

Should You Include Vitreoretinal Surgery in Your ASC?

Advice on what you should consider before adding retina to the mix.

BY STEVE CHARLES, MD

The recent changes to Medicare reimbursement rates for vitreoretinal procedures have increased the interest of owners of ambulatory surgery centers (ASCs) in offering these procedures, when traditionally, this specialty was not profitable in the ASC setting. When making this decision, however, it is important to evaluate all of the factors surrounding vitreoretinal procedures (see *Tips on Costs and Equipment*). Efficiency, outcomes, the surgeon's personality, case selection, and—possibly most important—

operating times are all components to consider when determining the suitability of a vitreoretinal surgeon for the ASC environment. This article describes the necessary conditions for successfully adding vitreoretinal procedures to an ASC.

PERSONALITY AND CASE SELECTION

First and foremost, look for a surgeon who is a calm, resourceful, pleasant team player. Second, a retinal specialist who operates slowly is probably better suited to a

TIPS ON COSTS AND EQUIPMENT

By Steve Charles, MD

It is important to control costs without compromising outcomes. For example, because vitreoretinal packs drive only 2.7% of costs in my ASC, I choose not to scrimp on my vitrectomy equipment. Labor-related costs, however, compose up to 75% of the costs in my ASC. I have found that disposable tools, such as 23- and 25-gauge DSP forceps and scissors (Alcon Laboratories, Inc., Fort Worth, TX), can significantly reduce the costs associated with cleanup, wrapping, sterilization, and storage. Disposables also eliminate the repair, backup, and replacement of reusable, fragile 23- and 25-gauge tools.

Microincisional 23- or 25-gauge surgery is appropriate for all cases except those involving dislocated lenticular material and intraocular foreign bodies that require enlarging a wound to 20 gauge. Many surgeons erroneously believe that they should not use 23- and 25-gauge vitrectomy for retinal detachment, proliferative vitreoretinopathy, giant breaks, or traction detachment. Actually, I find that microincisional vitrectomy is ideal for these cases. Perfluorocarbon liquids can reduce operating times and improve outcomes in some instances, but the internal drainage of subretinal fluid is effective in most cases. Careful fogging of the IOL is an absolute indication for N-perfluoro-octane to drain subretinal fluid.

I find that laser endophotocoagulation is better than laser delivery via an indirect ophthalmoscope for treating retinal breaks. I recommend treating specific retinal breaks rather than making many evenly spaced spots, usually in parallel rows, or performing panretinal photocoagulation. Flexible and articulating probes facilitate the treatment of the periphery.

I recommend that surgeons not make videos for all surgeries to avoid driving up the ASC's costs significantly.

Finally, surgeons must use a high-quality vitreoretinal system; phaco systems and previous-generation vitreoretinal systems are often inadequate, resulting in an increase in surgical errors and operating time.

hospital setting. In general, you want a retinal surgeon who will avoid potentially unpredictable cases that could slow turnover and displace anterior segment procedures (see *Speed in Procedures, Not Patient Care*). In addition, an ASC is not suited for the treatment of patients who are ill with concomitant conditions, because support from a medical consultant, a cardiac catheterization laboratory, intensive care units, cardiac pacing, and interventional radiology is not available.

CHOICE OF PROCEDURES

In an ASC, surgeons should avoid scleral buckling with vitrectomy, because this practice increases operating time and labor costs but has not been shown to improve outcomes.¹⁻⁴ Buckles cause pain, significant refractive error, strabismus, and ptosis.⁵ Other procedures that are ineffective and should not be performed in any setting include radial optic neurotomy and

“A retinal specialist who operates slowly is probably better suited to a hospital setting.”

branch retinal vein decompression (sheathotomy). Submacular surgery for age-related macular degeneration and retinal translocation are never indicated. The owners of ASCs should avoid retinal surgeons who perform any of these procedures.

Another procedure that is problematic for the ASC setting is combined phacoemulsification and vitrectomy, which lengthens operating times, achieves worse refractive outcomes, and results in postoperative posterior synechiae and reduced visibility, if phacoemulsification is

SPEED IN PROCEDURES, NOT PATIENT CARE

By Pravin U. Dugel, MD

Ophthalmic surgeons are under pressure to maximize efficiency. When seeking a retinal specialist to join an ASC, it may be tempting to focus on time, but where should one gain speed? The answer is certainly not to take shortcuts while performing surgery. Rather, surgeons can gain speed by making the events and tasks surrounding a retinal procedure move more quickly.

In 2006, the average turnover time at the Spectra Eye Institute in Sun City, Arizona, where I practice, was 14 minutes between vitreoretinal cases. The next year, my colleagues and I shaved 2 minutes off that figure. Our goal this year is 7 minutes. If we are successful, we will save 1.5 hours a day on turnover time alone.

I have often told ophthalmologists who visit me that, at the end of a day's observation, they should be underwhelmed by my surgical skills and overwhelmed by my surgical staff. Efficiency requires that retina surgeons be devoted to improving themselves and their staff. The direction and goals must come from the surgeon, who must reinforce and vertically integrate the idea that efficiency in an ASC cannot be achieved by compromising patient care.

Based on changes in reimbursement in Arizona between 2007 and 2008 and my studies of procedural volume and reimbursement at the Spectra Eye Institute, the average retina case should last no more than 2 hours in order to be profitable.¹ In my opinion, this is a very reasonable goal for a well-trained, efficient surgeon. My colleagues and I never exclude any type of surgery that can be done safely in an ASC based on duration alone. We feel it is essential for the surgeon to feel that he has provided the best possible care to his patient, regardless of the surgical volume.

My studies also show that the cost of vitreoretinal disposable instrumentation is consistently less than 10% of the total overhead per case.¹ This finding is particularly relevant, as vitreoretinal surgical instrumentation is currently undergoing a major transformation to microincisional surgery.

The bottom line is that there is no need whatsoever to compromise on patient care in an ASC. The well-managed center can be profitable while providing the efficient vitreoretinal surgeon with a venue in which to deliver optimal patient care with the best possible equipment.

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CATARACT SURGERY FEATURE STORY

performed first. Patients may undergo phacoemulsification 1 to 2 weeks before vitrectomy, however, if their cataract obscures the surgeon's view such that a high-quality vitrectomy procedure is impossible. When the vitreoretinal surgery occurs before phacoemulsification, refractive outcomes improve, because more accurate eye A-scans and keratometry readings can be obtained for IOL implantation.

CONCLUSION

Vitreoretinal surgery in an ASC can be efficient and beneficial to the patient and surgeon. For many retinal specialists, however, this change in setting requires a significant change in attitude and approach. It is therefore important for the owners of ASCs to choose a retinal surgeon carefully. ■

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