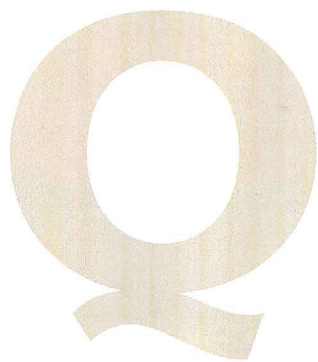


# Opinion

BY RICHARD P. MILLS, MD, MPH

## Presbyopic IOLs: Another Feeding Frenzy?



quite unexpectedly, the proclamation came forth. (Not from on high; we are talking about the government here.) Medicare will henceforth allow direct-to-patient billing for noncovered services for presbyopia in conjunction with billing Medicare for a covered cataract extraction. Who knew that CMS would reverse decades of policy in which services were either covered or not, and never the twain shall meet? Cynic that I am, I figure this is just the first step in a government conspiracy to offload to patients the costs of “premium” services of all types across medicine. What better place to start than to allow patient billing for a condition that Medicare claims it has never covered? (Never mind that bifocal spectacles and the first bifocal implants have always been a covered service following cataract extraction.) I’ll refer generically to the new presbyopia-busting IOLs as pseudoaccommodative devices, since the optic shape doesn’t change.

My real and virtual inboxes have been stuffed with harbingers, singing the song of a new era of opportunity for patients and ophthalmologists. Before the proclamation, Medicare patients were essentially barred from accessing this new technology. It was the geriatric biologic clock. Either get your cataract out and a pseudoaccommodative device placed before age 65, or consign yourself to the heartbreak of spectacle dependence. Thus, the proclamation unequivocally

helps patients who happen to discover their cataracts after age 65. For ophthalmologists, it is an opportunity to increase revenue. Depending on CMS rulings, ophthalmologists may be able to bill above the Medicare maximum-allowable charge for cataract surgery. What a potentially great prospect for us all! So why am I worrying? It reminds me a lot of the early days of LASIK. Some ophthalmologists offered it as a premium service with a big price tag. Others advertised a lowball price, hoping to recoup their marketing expenses on volume. Corporate entities smelled profit, and the feeding frenzy was on. Later, the marketplace adjusted. But while it was frenzied, we lost some credibility with the public, our medical services became more of a commodity, and patient expectations went through the roof.

This time around, some will charge a lot for the presbyopic services, reasoning that a “touch-up” LASIK will be needed for the residual refractive error and you’d better charge for it up front. Others will let the ASC charge extra for the device, but add only a minimal professional component. And marketing for both will raise patient expectations

to a level we are not likely to fulfill consistently.

My worrying about it in this column isn’t going to matter much because it’s going to happen. Except that maybe I can find resonance with some readers that it’s still all about the patient’s needs. Some patients will find the pseudoaccommodative devices a godsend. Others, like me, are quite happy with glasses. I think I look better with them. I can see distance, intermediate and near with a (retro) conventional trifocal. When I get cataracts, I don’t want my ophthalmologist recommending a pseudoaccommodative device to me because it’s more profitable. I’d rather that he or she listen to my needs and leave the feeding frenzies to sharks and their ilk.



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