Letters

Letter From the Editor

The editors of *EyeNet* have received some questions regarding the advertisement that appeared on page 32 of the July issue for laser treatment of "floaters." There is little peer-reviewed research to support the use of laser for vitreous opacities. *EyeNet*'s policy is to not accept advertisements for unproven techniques and procedures to avoid any implication that the Academy endorses them. In running this ad, we were not in compliance with our advertising policies. We regret this lapse and are strengthening our review process. —*Eds*

Response From Omeros

To ensure accurate information, we are correcting misstatements about Omidria (phenylephrine/ketorolac 1%/0.3%) in "Strategies for Preventing Intraoperative Miosis" (Clinical Update, June). Given *Eye-Net* space constraints, we simply list corrections:

- When a 4-mL Omidria vial is diluted in 500 mL BSS, w/v concentrations are 0.0098% (phenylephrine) and 0.0034% (ketorolac).[1]
- Omidria is 4-fold and 6-fold better than phenylephrine and ketorolac, respectively, in preventing intraoperative pupil diameter <6 mm.[2]
- Preoperatively administered ketorolac is washed out during surgery.[3] In a canine model of phacoemulsification/lens replacement with Omidria, ketorolac uptake throughout intraocular structures (e.g., retina) is sufficient to ablate COX-1/COX-2 pathways for ≥10 hours postoperatively.[4,5]
- 100% of Medicare Administrative Contractors have already reimbursed for Omidria. MedAdvantage and commercial payers are following suit.[6]
- Pass-through product Omidria has no effect on physician fees[7] or the health care system and, after bundling by CMS, will increase facility fees.[8]
- Pass-through is intended by Congress and CMS to foster innovation.

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1 Omidria [package insert].
2 Data on file. Omeros.
3 Katsev D et al. Intracameral ketorolac concentration after topical ketorolac administration prior to cataract surgery. Electronic poster at: ASCRS; April 2015; San Diego, Calif.
4 Florio V et al. Ocular tissue distribution of ketorolac after administration of OMS302 to dogs during IOL replacement. Electronic poster at: ASCRS; April 2015; San Diego, Calif.
5 Waterbury LD et al. *Curr Med Res Opin.* 2006;22(6):1133-1140.
6 Data on file. Omeros.
7 "Medicare Physician Fee Schedule" in Medicare's Payment System Fact Sheet Series; pages 2-3. www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedcrephysFeeSchedfctsht.pdf. Accessed July 20, 2015.
8 *Federal Register.* Dept. of Health and Human Services; April 7, 2000;65(68):18478-18480, 18482. www.gpo.gov/fdsys/pkg/FR-2000-04-07/pdf/00-8215.pdf. Accessed July 20, 2015.

EDITOR'S NOTE: Innovation in ophthalmology is fundamental to quality patient care. Congress has recognized that need by providing funds to pay the pass-through costs for newly introduced drugs and devices that meet threshold costs.[1] After 2 or 3 years, most drugs, all devices, and surgical supplies are bundled into an applicable Ambulatory Payment Classification (APC) by CMS, and that APC payment is increased with a formula dependent on costs reported by hospital outpatient departments. Overall growth in facility costs for outpatient care is subject to budget neutrality. These impacts do not affect the physician fee schedule.

Increased spending by Medicare, beneficiaries, taxpayers, and commercial insurers certainly affects overall expenses in the health care system.

1 *Federal Register.* Dept. of Health and Human Services; April 7, 2000;65(68):18476-18503. www.gpo.gov/fdsys/pkg/FR-2000-04-07/pdf/00-8215.pdf. Accessed July 23, 2015.

The Affordable Care Act

Your review of how the ACA has impacted ophthalmology (Feature, May) confirmed what I have experienced: not very much.

I would add that those who have bought private insurance through the ACA marketplace make up only 3% of the population in the United States. The vast majority receive care through largely unaltered employment-based insurance, Medicare, Medicaid, and the VA.

Medicaid recipients go to hospitals and community clinics, so most ophthalmologists will not encounter those who benefited from the ACA's Medicaid expansion.

As your article points out, the other changes medicine is experiencing—like electronic health records, payment mechanisms that prioritize quality over quantity, and a rush of hospital mergers—are due not to the ACA but to pressures over decades to transform an unconscionably expensive, poorly functioning health care system. Even the trend of insurance shifting more and more health care costs to consumers started long before the ACA was enacted.

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