The Consequences of Not Offering Premium Lenses

It's all relative.

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What are the consequences of not offering premium lenses? It depends. If Congress starts giving ophthalmology practices an annual update to fees that keeps up with inflation, the price of not offering premium lenses will be minimal. Should Congress decide to keep fees frozen or reduce them from 2009 levels, the consequence of not offering premium lenses will be harsh.

DECLINING FEES AND OFFSETTING MEDICAL INFLATION

As an example, we will assume that Congress will freeze fees at 2009 levels for the future. A review of a few major ophthalmology fees since 2005 shows a consistent downward trend in reimbursement (Table 1). For many years, practices were able to offset the declining fees by being more productive in other areas of ophthalmology. Since about 2006, increased productivity has not been able to offset the combination of medical inflation and a declining fee schedule. Overheads are rising in both small and large practices. With most expenses cut to the bone, the only operating costs left to slash are employees' salaries and physicians' incomes. For owners of a group practice and employed doctors in private practice, reduced take-home pay is imminent. Practices can freeze employees' salaries for a year or so. This is a short-term maneuver, however, because skilled employees will migrate to better-paying jobs, either within or outside of health care.

The ability to offer premium lenses and charge a fee to the patient is almost equivalent to removing the limiting-charges rules from the Medicare fee schedule. Most cataract surgeons can integrate toric IOLs into their practices. These lenses produce good outcomes, and patients like the visual results. To offset a frozen fee schedule and medical inflation, a goal of a 7.5% conversion factor for use of the toric IOL in 2010 is necessary. The conversion factor will have to increase by 0.5% to 1.0% per year going forward (Table 2).

PATIENT DEMOGRAPHICS

Demographics are coming into cataract surgeons' favor. The populations that drive cataract surgery and premium lens upgrades are the silent generation and baby boomers. The silent generation represents patients born before 1946. This group is composed of approximately 35 million people. Their average age this year will be around 71, which coincides with the average age at which people undergo cataract surgery. Patients choosing toric upgrades are usually 2 years younger than the average cataract patient. Thus, one can assume that the toric IOL market will grow faster than the presbyopia-correcting IOL market. The baby boomers were born between 1946 and 1964. They number approximately 78 million, and their average age in 2010 will be around 55, with a leading age of 64. Patients selecting presbyopia-correcting IOLs are generally 8 years younger than the average cataract patient. Thus, the leading edge of the baby boomers is just entering the presbyopia-correcting IOL market. This market should grow from sheer demographic movements.

CONVERTING TO PREMIUM LENSES

Offering premium IOLs is a technological path. The transition is much like converting from extracapsular cataract extraction to phacoemulsification: surgeons who did not make the change felt the consequences. Premium lenses have raised and accelerated the technological path, which can be compared to the transition from fax machines to voicemail, voicemail to e-mail, e-mail to texting, and texting

TABLE 1. MEDICARE ALLOWABLE TRENDS, 2005 TO 2009

CODE	DESCRIPTION	2005 Medicare Allowable	2009 Medicare Allowable	$$$ Decrease	% Decrease
92004	NP comprehensive	$127.00	$123.00	$(4.00)	-3%
99203	NP level 3	$96.00	$90.00	$(6.00)	-6%
66984	Cataract surgery	$675.00	$628.00	$(47.00)	-7%
76519	A-scan	$80.00	$69.00	$(11.00)	-14%
92083	Visual field extensive	$72.00	$70.00	$(2.00)	-3%
92135	GDx/OCT	$43.00	$41.00	$(2.00)	-5%

Abbreviations: NP, new patient; OCT, optical coherence tomography.
Note: The GDx is manufactured by Carl Zeiss Meditec, Inc. (Dublin, CA).

TABLE 2. TORIC LENS CONVERSION FACTOR

	2009 Volume	2010 Volume	2011 Volume	2012 Volume
Cataract volume	300	300	300	300
Cataract reimbursement	$628.00	$628.00	$628.00	$628.00
Cataract annual reimbursement	$188,400	$188,400	$188,400	$188,400
Medical inflation @ 6%		$11,304.00	$11,982.00	$12,701.00
Additional revenue to stay even		$199,704.00	$211,686.00	$224,387.00
Toric net upgrade	$500.00	$500.00	$500.00	$500.00
Toric volume to offset inflaton		23	24	25
Toric conversion rate		7.5%	8.0%	8.5%

to instant messaging. Adults who do not text have a hard time communicating with their kids. Cataract surgeons who do not implant premium IOLs will have a hard time satisfying the wishes of their patients in the future.

EXTRA WORK FOR PREMIUM LENSES

We have been involved with accommodating IOLs since 2000 when the FDA trials started. We have used multifocal refractive and diffractive IOLs since their approval in the United States. We therefore well know that there is no perfect presbyopia-correcting IOL with a zero-hassle factor for patients, staff, or doctors. A lot of work is involved. Specifically, patients' astigmatism must be reduced to below 0.50 D postoperatively, either by corneal incisional surgery or laser vision correction. The spherical equivalent refractive error must be within ±0.50 D of the target, or the patient will likely need or request an enhancement in the form of laser vision correction.

Probably at least 25% of all presbyopia-correcting IOL patients require an enhancement. This is a huge issue for the surgeon and his or her staff to understand and manage. With standard IOLs, we would estimate that the typical percentage of eyes ±0.50 D from the target is 45%. This means that 55% of eyes will not have an acceptable uncorrected distance vision and that patients will seek spectacles from the optical shop for better visual performance. Patients who pay for presbyopia-correcting IOLs typically do not go to the optical shop, but they do seek laser vision correction. Fortunately, if a surgeon is extremely compulsive, he or she can increase the 45% rate to 75% and thus reduce the number of patients seeking laser vision enhancement.

CONCLUSION

Despite all the additional work and skills required for patients' postoperative satisfaction with premium IOLs, we believe the extra steps are necessary. Surgeons and practices have a choice. Either they accept what the central planners pay, which is only going to decrease, or they offer premium services and are reimbursed for their extra time and effort, which will promote a healthy financial balance sheet. ■

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