OASC MIGS

# Road Map for<br/>hop for<b

INVENTORY

Logistical tips for bringing today's glaucoma surgery to your ASC

THE OPHTHALMIC ASC | OCTOPER 2018

REIMBURSEME

SCHEDULING

# In 2018, chances are good that minimally invasive glaucoma surgeries (MIGS) are either in your ophthalmic ASC or coming soon.

New technologies that were exciting for glaucoma specialists from the very early stages are now in the hands of cataract and refractive surgeons as well, offering unprecedented opportunities for cataract surgery to be a life-changer in terms of both vision and glaucoma management.

Blake Williamson MD, MPH, MS, of Williamson Eye in Baton Rouge specializes in high-volume refractive cataract surgery, yet he performs several different MIGS procedures on a weekly basis.

"We're getting closer to mainstreaming MIGS," he says, but he still sees lingering reservations among his peers. Dr. Williamson says reimbursement is a legitimate concern, as some insurance companies continue to take longer than others to cover MIGS procedures, but he and others are succeeding on that front while industry continues to fight for regulatory change.

Dr. Williamson recognizes other concerns among his peers as well. "Some refractive cataract surgeons worry that MIGS will affect visual outcomes, although we have found that is not the case in normal eyes. I also see apprehension among high-volume cataract and refractive surgeons about facing the learning curve for a new procedure. These are surgeons who can perform 30 cataract surgeries in a morning without breaking a sweat, but in the angle, they struggle. That's not a fun feeling. It's something we must get over; I did, though I still struggle a bit each time I learn a new MIGS procedure," Dr. Williamson explains.

"As my refractive colleagues have begun to observe firsthand the low risk and positive benefits of MIGS, such as clearer corneas and crisper vision due to fewer BAK-heavy glaucoma drops on the corneal surface, more of them have overcome their initial hesitation and started using MIGS, particularly during cataract surgery," says Williamson. "If about 1 in 5 of our cataract patients has glaucoma, then providing the best care requires us to treat the IOP simultaneously. At the very least, we must inform those patients that the option to enhance their lives with a MIGS procedure exists. We're in the MIGS revolution now, and I encourage my colleagues to jump in so we can all better serve patients who suffer from glaucoma. Any cataract surgeon can start with a MIGS procedure that has a shorter learning curve and expand over time when working in the angle feels more comfortable."

Heather Nesti, MD, performs trabeculectomy and tube shunt surgeries and uses Xen Gel Stent (Allergan) and iStent (Glaukos) as a specialist in both glaucoma and cataracts at Chesapeake Eye Care and Laser Center in Annapolis, MD. She views MIGS as a transformative group of technologies with momentous potential for her patients.

"Patients with mild to moderate glaucoma have historically not been candidates for surgery. Now we can perform low-risk MIGS procedures that help control IOP, which is important for preventing progression and vision loss, and potentially reduce the burden of using drops, which can improve quality of life. We now view cataract surgery as a decision point where we say, 'We're already in the eye; should we treat two problems at once?"

For surgeons who want to bring MIGS into their ASC, we asked several physicians and administrators to give their nuts-and-bolts advice for what you need to get started. Some work in ASCs where standalone interventions, such as Xen or gonioscopy-assisted transluminal trabeculotomy (GATT) are common, and all of their centers offer cataract-MIGS combination procedures with devices, such as Hydrus (Ivantis) and iStent. Their tips include what to buy, how to schedule and learn, and how to approach reimbursement.

## Purchases and Inventory

Brian A. Francis, MD, MS, specializes in glaucoma and cataracts at Doheny Eye Center UCLA in Pasadena, CA. In addition to standard cataract surgery, traditional glaucoma surgeries, such as trabeculectomy and tube shunt, and Xen implantation, Dr. Francis uses a range of other procedures and devices: ab interno canaloplasty (ABiC) (iTrack, Ellex), endoscopic cyclophotocoagulation (ECP), GATT, iStent, Kahook Dual Blade (New World Medical), TRAB 360 (Sight Sciences), and Trabectome (NeoMedix). focus, while a surgeon outside of the practice utilizes the ASC for traditional glaucoma surgeries and MIGS procedures. Key-Whitman cataract surgeons now perform cataract-MIGS combination surgeries.

"For centers looking to incorporate MIGS procedures or traditional glaucoma procedures, it can be expensive to maintain inventory. It may

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In his work, Dr. Francis alternates between Doheny satellite offices that utilize private ASCs and the academic environment at UCLA. He finds that both settings are well-outfitted for MIGS procedures, some of which require new equipment purchases and a variety of items in inventory.

"There is no major equipment purchase required to start performing most MIGS procedures, which makes it easy to move between facilities or for any surgeon to begin offering MIGS," explains Dr. Francis. "Trabectome and ECP require a device in the OR, and we need a light box to see the fiber optic tip of the catheter used in ABiC. For some implants, we may need a gonio prism, mitomycin C, or extra viscoelastic to reform the anterior chamber. All of these things are readily available - surgeons just need to be prepared and educate their staffs."

Nikki Hurley, RN, is director of surgical services for the Key-Whitman Eye Center in Dallas, where cataract and refractive surgery are the primary help to concentrate on implementing one device at a time to better handle up-front costs," she advises. "We usually stock enough supplies for 2 weeks of surgery, which typically includes both traditional glaucoma procedures by the glaucoma specialist and cataract combination procedures. We typically stock 10 to 15 of each available stent and at least 5 of each shunt device that surgeons use, as well as the disposable gonio lenses preferred by some surgeons."

Vanessa Sindell, RN, BSN, MSN, is a senior consultant at Progressive Surgical Solutions, a division of BSM Consulting that specializes in surgical centers. Like Hurley, she notes the expense of stocking gonioprisms in this case, about two to six reusable instruments in busy ASCs to account for sterilization processing time.

"Something else for centers to keep in mind is that with MIGS, we can't order one for each patient," she adds. "To be ready for every surgery, we need to know how many devices are scheduled to be placed, and then pad that number by 25% to 50% to include backup inventory."



### Scheduling MIGS Procedures

Glaucoma specialists are accustomed to scheduling a variety of procedures that have different time requirements, so adding MIGS doesn't greatly affect the planning of their surgery days. But what about cataract and refractive surgeons? Their procedures tend to follow a predictable rhythm. How does that change when they add MIGS?

With the exception of medically unstable patients, Dr. Nesti performs all of her glaucoma procedures in the ASC. Her independent glaucoma procedures vary in length.

For example, Xen takes about 10 to 15 minutes for the procedure itself, contained in a 30-minute block to accommodate additional anesthesia and the occasional need to adjust the stent. She schedules Xen and hourlong trabeculectomy and tube shunt surgeries in blocks at the beginning and end of the day, with straight cataract surgeries in between.

"When I started using iStent during cataract surgery, I scheduled myself an extra 15 minutes," explains Dr. Nesti. "Once I became proficient, MIGS added less than 5 minutes to surgery, so now we schedule cataract-MIGS patients in a standard cataract slot, without any extra time or specific block of time. Undergoing two procedures at the same time is of enormous benefit to patients, and it doesn't change the flow of our center at all."

Dr. Nesti suggests that those who are thinking of performing combination procedures should utilize the usual videos and wet lab experiences and schedule more time for their first cases as she did. She also recommends that surgeons initially select patients who have clear corneas and very good visible anatomy in the angle. She considers combination procedures to be a very important advance for patients who have cataracts and glaucoma.

"For any patient with both problems, we need to consider adding MIGS treatment. Our patients deserve and appreciate any chance they can get to lower pressure and decrease their dependence on drops."



# **Postoperative Care**

The pre- and postoperative regimen tends to be the same for all patients undergoing cataract surgery, regardless of whether a MIGS procedure is added. However, some standalone procedures require additional efforts.

Dr. Nesti says, "Nothing is different pre- or postoperatively for iStent procedures, compared to standard cataract surgery. In my experience, they do not create any additional corneal edema, and vision resolves just as quickly. We often have patients continue glaucoma drops - unless someone experiences very low pressure, in which case drops are discontinued in the first week."

Xen is a welcome addition for Dr. Nesti, who appreciates that the procedure uses the same mechanism as trabeculectomy and achieves similar results without the same level of risk. Still, patients do require postoperative care.

"A bleb is created, but there are no sutures and no risk of wound leaks. Because there is less dissection and no sutures, patients are more comfortable than they would be after

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— Heather Nesti, MD

a trabeculectomy. Vision is 20/25 or 20/30 at day 1, which is very fast trabeculectomy. compared with Postoperatively, patients use antibiotic and steroid drops for 1 week, with tapering based on bleb appearance and conjunctival injection."

Sindell points to a few unique postoperative responsibilities for MIGS.

"Physicians have to send patients home with an ID card that states they have an implant. In addition, some implants have MRI restrictions, so patients need to be notified of that as well."

### **MIGS Reimbursement**

\$ "Before surgeons perform any MIGS procedure, the center should make sure that they will be reimbursed," Sindell urges. "The facility has to ensure that the procedure is covered and will be reimbursed at an acceptable rate."

This is not a clear process. According to Hurley, although her facility obtains preauthorization for MIGS procedures, insurance companies sometimes still require back-and-forth and can delay payment for up to 120 days. In an effort to take control of the process on the practice side, Hurley sits down with physicians to get every letter of their documentation in order.

"We aim to ensure that surgeons understand what they have to present to the ASC to be certain the costs are covered. They must include the clinical record or surgical plan and diagnosis, so that the billing center can make sure costs are covered by insurance. In addition, they must tell patients about any out-of-pocket responsibility up front."

In Dr. Francis' experience, ASC administrators look to CMS as a starting point for guidance on MIGS coverage.

"We have to work through the headaches of initial reimbursement for a new MIGS procedure. Once a procedure has been used and evaluated for a few years and is assigned a T code, private ASCs are more willing to work with surgeons to permit the procedure. On the other hand, if an ASC permits a new procedure and then encounters problems with reimbursement, the ASC often refuses to allow the procedure again," he explains.

In the academic environment, Dr. Francis experiences the reverse.

"In the teaching hospital, I can access MIGS procedures/devices that are in clinical trials," he says. "But once something is approved, it can be challenging to justify its use through the hospital's committee process."

Dr. Francis points out that private surgery centers are having success increasing revenues through the addition of MIGS.

"Adding MIGS isn't a big transition for centers that already offer glaucoma surgery. It may be outside the comfort zone of ASCs with a cataract and refractive focus, but when surgeons get comfortable with MIGS, the procedures can make a great deal of sense financially as an efficient addition to cataract surgery." ■