

A New Profit Center....

It's time to seriously consider adding
Low Vision Care to your practice!

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Low Vision Care



- The need for Low Vision Care is skyrocketing
 - The fastest growing segment of the US population is 55 years and older—the age range of most people with vision loss
 - AARP estimates that 10,000 baby boomers turn 65 every day!
 - Already there are between 20 and 30 million people in the US alone that have low vision
 - That will double in the next 20 years
- Due to the improvement of treatments for the major eye diseases causing vision loss, about half of the LV patients seen in low vision clinics today have BVA's of about 20/50 to 20/120 so they can be easily cared for in primary eye care practices because:
 - These patients can often be helped with little additional chair time
 - Much of the service can be done by support staff

Important additional thoughts



- Remember, patients rarely go to bed one night seeing normally and wake up “legally blind”. They go through a period of vision transition.
- These patients in the 20/50-20/120 range can and should be handled in your primary eye care settings.....
- In 2017 the American Academy of Ophthalmology stated that referral to “vision rehabilitation is the standard of care”.
- Early intervention benefits everyone!



**SHOW
ME THE
MONEY!**

Quick case example...



“Classic AMD.....



5 years ago A.J. was diagnosed by you with “dry” AMD and was referred her to the local Vitreous and Retina Consultants for further evaluation and management.....

Other than vitamins, Amsler Grid and periodic retinal exams, no treatment was offered for her AMD

And of course, they told her.... “nothing more could be done”

Mrs. A.J.....



Your staff found her best corrected VA today is about 20/100 in her better eye. You found her refraction hasn't changed

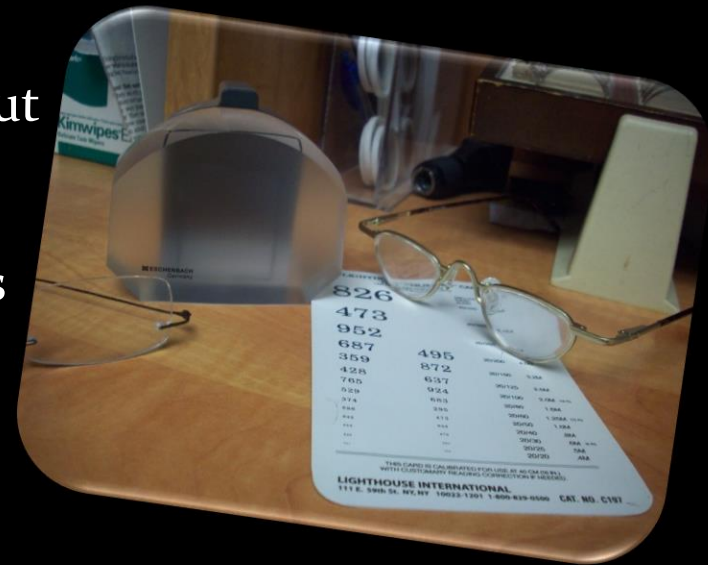
She can no longer read the mail, bills, food packages, medicine bottle labels and bank statements. She's had a couple of "trips and falls" recently also.

What do you do? Changing the glasses won't help and there is nothing medically to treat. Doing nothing helps no one!

Mrs. A.J.....

Here's what I did.....

- I used a “brightfield” type stand magnifier...
- This has the effect of doubling the add without reducing the reading distance.
- This was used for mail, bills, bank statements and other basic home reading tasks.



Mrs. A.J...



Here's what else I did.....

For very short reading tasks
and reading on the go.... like
shopping, etc

To help with mobility.....



Mrs. A.J.....



ow-up

s and was able to
achieve each of the initial goals she had mentioned

Just in passing she said she wished we could make her TV clearer, so on her next appointment, we dispensed a pair of MaxTV glasses

Total revenue generated



Two office calls (99214, 92015 and 30 day follow up 99212) \$ 260
(*total time* face to face for both visits was about 35 min)

Low vision aids visit #1 \$ 795
(Makrolux, EZPocket and Rx tinted glasses)

Low vision aid visit #2 \$ 195
(MaxTV glasses)

Gross income \$ 1,250

Less cost of goods - \$ 405

Gross profit before overhead **\$ 845**

(*all numbers rounded for convenience*)

Variables for to consider:

- Source of reimbursement, if any – any analysis should be based on your Medicare payor rates
- Patient volume... very simple marketing
- Availability of Staff... delegate whenever possible like you do in your other profit centers!
- *Conduct analysis for your practice*



Delivery Model and Per Patient Revenue

Based on information and expectations presented by the practice, to implement Low Vision Care in the practice, we recommend that **Dr. Smith** construct the Low Vision Care delivery model as follows:

New Low Vision Evaluations will be provided primarily to **established** patients

An Initial Low Vision Evaluation be conducted by **Optometrist** for approximately **25** minutes.

This Initial Low Vision Evaluation will be covered by **Medicare** under Code **99214** at a rate of **\$ 112**

The Initial Low Vision Evaluation and Initial Follow-Up Evaluation should result in the recommendation of devices at a rate of **50%**

The Initial Low Vision Evaluation is expected to result in the following devices being dispensed:

1	Near Extended Task Devices	at a retail price of approx.	\$ 300
1	Near Spotting Task Devices	at a retail price of approx.	\$ 200
1	Contrast Enhancing Filters	at a retail price of approx.	\$ 50

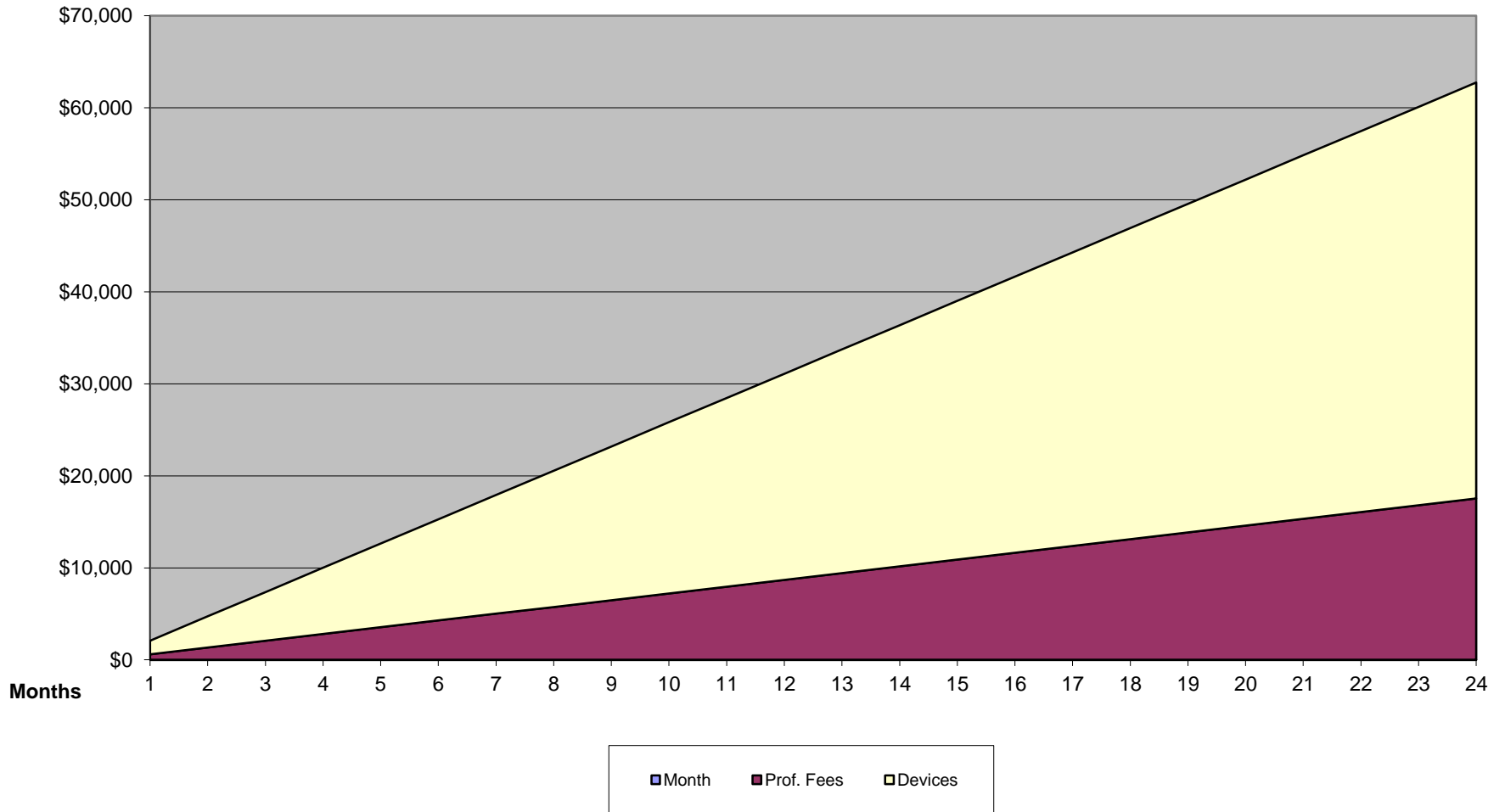
An Initial Follow-Up Evaluation should be conducted 7-10 days after the Initial Low Vision Evaluation and be conducted by the **Optometrist** for approximately **15** minutes.

This Initial Follow-Up Evaluation will be covered by **Medicare** under Code **99213** at a rate of **\$ 72**

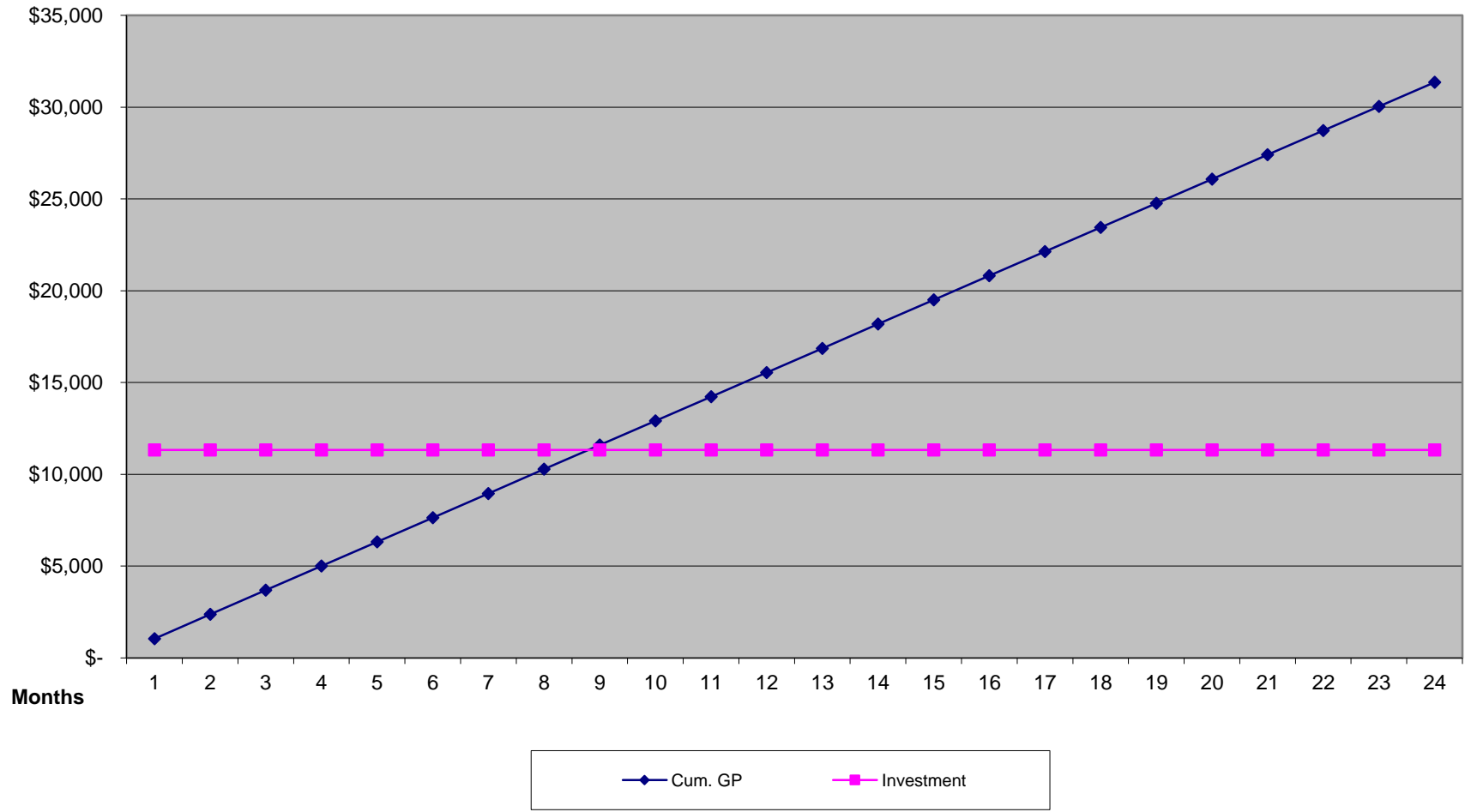
The Initial Follow-Up appointment is expected to result in the following devices being dispensed:

1	Distance Extended Task Devices	at a retail price of approx.	\$ 200
1	Distance Spotting Task Devices	at a retail price of approx.	\$ 200
0	Intermediate Task/Other Devices		\$ -

Revenue by Type, 1 Low Vision Patient per Week



Break Even Analysis, 1 Low Vision Patient per Week



Marketing your Low Vision Care Service / Cultivating Referrals

- The best and easiest low vision patients are those right in your own practice—patients with acuities of 20/50 or worse.
 - Get your staff to suggest a low vision appointment for anyone in that acuity range (e.g., use reminder Post-it Notes)
- Building referrals outside of your practice
 - Start with retinal specialists and ophthalmologists in your area, particularly those to whom you send patients for treatment

Take home points..



- As the population ages the number of LV patients “automatically will increase”
- Diabetes numbers are skyrocketing
- Problems start at about 20/50!
- Now is *the perfect time* to incorporate Low Vision care as a new profit center for your practice
- Doing nothing helps no one
- Not hard to do and *It makes economic sense!*

