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BUSINESS MATTERS

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WHEN AND HOW TO HIRE

Bringing on an associate is a big decision—here's how to get it right.

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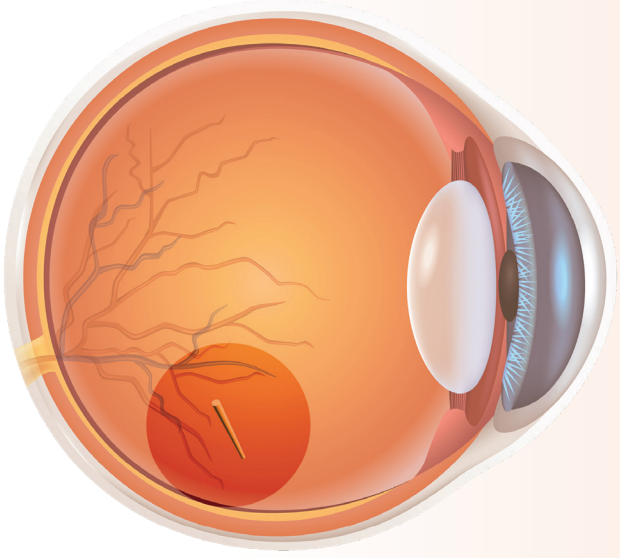

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THE RIGHT TEAM AT THE RIGHT TIME

With patient volumes on the rise and new therapies broadening the populations we can treat, our retina clinics are busier than ever before. And it's likely to get worse before it gets better. According to one study, the field of ophthalmology is facing a projected mismatch of 30% workforce inadequacy by 2035.[1] That means the workforce will only be able to care for 70% of the patient population (keep in mind that this study, published in February 2024, does not consider the growth in our patient base due to the FDA approval of treatments for geographic atrophy).

For many, this means either squeezing even more patients into already packed schedules—or hiring. Unfortunately, the hiring process isn't something you learn in fellowship, and even if you've become a savvy business owner, bringing in a partner requires an entirely different set of skills. To make matters worse, that same 2024 study projected a decrease in the ophthalmology workforce of 12% by 2035, meaning there will likely be fewer clinicians out there to interview.[1]

If you find yourself looking to add an associate to your practice, this issue of *Business Matters* is here to help. David Chin Yee, MD, FASRS, shares the nuances of hiring, starting with a reminder that the decision must be data-, not stress-, driven. If you monitor your patient flow data carefully, you can tackle the second most important nuance with ease: timing. Hiring too early or too late can significantly affect the success of the practice, no matter how talented that new doctor is. As a bonus, we also have a wonderful article by our anterior segment colleagues Neda Nikpoor, MD, and Neda Shamie, MD, on ways to build strong practice partnerships. Paired with Dr. Yee's advice, their tips can help you onboard a new physician to ensure long-term happiness for you, the new associate, and the practice.

If you're already set with your core team of physicians, check out the other articles in this issue, in which practice management experts dig deeper into harnessing your data to make the best business decisions, how to properly follow Medically Unlikely Edits when coding for your services, and an excellent review of cash value life insurance.

Building and maintaining a practice isn't for the faint of heart, but if you choose your team carefully and add to it at the right time, you will enjoy caring for patients while also nurturing your business. ■

ALAN RUBY, MD
SECTION EDITOR

1. Berkowitz ST, Finn AP, Parikh R, Kuriyan AE, Patel S. Ophthalmology workforce projections in the United States, 2020 to 2035. *Ophthalmology*. 2024;131(2):133-139.

TABLE OF CONTENTS

4 **Medically Unlikely Edits in Retina Coding**
By Matthew Baugh, MHA, COT, OCS, OCSR, and Joy Woodke, COE, OCS, OCSR

6 **The Nuances of Hiring an Associate**
By David Chin Yee, MD, FASRS

9 **BONUS FEATURE: Building Strong Practice Partnerships**
By Neda Nikpoor, MD, and Neda Shamie, MD

11 **Understanding Cash Value Life Insurance**
By Jason M. O'Dell, MS, CWM, and David B. Mandell, JD, MBA

13 **Using Data Monitoring to Drive Practice Success**
By Tonya LaRue, MBA

CODING ADVISOR
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MEDICALLY UNLIKELY EDITS IN RETINA CODING

Understand how these limits on reimbursement may affect your claims.

BY MATTHEW BAUGH, MHA, COT, OCS, OCSR, AND JOY WOODKE, COE, OCS, OCSR

Accurate coding for retina procedures requires more than selecting the correct Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes. Medically Unlikely Edits (MUEs) play a critical role in determining how many units of a service may be reported and paid on a single date of service. When MUE requirements are not followed, claims may be denied or underpaid—even if the services reported are medically necessary and well-documented.

WHAT ARE MEDICAL UNLIKELY EDITS?

MUEs are established by the CMS and updated quarterly. An MUE for a CPT or HCPCS code is the maximum units of service that a provider would report under most circumstances for a single patient on a single date of service.[1] Not every CPT code has an assigned MUE; however, if an MUE exists, it must be followed, as claims submitted with units exceeding the MUE will be denied. Think of it like an ATM that allows only one withdrawal per day—even if you feel justified that an additional withdrawal is warranted, the system can process only one transaction. The most current MUEs can be found on the CMS website[2] or in the AAO's Ophthalmic Coding Coach.

MUEs apply to both unilateral and bilateral services, in most instances. Many commonly reported retina services, including examinations, diagnostic testing, and both minor and major procedures, will have an MUE of 1. Examples include evaluation and management services, OCT imaging, fundus photography, intravitreal injection, retinal photocoagulation, and vitrectomy procedures. Because these services are limited to a single payable unit per day, understanding the assigned MUE is essential before claim submission.

Procedure Codes Versus Drug Codes

While most retina CPT codes are limited to 1 payable unit per eye per day (ie, MUE of 1), HCPCS drug codes are different. MUEs for drug codes are typically set high enough to accommodate bilateral dosing when medically necessary, often allowing double the per-eye number of billing units. Examples of MUEs for HCPCS drug codes include:

- J2778 (ranibizumab 0.3 mg or 0.5 mg [Lucentis, Genentech/Roche]) has an MUE of 10 units
- J0178 (aflibercept 2 mg [Eylea, Regeneron]) has an MUE of 4 units
- J0177 (aflibercept 8 mg [Eylea HD, Regeneron]) has an MUE of 16 units
- J2781 (pegcetacoplan 15 mg [Syfovre, Apellis]) has an MUE of 30 units

This distinction is critical: While drug MUEs are designed to support bilateral treatment and reimbursement, the injection procedure itself is subject to billing only 1 unit.

Bilateral Indicators

It is important to distinguish MUEs from bilateral indicators. Bilateral indicators define how a payer calculates payment when a procedure is performed on each eye during the same session. Returning to the ATM analogy, MUEs determine how many times a withdrawal is allowed per day, while bilateral indicators determine how that approved amount is distributed. If the billed units on a

claim exceed the MUE without a bilateral modifier, it is stopped at the first checkpoint, and the bilateral payment rules are never applied. However, if a bilateral procedure is performed, the indicators must be considered to determine if modifiers are appropriate (eg, modifier -50, -RT, -LT).[3]

CPT 67028: A Common Coding Challenge

When intravitreal injections are medically necessary in each eye on the same date of service, coding confusion is common. Although CPT code 67028 is limited to 1 payable unit per date of service due to its MUE, the bilateral indicator is 1, which allows for a 150% payment. Some payers allow the bilateral service to be reported on a single line with modifier -50, 1 unit, and a doubled fee, in accordance with their bilateral billing guidelines and indicator.

Treating Wet and Dry AMD in the Same Eye

Patients with geographic atrophy (GA) may also have wet AMD in the same eye, requiring concurrent treatment with anti-VEGF therapy. When both conditions are treated during the same visit, two separate intravitreal injections may be clinically appropriate in the same eye, but only 1 unit of CPT 67028 will be reimbursed.[4] In these cases, accurate diagnosis-to-code linking on the CMS-1500 claim form (or electronic equivalent) is essential. Practices should:

- link both the wet and dry AMD ICD-10 codes to CPT 67028,
- link only the wet AMD ICD-10 code to the HCPCS code for the anti-VEGF medication, and
- link only the dry AMD ICD-10 code to the HCPCS code for the GA medication.

Although payment is limited to a single injection code per eye, proper diagnosis linking supports medical necessity for both drugs and helps reduce denials related to diagnosis mismatches.

Bilateral Surgery

Although bilateral surgery is uncommon in retina practice, it does occur and requires careful attention to MUEs. CPT 67210 (focal laser photocoagulation for wet AMD) has an MUE of 1, same eye, same session. When performed on both eyes during the same session, Medicare Part B requires the bilateral service to be reported as a single line item with 1 unit, per the MUEs.

Since April 1, 2013, CMS policy has required this submission format for Medicare bilateral surgeries subject to an MUE of 1.[5] When reported correctly, Medicare applies the bilateral payment methodology, reimbursing 100% of the allowable for the first eye and 50% for the second eye. Commercial payer requirements may differ, and payer-specific guidelines should always be verified.

If bilateral surgery is incorrectly reported with multiple units or separate line items without a bilateral modifier, the payer may pay for only one eye, deny the additional unit, or fail to apply the bilateral payment adjustment. These automated edits occur even before documentation is reviewed, which can lead to underpayment or denial despite clearly documented bilateral surgery.

KEY TAKEAWAY

When an MUE exists, exceeding the allowable units will result in denial, regardless of medical necessity or documentation. As retinal therapies become more complex, understanding and applying MUE rules remains essential for accurate coding and timely reimbursement. ■

1. Medically Unlikely Edits. Palmetto GPA. Accessed January 12, 2026. palmettogba.com/jjb/admin/tools/mue
2. Medicare NCCI Medically Unlikely Edits (MUEs). CMS.gov. Accessed January 12, 2026. www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-medically-unlikely-edits-mues
3. Woodke J. The effect of bilateral rules on retina coding. *Retina Today*. 2024;7(4):5.
4. Shah AR, Woodke J. Geographic atrophy—how to get paid for new treatments. American Academy of Ophthalmology. November 1, 2023. Accesses January 14, 2025. www.aao.org/eyenet/article/geographic-atrophy-how-to-get-paid-new-treatments
5. CMS Manual System. Department of Health & Human Services. August 15, 2014. Accessed January 22, 2026. www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r1421otn.pdf

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FURTHER READING

WHAT, WHERE, AND WHY: CRUCIAL QUESTIONS GUIDING ACCURATE CODING

The details of the treatment approach matter when coding retinal injections and surgical procedures.

By Joy Woodke, COE, OCS, OCSR

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ASK THE EXPERT: COMMON RETINA CODING QUESTIONS

Knowing the answers could mean the difference between a successful claim and a denial.

By Joy Woodke, COE, OCS, OCSR

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THE NUANCES OF HIRING AN ASSOCIATE

This broad overview of metrics and considerations can help you bring an associate into a growing retina practice.

By David Chin Yee, MD, FASRS

As retina practices continue to experience steady growth—driven by an aging population, increasing prevalence of diabetic retinopathy, and expanding treatment options—practice leaders are frequently confronted with a pivotal decision: when and how to hire an additional physician. Adding an associate is often the most effective way to expand capacity, but it is also one of the most complex and high-stakes choices a practice owner can make. Unlike opening a satellite office or renovating existing space, hiring a new doctor introduces long-term financial, cultural, and operational implications that extend far beyond the immediate relief of a crowded schedule.

The decision to hire typically emerges from the day-to-day realities of a busy retina clinic. Physicians and staff may feel overwhelmed by emergent cases, delayed follow-ups, or

KEY TAKEAWAYS

- The decision to hire typically emerges from the day-to-day realities of a busy retina clinic. Physicians and staff may feel overwhelmed by emergent cases, delayed follow-ups, or difficulty accommodating new referrals.
- The ideal timing to hire is when existing physicians are consistently over capacity, but the practice has a predictable pipeline of patients to support the new hire within 12 to 18 months.
- The path to partnership is where many practices encounter friction. Transparent timelines and criteria are essential.

difficulty accommodating new referrals. Referring doctors express frustration when their patients face long wait times, and the practice owner senses diminishing returns on personal effort. While these qualitative signals are important, they must be validated with objective data before committing to the significant expense of a new associate.

ASSESSING THE NEED: METRICS OVER INTUITION

The first nuance in hiring is moving from subjective stress to data-driven certainty. To decide if hiring an associate is the right path forward, the practice owner must evaluate key metrics, including the following:

New patient wait times: If routine new patients wait more than 4 to 6 weeks or urgent referrals more than 1 to 2 weeks, capacity constraints are likely affecting referral relationships.

Physician use: Track the percentage of available appointment slots filled and the average number of patients seen per clinic day. Sustained rates above 85% to 90% suggest the practice is at or beyond optimal capacity.

Injection and procedure volume: High-volume practices often reach a tipping point when the number of intravitreal injections or laser procedures exceeds what the current team can comfortably manage without compromising quality or patient experience.

Revenue per provider: Compare current revenue per full-time equivalent physician against industry benchmarks. If revenue growth is plateauing despite increasing demand, adding a provider may unlock additional capacity.

A common mistake is hiring too early—before the practice has sufficient volume to support the new physician's salary and benefits—or too late, when referral patterns have already shifted to competitors. The ideal timing is when existing physicians are consistently over capacity, but the practice has a predictable pipeline of patients to support the new hire within 12 to 18 months.

FINANCIAL MODELING: BEYOND THE PRO FORMA

Financial planning for an associate requires more than a simple pro forma. While initial projections often focus on collections, overhead allocation, and partnership buy-in timelines, experienced practice leaders should emphasize several subtler considerations, such as the following:

Ramp-up period: New retina specialists typically require 12 to 24 months to reach full productivity. During this time, the practice absorbs salary, benefits, and malpractice costs without proportional revenue. Conservative models assume only 50% to 70% productivity in the first year.

Ancillary revenue: Retina practices derive significant income from imaging, injections, and clinical trials. A new associate must be positioned to contribute to these streams, not just clinic visits.

Partnership track: Clear, written terms for partnership eligibility (usually within 2 to 3 years) prevent future disputes. Compensation structures often evolve from guaranteed salary to productivity-based models as the associate matures.

Noncompete and tail coverage: These protections, while standard, require careful legal review to ensure enforceability without alienating the candidate.

RECRUITMENT: FINDING THE RIGHT FIT

The search process reveals another very important layer of nuance: Cultural and philosophical alignment between the current staff and any new hire often matters more than pure clinical skill. Retina is a small specialty, and reputation travels quickly. Top candidates typically emerge through fellowship networks, conferences such as the annual American Society of Retina Specialists meeting, direct outreach to training programs, or from colleagues looking to change practices.

When a practice is ready to start the search, owners and hiring managers should prioritize the following key qualities:

FURTHER READING

AAO RESOURCE: ACTIONABLE STEPS AND CONSIDERATIONS WHEN EXPANDING RETINA PRACTICES

By Stephanie Collins Mangham, COA, MBA, OCSR; Moss J. Fenberg, MD; Joanne Mansour, OCSR; and Joy Woodke, COE, OCS, OCSR

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A GUIDE TO STARTING YOUR OWN PRACTICE

These 16 steps will set you on the path to success as a solo practice owner.

By Debra Phairas, MBA

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ADDRESSING SPACE CONCERNS IN THE RETINA PRACTICE

When patient volumes necessitate growth, here's what you can do to avoid disruption in the clinic.

By Larry R. Brooks, AIA

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HIRING AN ASSOCIATE IS NOT MERELY ADDING CLINICAL CAPACITY—IT IS A STRATEGIC INVESTMENT IN THE PRACTICE'S FUTURE.

Clinical competence: New hires must be proficient in all aspects of the practice, including strong surgical skills, if the practice performs vitrectomy, and comfort with widefield imaging and anti-VEGF protocols.

Work ethic and resilience: Retina demands long hours, frequent emergencies, and emotional stamina. Make sure the right candidate is ready for the challenge.

Personality fit: The new associate must complement the existing team's communication style and patient approach. A brilliant clinician who disrupts staff morale can undermine the entire practice.

Long-term commitment: Candidates seeking short-term positions (eg, to build a CV before leaving for academia) pose risks to practice stability.

The interview process should include multiple touchpoints, such as dinner with the partners and their spouses, clinic observation days, and candid discussions about call schedules, income potential, and lifestyle expectations to shed light on the candidate's key qualities.

From a practice perspective, communicating with mentors or colleagues who can serve as references to gauge personality or fit can also go a long way in avoiding issues. Being open about the current practice culture and day-to-day expectations and highlighting future plans or projections of possible changes has been vital for our practice's growth.

The employment contract is a foundational document that outlines compensation, responsibilities, noncompete clauses, partnership tracks, and termination terms. Having both the practice's and the candidate's lawyers review the contract ensures a balanced, transparent process. This dual review protects both parties, minimizes risks, and fosters a stronger long-term relationship.

ONBOARDING AND INTEGRATION

The first year with a new associate is critical. Poor onboarding can lead to frustration, reduced productivity, and even early departure. Best practices for this step of the process include the following:

Mentorship structure: Pair the new physician with a senior partner for complex cases, surgical assistance, and chart review.

Gradual ramp-up: Start with lighter clinic schedules to allow the associate time to learn the practice workflows, electronic health record templates, and staff dynamics.

Staff preparation: Train technicians and scribes on the new physician's preferences to ensure smooth clinic flow from day one.

Marketing support: Actively introduce the new doctor to referring physicians through joint visits, lunch-and-learns, and co-signed letters.

COMPENSATION MODELS

Compensation remains one of the most nuanced aspects of associate hiring, and practices have several ways to approach this, depending on the practice and the associate they hire. Common structures include the following:

Guaranteed salary with bonus: This compensation model provides the new associate security during ramp-up but may reduce incentive.

Pure productivity (eg, work relative value unit or collections-based): This approach aligns the physician's effort with reward, but it also risks financial stress early in the onboarding process.

Hybrid models: Practices can consider providing a base salary plus a productivity bonus after a threshold; this is increasingly popular for balancing risk and motivation.

Choosing one model over another depends on factors such as practice maturity, financial stability, associate experience, and regional market dynamics. New or growing practices favor guaranteed models to attract associates during ramp-up (12 to 24 months to full productivity). Established groups lean toward productivity to motivate efficiency.

The practice can consider balancing risk and incentives, as guaranteed models provide security but may reduce drive; productivity maximizes earnings (eg, $750,000+ for high-volume doctors) but exposes the practice to volume fluctuations. Practices heading into a growth phase can consider starting with a hybrid and shifting to productivity after 2 years to align with partnership tracks.

Thus, practices should consider a guaranteed/hybrid for ramp-up and security or a productivity-based model for motivation in mature practices, and vary the model based on ownership for long-term alignment.

Benefits packages—health insurance, 401(k) matching, CME allowance, and malpractice tail coverage—can make or break an offer in a competitive market.

PARTNERSHIP TRACK: SETTING EXPECTATIONS

The path to partnership is where many practices encounter friction. Transparent timelines and criteria are essential. The typical track is 2 to 3 years for a new associate and can vary depending on the experience of the new hire (ie, just out of fellowship vs a more seasoned clinician looking to make a move), and the buy-in formula is often based on

(Continued on page 14)

BUILDING STRONG PRACTICE PARTNERSHIPS

Lessons in transparency, flexibility, and mutual support.

By Neda Nikpoor, MD, and Neda Shamie, MD

Neda Nikpoor, MD: What was it like being first a newly added partner and then bringing someone else into the partnership?

Neda Shamie, MD: Becoming part of a partnership initially felt like a journey of self-discovery and alignment. Early in my career, I experienced multiple practice settings—from academic private practice to traditional academia—before joining Robert K. Maloney, MD, MA.

I wondered if the frequent changes meant something was wrong with me, but I came to realize that finding the right practice is much like a marriage; it's about compatibility, timing, and mutual respect.

Joining Robert was transformative because, at that point in my career, I clearly knew what I wanted and had something valuable to offer, which allowed me to negotiate effectively and take on a substantial role. Robert, who had previously had only associates and not partners, immediately treated me as an equal.

A defining moment was when we did a photo shoot for our practice website; Robert purposely positioned me front and center, symbolizing his confidence in me and his willingness to elevate my presence in the practice. This small gesture taught me an essential lesson: When you bring on a new partner, you must endorse and elevate them, allow them to flourish rather than dim their spark. When it was my turn to bring on a new partner, Arjan Hura, MD, I adhered to this principle. Recognizing his talent and value to our practice, Robert and I intentionally placed him prominently on our website—even before he was officially named a partner.

I also learned that being a senior partner requires thoughtful planning and transparency. Our search for Arjan began 2.5 years before he joined our practice.

Our approach to recruitment allowed us to choose the right person and wholeheartedly support his integration and growth.

The dynamic between partners can vary based on age, career stage, and goals. My partnership with Robert involved transferring responsibilities and roles as he planned for more personal freedom. In contrast, my partnership with Arjan is about mutual expansion and growth because we are both committed to the long-term development of our practice. This difference shapes how we support and collaborate with each other.

Ultimately, the keys to a successful partnership are clear communication, thoughtful strategic planning, genuine enthusiasm, and mutual support—always ensuring your new partner's growth and happiness are aligned with your own and with your long-term vision for the practice.

Dr. Nikpoor: Do you think senior partners are always considering what the newer partner might want?

Dr. Shamie: Not always. Senior partners sometimes think primarily from their own perspective—what they need or want at that moment—rather than fully consider what a new partner is looking for. I've seen senior partners decide to bring someone on out of urgency or to off-load less desirable parts of their practice rather than with shared intentions that align with their colleague's professional goals and aspirations.

A thoughtful senior partner starts recruitment early, clearly articulates their intentions, and remains flexible enough to adjust the practice to accommodate and support the new partner's development and ambitions. Most mutually beneficial is to keep the big picture in focus—to foster the growth and sustainability of the practice as a whole rather than approach recruitment in a self-serving way.

For instance, a senior partner engaged in succession planning might aim to scale back while intentionally facilitating the transfer of patient goodwill and referral relationships. A senior partner who plans to stay on might recruit a new partner to expand the scope or reach of the practice. In both scenarios, the approach aligns with the new partner's goals of professional growth and integration within the practice.

The successful onboarding of a new partner requires the senior partner's (1) introspection and transparency about their true timeline and willingness to let go of responsibilities and (2) dedication to ensuring the new partner feels fully integrated, valued, and empowered.

Dr. Nikpoor: Can you share any advice for surgeons early in their careers or those who might be negotiating their first position? What should they ask for or think about early on?

Dr. Shamie: It's critical to clearly communicate your personal and professional values, goals, and expectations from the outset. Be honest about what matters most to you—whether it's your clinical role, your schedule, family considerations, or opportunities for professional growth. Ask yourself questions such as, "What do I need to feel satisfied and valued in this position?" and "Am I comfortable openly sharing these expectations now to avoid future resentment?"

When you're negotiating, be specific about practical things, such as clinic start times, flexibility for family or personal obligations, and opportunities for mentorship and career development. It's also important to remain flexible early in your career but to be clear about your top priorities. For example, you might express a goal to transition to a shorter workweek after 3 to 5 years and outline how you intend to help the practice achieve the efficiency required to accommodate that goal. Similarly, if medical mission work is important to you, ask how that could be integrated into your schedule without negatively affecting the practice.

My philosophy is not to hesitate to discuss up front if you anticipate life changes (for example, starting a family) that could affect your role. These discussions are neither expected nor required, but I believe transparency fosters trust. Trust and mutual respect are the two most important pillars of a healthy partnership. Having these conversations early helps set clear expectations and ensures you enter a partnership where both you and your senior partner are aligned, ultimately promoting a healthy, supportive environment and avoiding misunderstandings later. ■

EDITOR'S NOTE

This article was adapted from an episode of *Neda Squared*, a series on *CRST: The Podcast*. Scan the QR code to listen to their conversation in full.

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A REVIEW OF CASH VALUE LIFE INSURANCE

Key success factors every retina specialist should understand.

BY JASON M. O'DELL, MS, CWM, AND DAVID B. MANDELL, JD, MBA

An important topic in personal finance for all types of physicians, including retina specialists, is the use of permanent, or "cash value," life insurance. Proponents point to several benefits, including the variety of cash value accumulation options that can be customized to a particular doctor's goals, the asset protection offered (in many states), and the significant tax benefits afforded by such policies. Detractors focus on policy costs and opine that it is often better to "buy term and invest the difference." As advisors who recommend (and personally own) both term and permanent policies, we understand that each product type has specific pros and cons and its proper place in wealth planning.

However, cash value insurance products can be complex, and carriers and products differ. Thus, it is critical that physicians understand them well and work with professionals who have experience in the marketplace. Here, we highlight several important success factors when implementing cash value life insurance in a physician's wealth planning.

LONG TIME HORIZON

Whether a permanent life policy is designed to accumulate significant cash values for the policyowner's retirement, for an executive's buyout, or for another purpose, it is important that the purchaser have a relatively long time horizon (ie, 15 years or more). Of course, if the policy is designed for estate planning, the time horizon may be 30 years or more, depending on the age of the insured.

A long time horizon is important because most cash value life policies frontload expenses, including agent commissions. To better understand this, consider an "A" share mutual fund where the sales load is charged up front and there are no ongoing charges. Compare this with a "B" share fund, for which there is no sales load upfront, but there is an annual fee. Which of these funds is more cost-effective depends on how long the investor intends to hold the fund: One can calculate a break-even point before which the B share is best and after which the A share is best.

Permanent life insurance is like the A share mutual fund example. Rather than a sales load in a fund, many life policies have a surrender charge that is imposed if you surrender the policy in full. Importantly, however, the surrender charge does not apply if you access only a portion of the cash value.

The amount of the surrender charge covers many of the insurance company's upfront expenses, including the agent commission, and the surrender charge goes down with time. In many policies, the surrender charge hits zero between 8 and 15 years after purchase of the policy. If you keep the policy in force beyond the surrender period, you have effectively amortized the upfront costs over time and will not be penalized if you surrender the policy.

Taxes are another important reason to keep these policies in place for the long term. This is especially true if you plan to use these policies for future retirement income because the tax benefits afforded by a cash value life insurance policy—tax-free growth within the policy and tax-free access through basis withdrawals and policy loans—gain value as the policy growth compounds with time. As with a Roth IRA, simple math dictates that the longer you can enjoy tax-free growth and access, the better.

REGULAR REVIEWS AND MAINTENANCE

Permanent life insurance is like any other asset class in which you can invest: Regular performance reviews are

mandatory. Just as you review your investment performance with your investment advisor annually (or even quarterly), so too should you review your life policy with your insurance agent on a regular basis. It is during these reviews that you can make decisions on myriad options within the policy. Whether this means changing investments within the policy, paying a higher or lower premium, changing premium frequency, adjusting the death benefit, adding or removing a beneficiary, or even exchanging the policy for a different type, regular reviews are the time when the agent and policyowner bring issues to light and make decisions accordingly. Permanent life insurance is not a set-it-and-forget-it asset; few valuable assets are.

CHOOSE YOUR AGENT WISELY

The most important of the success factors for using a permanent life insurance policy (all covered in our book) may be working with an ethical insurance agent who understands the plethora of products in the market and is familiar with the details of the specific policy types you can choose. If you work with such an agent, they will make sure the other success factors are in place. The absence of any of the success factors discussed here could undermine the performance of the policy and how you evaluate the use of the asset class in your planning.

When looking for a life insurance agent, it is important to work with one who is not operating under a captive or quasi-captive arrangement, in which the agent can only sell one company's products (or is highly incentivized to do so). Rather, seek an insurance advisor who is independent with no restrictions on the policies they can provide and without any overhead payment incentives to prioritize one company's products over another.

Beyond independence, the agent should have significant experience with permanent life insurance policies along with overall expertise in the insurance marketplace, so they understand what could go awry and can build in flexibility to avoid such situations. Finally, it is always a good idea to work with professionals who are well regarded in the industry and can provide numerous references.

WEIGH YOUR OPTIONS

Permanent life insurance, also called cash value life insurance, offers tremendous tax, wealth accumulation, asset protection, and estate planning benefits. However, as with any sophisticated financial strategy, there are important success factors to consider when choosing and implementing one. ■

SPECIAL OFFER: Mr. Mandell and OJM Group partners are pleased to announce the publication of our newest book, Wealth Strategies for Today's Physician: A Multi-Media Playbook. *The Playbook's innovative format features more than 90 links to videos and podcast episodes to enhance important financial topics for physicians. To receive a free print copy or ebook download, text RETINA to 844-418-1212, or visit www.ojmbookstore.com and enter promotional code RETINA at checkout.*

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By David B. Mandell, JD, MBA, and Carole C. Foos, CPA

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PRACTICE MANAGEMENT

USING DATA MONITORING TO DRIVE PRACTICE SUCCESS

The process involves more than crunching numbers.

BY TONYA LARUE, MBA

As an ophthalmologist, your treatment decisions are based largely on scientific data coupled with patient feedback. Are you approaching practice operations in the same way?

Like patient care, business decisions within your practice should be based on data-driven insights acquired through the regular tracking and monitoring of key metrics. What you cannot see may be costing you money and affecting your ability to provide quality treatment. So, what areas should you be monitoring to ensure the smooth operation and administration of your practice?

WHAT TO TRACK

The right metrics focus on the most relevant aspects of your business. The following is a list of data points to consider tracking. Ask your practice administrator to identify any additional areas that may affect business operations and patient care.

Profit and Loss Statements

Profit and loss (P&L) statements are not just an accounting exercise. These reports provide a picture of your practice's financial health. At the broadest level, P&L statements show whether your practice is operating at a profit or incurring losses. The components of each item on the statement, however, can help identify areas where costs could be reduced or revenue increased.

Additionally, the monthly costs of sales and expenses are reported on your P&L statements. Review these in detail to inform purchasing decisions and usage.

Inventory

Inventory management is essential for maintaining smooth and profitable operations. Tracking inventory data avoids shortages, expirations, and overstock situations that can affect patient care and lead to unnecessary costs. Effective inventory management, backed by data analysis, helps maintain an efficient supply chain by minimizing waste and maximizing cost savings.

Accounts Receivable and Collections

Today's accounts receivable balances become tomorrow's practice collections. Accounts receivable balances should be monitored continuously—not just when cash flow becomes tight. These figures reveal your practice's pending cash flow and whether collections are happening as expected. A large gap between revenue generated and collections received may signal problems within the patient charting, practice billing, or collections processes.

Examine accounts receivable balances thoroughly and often to ensure the monies earned from services provided are paid accurately and in a timely fashion.

Balance Sheets

Balance sheets offer a snapshot of your practice's assets, liabilities, and equity. Regularly review these reports to understand loan balances, outstanding vendor payables, and the current cash position of your organization. These metrics indicate whether your practice is financially stable. When making decisions, balance current cash needs against future expenditures.

Doctor Productivity

Understanding how much time each of your practice's doctors spends per patient, how many patients they see per day, and what conditions they treat can reveal patterns in workflow efficiency. With this information, adjustments can be made to reduce bottlenecks and improve the delivery of patient care.

Scheduling

Review schedule templates to determine if there are gaps in appointment slots, periods of overbooking, or areas where patient flow could be more efficient. Improved

scheduling can increase patient satisfaction while ensuring that each provider is working at optimal capacity.

Referrals

Monitoring where patients come from and which specialists or providers receive the most referrals allows your practice to optimize these networks and make data-driven decisions about future referral strategies.

BRINGING IT ALL TOGETHER FOR ANALYSIS

Once you've gathered the data, enter it into a centralized location or tracking system to show at a glance everything that is happening. You may use your practice management software for some components. For other pieces, it may be necessary to collect the data manually and then collate the information into a format your practice finds useful—often a consolidated spreadsheet.

Once the data have been compiled, decide how often to review the information. Monthly tracking typically reveals any trends or patterns. Consistent monitoring not only highlights areas for immediate improvement but also helps identify long-term trends and cyclical patterns. When tracked over time, the numbers tell a compelling story about the overall health of your practice.

As trends are identified, seek input from the professionals in your practice who are responsible for these areas. For example, if doctor productivity appears to be lagging, the practice manager can speak with the physicians to determine the root causes and explore potential solutions.

In some instances, it may be beneficial to bring in an external professional consultant to analyze your practice data. Consultants may identify issues or solutions that internal team members have overlooked. Be sure to choose someone who specializes in ophthalmology so that their insights are tailored to your needs.

Finally, set benchmarks against your practice's past and current performance. Goals for your organization should be based on your data rather than a comparison to far-off competitors to avoid unrealistic expectations.

FINAL THOUGHTS

There can be no intentional success without measuring performance. Collecting and analyzing data may seem like a time-consuming task, but it is time well spent. Investing in data tracking can improve operational efficiency, patient care, and your practice's financial health. With regular analysis, you can develop strategies to head off minor issues before they become major problems. ■

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(Continued from page 8)

tangible assets (eg, equipment, inventory) plus a multiple of average collections. Practices should carefully consider the governance rights included in the partner track, including voting power, committee roles, and profit distribution.

Practices that delay or obscure partnership terms risk losing talented associates to competitors offering clearer paths to ownership. Even in a private equity (PE)-owned practice, those with ownership may be able to purchase stock in the organization. Concerns about PE risks can be addressed by front-loading protections in the employment contract, staying vigilant, and prioritizing your values. Many associates thrive in PE environments with proper preparation, but others regret lost independence. Prospective hires should discuss the potential of a PE acquisition with a lawyer early in the process—it's the best insurance against surprises.

RISKS AND PITFALLS TO AVOID

If you follow these tips, your practice should have a smooth transition. However, even well-executed hires carry risks. The hiring process is short, and personality conflicts are possible, even after careful vetting. A poor cultural fit can erode morale across the practice. In addition, the practice may have issues with the productivity gap introduced; if the referral volume doesn't materialize as projected, the new associate may struggle financially and emotionally.

If your new hire doesn't work out after a few weeks or months, the departure costs can be steep for the practice. Noncompete enforcement, tail insurance, and patient retention battles can be expensive and divisive.

A STRATEGIC INVESTMENT

Hiring an associate is not merely adding clinical capacity—it is a strategic investment in the practice's future. When timed correctly, with careful attention to financial modeling, cultural fit, and clear expectations, adding a new retina specialist can transform a stressed, overburdened practice into a sustainable, thriving group that better serves patients and referring doctors alike.

The nuances lie in resisting the temptation to hire reactively during busy periods and instead approaching the decision with the same rigor applied to complex surgical cases: thorough preparation, data-driven analysis, and meticulous execution. Done well, adding an associate doesn't just relieve today's pressures—it positions the practice for long-term success in an increasingly competitive landscape. ■

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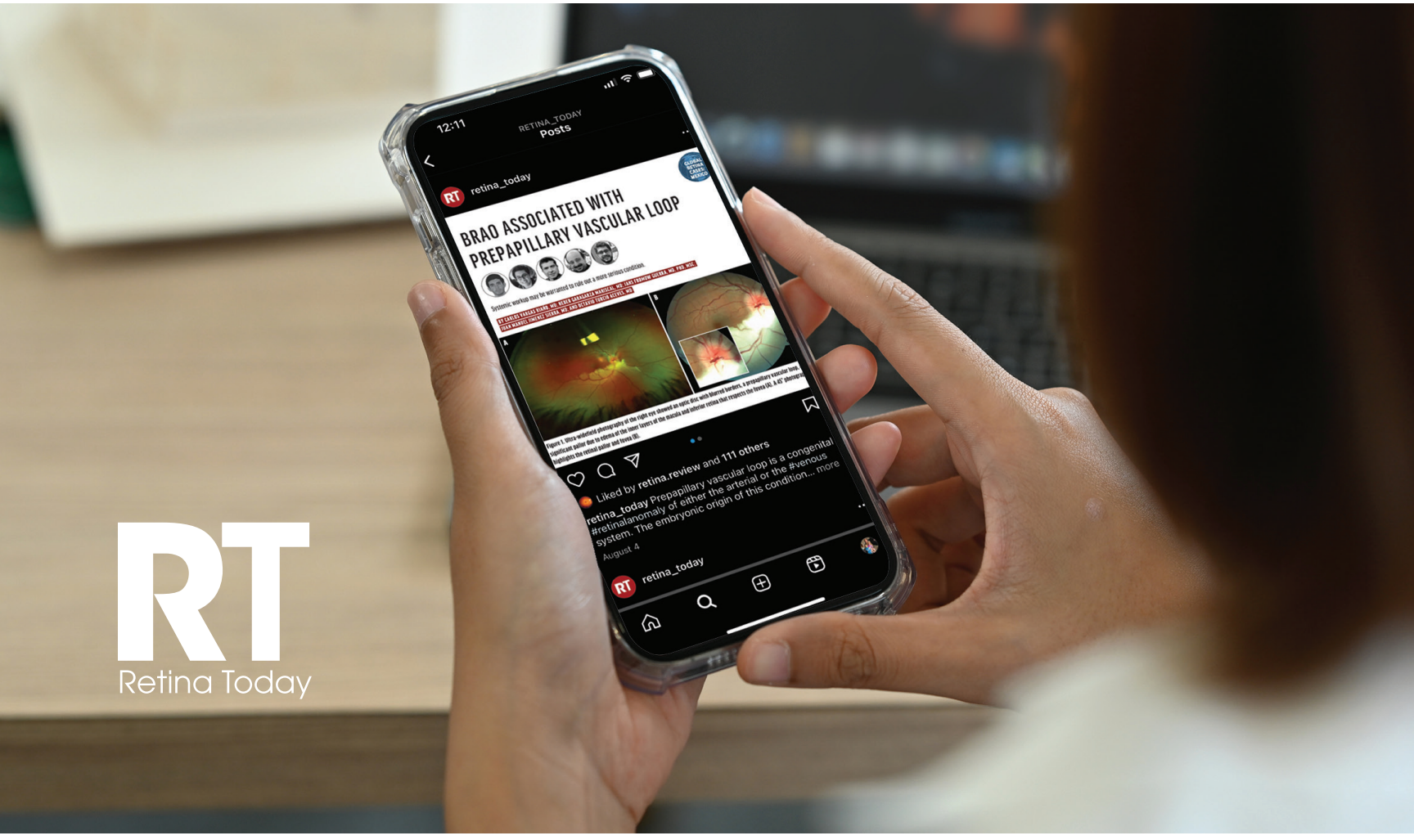

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