate predictions.

### Information and Service

Our practice enjoys what I consider to be a reasonable level of conversion (about 30%), and I charge a fairly high price for premium IOLs. To be successful, we have to see people on time, give them the right education, ground their expectations, and hit their targeted refraction. To the last point, we have to explain to patients in advance what the odds are of our achieving the targeted refraction, what our plan is if we do not (ie, astigmatic, LASIK, or PRK enhancement), and how those costs will be handled. Our practice amortizes the cost of enhancement fees and includes it in the global fee for premium packages. We also offer financing.

Our practice provides information to patients before and during their visit. Based on their examination and what they want, we will also discuss with patients their options and which might be the best one for them.

### Desired Outcomes

Using the A-constant off the IOL's box, the likelihood of hitting the refractive target (plano, etc.) is probably 50% to 60%. Most ophthalmologists offering premium IOLs at least take the average from a small sample of their cases to develop a surgeon factor, which may increase their success rate to 70% or 75%, (often lower than they believe they are achieving).

Truly optimizing outcomes requires surgeons to track their results in every case. That is a tall order. It entails entering data on every patient, including all refractions and 1-month postoperative results, and someone must manage this information. In our office, we optimize our surgeon factors every day in real time, so what I am going to do tomorrow in the OR will be different from what I did today. We now have a separate optimized surgeon factor for laser cataract versus traditional cases; that is how specific we are getting. These efforts have increased our success rate to the 80% to 85% level from 75%, and we are getting better.

A key factor in satisfying patients is managing their astigmatism, even when a toric IOL is not used. Most surgeons are not sufficiently aggressive in this area. Early results with the femtosecond laser indicate that it may produce a better effective lens position based on the roundness of the capsular opening.[1] The most recent data sets at our practice show that we are at the 89% to 90% level, demonstrating that a more predictable effective lens position with a femtosecond laser may translate as better visual outcomes. That puts us close to LASIK numbers in terms of hitting the refractive target.

Our success represents lots of effort on the part of everyone in the office to own the data, to manage patients' data pre- and postoperatively, and to have all of the latest tools, including femtosecond laser technology. That is what I think it is going to take to meet patients' expectations of "If I'm going to pay X dollars for an accommodating or multifocal IOL, I want to know that I have a good chance of seeing without glasses, and I want the likelihood of my needing an enhancement to be as low as possible." ■

*Kerry D. Solomon, MD, is a partner at Carolina Eyecare Physicians, the director of the Carolina Eyecare Research Institute, and an adjunct clinical professor of ophthalmology at the Medical University of South Carolina, all located in Charleston. Dr. Solomon may be reached at (843) 881-3937; kerry.solomon@carolinaeyecare.com.*

1. Solomon KD, Sandoval HP. Effect of manual vs. laser capsulotomy on monofocal IOL refractive predictability. Poster presented at: AAO Annual Meeting; October 24, 2011; Orlando, FL.