Immediately Sequential Bilateral Cataract Surgery

SHIFTING TOWARD ISBCS DURING THE PANDEMIC AND BEYOND

BY ROSA BRAGA-MELE, MD, MED, FRCSC

Immediately sequential bilateral cataract surgery (ISBCS) became an attractive option for many clinicians—myself included—during the COVID-19 pandemic. At first, I saw it as an efficient solution to the challenge of social distancing. ISBCS helped reduce the volume of patient encounters and ensured better safety for both patients and staff. Over time, I began to appreciate other benefits, including a more efficient use of health care resources, fewer preoperative assessments and postoperative visits, reduced patient traffic, and increased convenience. The pandemic is over, but I continue to perform ISBCS. My contribution to this article explains why.

One concern with ISBCS regards the risk of complications such as toxic anterior segment syndrome and endophthalmitis. These are negligible, however, if the procedure is conducted in accordance with the International Society for Bilateral Cataract Surgeons' General Principles for Excellence in ISBCS. These guidelines emphasize measures such as using different lot numbers and intracameral moxifloxacin to minimize complications.

Patients must be educated about the risks of ISBCS. They should be informed that each eye is treated as a separate procedure to minimize the risk of complications. They should also understand that surgery on the second eye can be postponed if a complication occurs during surgery on the first eye.

About 90% of my refractive cataract surgery cases are performed as ISBCS. It's

ISBCS AS A ROUTINE PRACTICE COMES WITH CHALLENGES

BY MICHAEL PATTERSON, DO, AND MARK A. KONTOS, MD

Why My Practice Rarely Performs ISBCS

BY MICHAEL PATTERSON, DO

Immediately sequential bilateral cataract surgery (ISBCS) is a hot topic, but in my practice, it's a rare event reserved for special cases such as uninsured patients or those requiring urgent bilateral vision correction. This article outlines why I prefer a traditional cataract surgery approach.

CONSIDERATIONS

Financial. To quote the political strategist James Carville, "It's the economy, stupid." The reimbursement rates for cataract surgery continue to decrease. At the end of 2022, CMS reported an estimated 1% year-over-year reduction in aggregate Medicare payments to ophthalmologists and optometrists for 2023. Furthermore, the reimbursement for *Current Procedural Terminology* code 66984 (cataract surgery with IOL implantation) has dropped from an already low $545 to $542.[1] Medicare reimburses facilities at 100% for the primary cataract procedure but only 50% for the second eye when both are performed on the same day. Additionally, the reimbursement rates from insurance companies often do not cover the cost of new supplies for the second eye. Such a drastic reduction in reimbursement for the second eye, if ISBCS were performed routinely, would necessitate financial adjustments to the practice, affecting staff compensation and job security. It is my strong belief that staff must be protected from financial instability.

Is it time to adopt this approach?

also a great option for patients who live far from the practice, those with mobility issues, and those who require a general anesthetic. In my experience, patient satisfaction with ISBCS is excellent. They don't have to wait 2 weeks or more between eyes, and they often experience a wow effect much like after LASIK surgery. ISBCS can also reduce total procedural time, making the process more efficient for both the surgeon and the patient.

ISBCS is contraindicated in certain situations. If a patient presents with unique challenges, such as pseudoexfoliation, visibly loose zonules, and extremely dense cataracts, I use a staged approach so I may assess the response of the first eye before proceeding with the second eye. Additionally, if the refractive outcomes targeted in the patient's eyes differ, I typically opt for delayed sequential bilateral cataract surgery so the target for the second eye may be fine-tuned based on the first eye's outcome.

I believe ISBCS volume will continue to grow. Advances in diagnostic tools and phaco technologies should improve refractive outcomes, making concerns about refractive accuracy less significant.

CONCLUSION

ISBCS offers improved efficiency, convenience, and patient satisfaction. Reimbursement and complications are concerns but, in my opinion, are outweighed by the benefits. Adherence to guidelines and technological advances should enhance the safety and success of ISBCS. ■

ROSA BRAGA-MELE, MD, MED, FRCSC
- Professor of Ophthalmology, Department of Ophthalmology, University of Toronto, Canada
- Member, *CRST* Global Advisory Board
- rbragamele@rogers.com; Instagram @dr_rosa_fit
- Financial disclosure: None

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Medicolegal. Current Medicare guidelines mandate the evaluation of both eyes to determine the necessity of surgery. Performing ISBCS without reevaluating the need for intervention in the second eye after cataract surgery in the first eye can pose both ethical and legal risks. For example, the inability to adjust IOL power between surgeries can result in suboptimal outcomes. Moreover, complications such as infections arising from contaminated supplies could exacerbate these risks.

A real-world scenario. A case that influenced my stance on ISBCS involved a patient who developed endophthalmitis in both eyes. After performing surgery on one eye, the patient developed endophthalmitis and underwent pars plana vitrectomy. Despite rigorous preventive measures, including oral, topical, and intracameral antibiotics, the second eye also developed endophthalmitis. Had both eyes been operated on simultaneously, simultaneous vitrectomies would not have been an option, increasing the risk of complications. The incident reinforced my belief that the risks associated with ISBCS, especially bilateral blindness, outweigh the benefits for most patients.

THE FUTURE OF ISBCS IN MY PRACTICE

The adoption of ISBCS in my practice could be reconsidered if CMS were to increase the reimbursement rates for second-eye surgeries performed on the same day. Before making such a transition, a comprehensive discussion with the medical team would be crucial. Are they willing to accept reduced compensation? Is the practice prepared for the financial and ethical challenges? The ethical considerations extend not only to patient care but also to the staff, who may be affected by reduced revenue streams. By being cautious in the adoption of ISBCS, I believe I am upholding my commitment to providing the best possible care to my patients, while also maintaining the financial and ethical integrity of my practice.

ISBCS isn't the riskiest procedure. The benefits include reduced patient visits, but ISBCS comes with challenges. For my practice, the benefits do not yet outweigh the risks and challenges, including financial and ethical considerations. ■

1. Corcoran SL. Coding & reimbursement. *Ophthalmology Management*. March 1, 2023. Accessed October 17, 2023. https://www.ophthalmologymanagement.com/issues/2023/march-2023/coding-amp;-reimbursement#table-3

MICHAEL PATTERSON, DO
- Private practice, Eye Centers of Tennessee
- Member, *CRST* Editorial Advisory Board
- michaelp@ecotn.com
- Financial disclosure: None

Same-Day Cataract Surgery? No Thanks

MARK A. KONTOS, MD

The question of whether ISBCS makes sense has been circulating in the ophthalmic surgical community for some time.

The safety of ISBCS has been demonstrated by numerous studies showing the risk of bilateral endophthalmitis to be close to zero. It must be emphasized, however, that the risk is not zero. Although there is certainly no arguing that ISBCS is more convenient for patients, many of them prefer some time to pass between surgery on each eye.

ISBCS can save money in terms of administrative costs and logistics. If it saved practices and surgery centers a significant amount of money, however, ISBCS would be more widespread.

Most surgeons would agree that ISBCS is more appropriate than delayed sequential bilateral cataract surgery (DSBCS) in some circumstances.

In brief, routine ISBCS makes sense for many practices and surgeons. I am just not one of them.

EXPERIENCE

Over the years, whenever I have prioritized patient convenience over what I feel is the best course of action medically, I have regretted it. If bilateral cystoid macular edema or endophthalmitis occurs, patient convenience as a motivator for surgical decision-making is a weak position to hold.

THE BENEFITS OF DSBCS

Less taxing for the surgeon. Some cases are complex and therefore physically and mentally exhausting for the surgeon. In this situation, the prospect of having to repeat the experience immediately with the second eye is unappealing.

IOL selection. DSBCS can be helpful when choosing IOLs for patients who desire postoperative spectacle independence. For example, a patient may request an IOL for the second eye that provides the uncorrected near visual acuity they lost after undergoing surgery on the first eye.

Reimbursement. The main reason the volume of ISBCS procedures I perform is not and probably never will be significant is that second-eye surgery is reimbursed at 50% the normal rate. This is a fiscal and philosophical issue for me.

I perform approximately 1,000 cataract procedures each year at $600 per case. About $150,000 of revenue would be lost per year if I switched to ISBCS. Over the course of a 30-year career, that would amount to a difference of about $5 million in revenue. Yet, I would still work the same amount, and I would not get to do more fly fishing, skiing, or golfing.

Moreover, by accepting 50% less reimbursement for cataract surgery on the second eye, I would be telling Medicare and other insurers that I am willing to devalue my services for them. That is a dangerous position to take. These entities already devalue my services without my help. Why would I encourage them further?

CONCLUSION

In the current environment, I do not find routine ISBCS to be a viable option. Maybe things will change in the future. Until then, no thanks. ■

MARK A. KONTOS, MD

- Senior Partner, Empire Eye Physicians, Spokane, Washington, and Coeur d'Alene and Hayden, Idaho
- Member, *CRST* Executive Advisory Board
- mark.kontos@empireeye.com
- Financial disclosure: None acknowledged