

Building a Successful Lens-Based Practice Model

High-volume ICL surgery is achievable with appropriate patient selection across an increased diopter range.

BY MATTHEW FORNEFELD, MD; AND STEVE H. CHANG, MD



Matthew Fornefeld, MD

I have been involved with refractive surgery since the early 1990s, and I have worked as a solo

practitioner for the past 12 years. I followed the Visian ICL (STAAR Surgical) FDA clinical trials with keen interest after seeing some of the initial postoperative patients in 2000. I was excited to get started with the ICL in 2006, directly after its approval by the FDA.

My ICL patients account for more than half of my overall refractive surgery volume. I designed my office, from the beginning, to be able to perform these procedures in-office. A section of the office is built similarly to an ambulatory surgery center, and I use it to perform refractive surgery (ICL and LASIK) as well as some eyelid procedures. This office-based surgery setup (Figure) is not only economical and convenient for the practice, but it helps me to keep the cost of the surgery for the patient lower by eliminating some of the associated surgery center facility fees, while maintaining patient safety.

I believe that higher-volume ICL surgery is achievable for any refractive surgeon who uses appropriate patient selection and takes advantage of the complete dioptric range of the ICL, which is -3.00 to -16.00 D.

With the approval of the Visian Toric ICL, we have even greater flexibility with patient selection, allowing correction of up to 4.00 D of cylinder at the corneal plane. I have gradually widened my indications for the procedure, and I now tend to confine my recommendation for LASIK to patients between plano and -4.50 D of myopia.

In my practice, the ICL is the first line treatment for anyone with greater than -4.50 D of myopia. My main rationale is that the ICL can correct the refractive error without altering the corneal surface. This means that the worries associated with laser vision correction in my practice—induced corneal ectasia, dryness, irregular astigmatism, and flap problems—disappear. Further, the ICL does not compromise the optics of the eye if the patient seeks an IOL in the future, meaning that patients will be able to take advantage of any new technologies in IOLs that may be developed.

ORGANIC GROWTH

We have seen our ICL volume continue to increase because of the strong word-of-mouth endorsements given by our patients. We have also cultivated a strong referral network among our optometry colleagues. Our practice does not do any traditional marketing; however, we have an

active social media footprint, and I count on our optometry colleagues to comanage these patients and build referrals.

The biggest source of new patients is organic—that is, word-of-mouth referrals from ICL patients. These patients are typically thrilled with their outcomes, and we rely on their excitement as a way to promote the procedure. Over the past few years, as LASIK numbers have remained static, our ICL practice is growing by approximately 20% per year.

After ICL surgery, we ask every patient to jot down a testimonial on the first postoperative day. At this point, their vision is usually about 90% of what it will be and they are just thrilled with the outcome. We encourage them to send family, friends, and coworkers in for a free consultation. Most patients assume that LASIK is the only option for refractive correction, so the free consultation is important to educate potential patients on the advantages of the ICL and to warm them to the idea, if they are a suitable candidate, that this technology will work best for them.

Two of our staff members have the ICL, so they are able to help with patient education and consultation. We emphasize that the ICL is easy for the patient to do, and in many ways, is less traumatic than LASIK, with quick vision recovery and return to normal activities.



Figure. The ICL can be implanted in an office-based surgical room (left); a close-up of the equipment used by Dr. Fornefeld and his staff (right).



Steve H. Chang, MD

I work in a high-volume cataract and refractive surgery practice with two other full-time

surgeons, one part-time surgeon, and two optometrists. We have our own surgery center in the building, which is a great setup for any type of refractive surgery, including ICLs. Two of us do all refractive surgery

TALKING WITH PATIENTS

“When trying to educate patients on the benefits of LASIK or PRK or ICLs while wearing glasses, it was always the elephant in the room. But now that I have the Visian Toric ICL (STAAR Surgical), it does make it easier to educate patients and put them at ease. They ask me more personal questions. They look at me, and I say, ‘Cosmetically you don’t see it, I don’t feel it, and I don’t see it. I have phenomenal vision, really high-definition vision. This is the best I’ve ever seen being a minimal cone patient. I’m thrilled. I’ve never seen as good as I do out of my left eye. I was always around 20/25 and now I’m 20/20, so I’m impressed.’

Walking patients through my process with the ICL puts them a little bit at ease. They know that I am giving them my honest feedback and actual results.”

— Zhaleh Sotoudeh, Marketing Director and Patient Counselor, Nevada Eye Consultants

We don’t have a crystal ball; we don’t know what the future holds. In my opinion, the ICL is attractive because it does not prevent patients from having state-of-the-art IOL technology in the future, when they’re ready for cataract surgery. In my mind, I think ICL is a particularly safe procedure for the indicated range, and it gives patients high-quality visual outcomes. Being flexible and willing to embrace new technology is important in our industry, and recommending procedures to patients based on their own ocular anatomy and refraction is practicing smart medicine.

We advocate for our patients, we advocate for our practice, and we do what we think is the best and safest procedure for our patients.

CONCLUSION

ICL surgery is a life-changing procedure. And now with expanded indications and the availability of the toric model, more patients can benefit from this technology. I think ICL is a wonderful procedure that I hope continues to gain momentum and comfort in other refractive surgeons’ minds and in the public’s mind. It is in our best interest to educate patients and get them to see the potential vision they will have with this technology. Having a staff member who has had the procedure is helpful, as is working with community optometrists. ■

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procedures—my colleague performs LASIK and other cornea-based procedures, and I do all the ICLs.

The philosophy that we’ve always had is to strive to offer the best and safest procedure for each patient. We look at each patient’s profile, age, prescription, and ocular anatomy to determine what the best procedure will be for that patient, whether it’s LASIK, ICL, or refractive lens exchange.

We don’t pigeonhole patients into one procedure over another, but we do follow a cutoff in terms of where we recommend ICL over LASIK. For us, that is about -6.00 D. We also recommend the ICL in patients who have dry eyes or thin corneas. For generally younger patients interested in refractive surgery, the option of an ICL as a primary procedure, in my mind, is a no-brainer if they are a strong candidate. The ICL is not a fallback procedure.

PATIENT EDUCATION

The key in preparing patients to make the best decision possible for their own eyes lies mainly in patient education. We rely on our patient counselor, Zhaleh

Sotoudeh, to meet with patients during their initial workup; educate them on the different procedures; and then focus on the procedure they are best suited for, based on their preoperative exam results.

Zhaleh has Visian Toric ICLs in her eyes, so she’s in a unique position to describe that procedure to patients who might not even know what it is (see *Talking With Patients*).

WORKING WITH COMMUNITY OPTOMETRISTS

We work a lot with community optometrists. I’ve done live surgery events with optometrists so they could see me do the procedure and see how simple it is. If they’re not comfortable with ICL surgery, it’s hard for them to explain it to their patients.

We have seen about 30% growth year over year with the ICL, and part of the reason we have been able to grow so much is our outreach efforts with optometrists. I also think another reason for that growth is the recent approval of the Visian Toric ICL, which has expanded the scope of the procedure. And from a revenue standpoint, being able to have a wider pool of patients can make a big difference in profitability.

Important Safety Information for the Visian ICL Product Family:

The Visian ICL is indicated for phakic patients 21–45 years of age to correct/reduce myopia with up to 4.00 D of astigmatism with a spherical equivalent ranging from -3.00 to -20.00 D and with an anterior chamber depth (ACD) 3.0 mm or greater.

The Visian ICL is contraindicated in patients with a true ACD of <3.0 mm; with anterior chamber angle less than grade III; who are pregnant or nursing; less than 21 years of age; and who do not meet the minimum endothelial cell density (ECD) listed in the Directions For Use (DFU).

Summary of the relevant warnings, precautions, and side effects: Endothelial cell loss; corneal edema; cataract; narrowing of the anterior chamber angle; pupillary block; increased intraocular pressure; glaucoma; secondary surgery to reposition, replace, or remove the ICL; loss of BCVA; increase in refractive astigmatism, glare, and/or halos; pigment dispersion; iris transillumination defects; endophthalmitis; hypopyon; corneal endothelial damage; ICL dislocation; cystoid macular edema; iritis; retinal detachment; vitritis; and iris prolapse.

Please review the DFU for complete safety and other information before performing the clinical procedure.