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BUSINESS MATTERS

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LEVERAGING DATA IN THE RETINA PRACTICE



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THE BRIGHT SIDE OF AI



In April 2026, we ran an excellent article detailing how owners and administrators can use data monitoring to improve their practices. Tonya LaRue, MBA, explained why it's important to track profit and loss statements, accounts receivable and collections, balance sheets, scheduling, and other metrics. While this is all very important data to monitor, the proposed monthly tracking with a spreadsheet and even (gasp!) some manual input may be a difficult ask for some practices. Isn't there an app for that?

For this issue, we asked data guru Bill James, MHA, COE, chief financial officer at Talley Eye Institute in Indiana, to discuss ways to automate some that data collection and analysis. During the 2025 ASRS Business of Retina meeting, he presented on his practice's AI program, which uses automated "scrubbers" to review their patient management and electronic health record databases and identify potential workflow, coding, and billing issues. In his article, *Using Data to Catch Problems Early*, he shares how the system flagged a change in the allowable reimbursement for an anti-VEGF medication, ensuring the practice had time to minimize any financial ramifications. It's a great example of how a carefully implemented AI system led to significant savings and efficiency without much ongoing work for staff. The key to its success isn't necessarily the programming itself, but the collaboration with staff to identify stress points that needed automated monitoring.

Once you have your data under control, we have several other important articles to help boost your practice management acumen. Team communication seems to be a recurring theme in this issue, as our finance author David B. Mandell, JD, MBA, outlines key pearls to consider before selling a practice (spoiler alert: Make sure your advisors work together!). In addition, Jefferey T. Brockette, MSHA, walks through the nuances of renting versus owning real estate for your practice, and our coding column touches on strategies to avoid denials and audit risks when it comes to retinal imaging.

This issue focuses on the practical and actionable, so you and your staff can get ahead of issues before they cause downstream problems. With thoughtfully implemented technology and robust communication, your practice can run like a well-oiled machine. ■

ALAN RUBY, MD
SECTION EDITOR

FURTHER READING

USING DATA MONITORING TO DRIVE PRACTICE SUCCESS
By Tonya LaRue, MBA

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USING DATA TO CATCH PROBLEMS EARLY

How operational safety nets can turn practice data into early warnings for workflow and reimbursement issues.

By Bill James, MHA, COE





As retina practices adjust to growing patient volumes, reduced reimbursement, employee turnover, and the introduction of new therapies (including biosimilars), the opportunity for operational mistakes is ever-present. At the same time, insurance companies are becoming increasingly aggressive in denying or underpaying claims for rendered services and intravitreal injections. In retina care, small operational misses can quickly become significant clinical or financial problems. While practice data is often used to monitor overall financial and operational performance, a deeper analytical approach can help identify workflow gaps, catch errors before they escalate, and monitor reimbursement at a granular level.

IDENTIFYING THE PROBLEMS

At Talley Eye Institute, we recognized that despite the best efforts of our staff, errors in appointment scheduling,

KEY TAKEAWAYS

- Leadership at Talley Eye Institute used structured query language (SQL) programming to develop operational "scrubbers" to identify potential workflow, coding, and billing issues.
- The SQL-based program reported an unexpected change in the allowable reimbursement for aflibercept 8 mg (Eylea HD, Regeneron), allowing the practice to identify the issue before significant additional underpayments occurred.
- Proactive data reporting can help practices identify workflow gaps and reimbursement trends early, so that staff can intervene before small issues become larger operational or financial problems.

Appointment Scrubber as of 6/2/2026				
Appointment Date	Acct Number	Scrub Rule	Provider	Facility
6/3/2026	CCCCCC	Glaucoma evaluation without visual fields	Johnson	TEI
6/5/2026	DDDDDD	New patient after 10:46 or 2:46	Davis	TEI
6/5/2026	EEEEEE	YAG appointment without same day 1 hour post-op	Thompson	TEI
6/12/2026	GGGGGG	Doctor does not see patients under 18	Currier	TEI
6/12/2026	HHHHHH	Early Injection	Jones	TEI

Figure 1. The SQL-based reporting system reviews scheduled appointments for potential errors. All names and data are fictional and for illustrative purposes only.

Patient Resposibility Reason Codes as of 5/29/2026						
Acct Num	DOS	Patient	Insurance	Reason Code	Reason	Amount
XXXXXX	8/21/2025	John Doe	GoldPath Medicare	PR27	Ins Termed	$429.00
XXXXXX	8/21/2025	John Doe	GoldPath Medicare	PR27	Ins Termed	$186.00
XXXXXX	8/21/2025	John Doe	GoldPath Medicare	PR27	Ins Termed	$445.00
YYYYYY	4/28/2026	Jane Doe	Sterling Health	CO22	Coordination of Benefits	$258.00

Figure 2. A daily email summary shows where balances transferred from the payer to the guarantor. All names and data are fictional and for illustrative purposes only.

coding, and billing can still occur. For example, patients may be added to the schedule after the day's prior authorizations for injections or surgeries had been completed, creating gaps that are easy to miss in real time. To help ensure that intravitreal injections were reimbursed accurately, we identified areas where rare scheduling exceptions could create operational or financial consequences if left undetected. These included patients being scheduled inside the 28-day injection window, patients being scheduled with providers who were not enrolled with the patient's insurance plan, and appointment changes that could bypass established authorization workflows.

On the coding and billing side, we identified rare administrative missteps, including Medicare claims being submitted to the incorrect state, claims billed with incorrect procedure or drug units, and other issues that could result in denials, delayed payments, or inaccurate reimbursement if not identified promptly.

Next, we set out to find a system to stop these errors before they affected our patient care and bottom line.

CREATING A FLAGGING SYSTEM

We started with the operational side of the business, and with the help of frontline staff members, we identified vulnerabilities and opportunities for improvement within their daily responsibilities. Based on those findings, we used structured query language (SQL) programming to develop a series of automated "scrubbers" designed to identify potential workflow, coding, and billing issues before they progressed further into the revenue cycle or patient workflow. The scrubbers created daily audit reports of the patient management (PM)/electronic health record (EHR) database that were delivered as automated emails to supervisors and team leads for review (Figure 1). If an issue required correction, staff could intervene before it resulted in claim delays, denials, or scheduling disruptions.

As the SQL system evolved, employees provided feedback that helped refine the reports and improve their effectiveness. These reporting systems initially focused on simple but preventable mistakes, such as scheduling intravitreal injections too soon or assigning an incorrect number of units to a J-code.

Over time, we developed methods to improve the reporting accuracy and reduce unnecessary alerts. For example, a patient may appropriately receive an injection in one eye and return 2 weeks later for treatment in the fellow eye. In these cases, staff could enter a predefined "all clear" code into the appointment notes to indicate that the situation had already been reviewed and approved. This prevented the same item from repeatedly appearing on subsequent scrubber reports and allowed staff to focus their attention on issues that required intervention.

High Value Drugs Paid Yesterday as of 1/26/2026											
Internal CPT	Tx Entry Date	Account	Primary insurance	Provider	DOS	Charge	Allowed	Prim Ins	Adj Chg	Adj Pay	Writeoff
J0177 (J0177JZ - MEDICATION - EYLEA HD 8MG/0.07)											
	1/26/2026		SUMMITCARE INSURANCE	SMITH	4/8/2025	$7,500.00	**$49.60**	$0.00	$0.00	($31.52)	$0.00
	1/26/2026		SUMMITCARE INSURANCE	SMITH	4/8/2025	$7,500.00	**$49.60**	$0.00	$0.00	($31.52)	$0.00
	1/26/2026		HORIZON MEDICARE	JONES	4/17/2026	$7,500.00	**$2,300.00**	$1,840.00	$0.00	$0.00	$460.00
	1/26/2026		HORIZON MEDICARE	SMITH	4/20/2026	$7,500.00	**$2,300.00**	$1,840.00	$0.00	$0.00	$460.00
	1/26/2026		RIVER VALLEY MEDICARE	SMITH	4/21/2026	$7,500.00	**$2,440.00**	$1,952.00	$0.00	$0.00	$488.00
	1/26/2026		RIVER VALLEY MEDICARE	SMITH	4/21/2026	$7,500.00	**$2,300.00**	$1,840.00	$39.39	$0.00	$460.00
	1/26/2026		RIVER VALLEY MEDICARE	SMITH	4/22/2026	$7,500.00	**$2,300.00**	$1,840.00	$0.00	$0.00	$460.00
	1/26/2026		RIVER VALLEY MEDICARE	JONES	4/23/2026	$7,500.00	**$2,300.00**	$1,840.00	$0.00	$0.00	$460.00
	1/26/2026		UNITYCARE	SMITH	4/27/2026	$7,500.00	**$2,300.00**	$1,840.00	$0.00	$0.00	$460.00
	1/26/2026		UNITYCARE	SMITH	4/28/2026	$7,500.00	**$2,600.00**	$2,080.00	$0.00	$0.00	$520.0 0
	1/26/2026		SENIORPLUS HEALTH PLAN	SMITH	5/8/2026	$15,000.00	**$4,600.00**	$3,680.00	$0.00	$0.00	$920.00
J0178 (J0178JZ - MEDICATION - EYLEA)											
	1/26/2026		GOLDPATH MEDICARE	JONES	1/8/2025	$3,885.00	**$1,700.00**	$1,643.96	$0.00	$0.00	$0.00
	1/26/2026		GOLDPATH MEDICARE	JOHNSON	1/17/2025	$7.770.00	**$3,900.00**	$0.00	$0.00	($152.00)	$0.00
	1/26/2026		UNITYCARE	SMITH	2/24/2025	$3,885.00	**$1,577.63**	$0.00	$0.00	($306.29)	$0.00
	1/26/2026		UNITYCARE	SMITH	5/5/2025	$3,885.00	**$1,566.25**	$0.00	$0.00	($318.34)	$0.00
	1/26/2026		BLUE RIDGE HEALTH	JONES	7/28/2025	$3,885.00	**$2,331.00**	$0.00	$0.00	($360.41)	$0.00
	1/26/2026		UNITYCARE	ROBINSON	8/6/2025	$3,885.00	**$1,557.26**	$0.00	$0.00	($439.66)	$0.00
	1/26/2026		BLUE RIDGE HEALTH	JONES	8/25/2025	$3,885.00	**$2,331.00**	$0.00	$0.00	($224.07)	$0.00

Figure 3. A daily email summary shows any payer or guarantor activity with intravitreal injections. The $49 allowable for aflibercept 8 mg (red circle) was the "canary in the coal mine" moment. All names and data are fictional and for illustrative purposes only.

2026									
Years (DOS)	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	APRIL	MAY
2025	$7,545.86	$6,995.21	$3,513.25	$2,807.11	$5,513.32	$946.37	$7.935.38	$726.17	$2,452.93
	$11,677.48	$5,564.20	$2,452.71	$1,048.52	$427.11	$1,444.98	$1,554.67	$4,278.13	$660.83
	$9,103.36	$4,045.23	$4,300.67	$841.65	$1,669.61	$309.59	$409.95	$660.46	$440.99
	$17,045.11	$12,467.43	$6,724.59	$1,779.95	$5,642.11	$654.50	$887.02	$1,450.21	$3,451.74
	$26,016.82	$4,045.17	$3,503.05	$2,424.97	$1,719.24	$2,717.65	$760.81	$278.02	$1,762.59
	$33,137.83	$9,673.31	$2,805.77	$1,086.08	$8,037.22	$3,704.43	$3,537.80	$1,375.06	$372.23
	$209,070.91	$57,064.57	$20,297.71	$3,098.33	$8,984.86	$3,363.23	$3,227.65	-$107.04	$1,921.46
	$1,500,622.89	$180,980.37	$20,130.20	$11,720.85	$13,649.77	$15,153.15	$4,216.29	$2,380.94	$1,680.34
	$885,415.71	$1,619,799.36	$120,432.15	$28,315.85	$10,167.66	$7,463.70	-$2,763.64	$1,687.40	$1,188.61
	$0.00	$791,984.54	$1,817,046.01	$163,423.37	$127,974.34	$22,945.46	$11,860.10	$6,812.91	$2,618.22
	$0.00	$0.00	$691,347.68	$1,232,390.42	$341,470.05	$36,733/70	$13,923.07	$6,707.94	$6,448.04
	$0.00	$0.00	$0.00	$993,289.70	$1,573,420.40	$204,136.32	$48,821.15	$20,412.92	$7,097.12
2026	$0.00	$0.00	$0.00	$0.00	$652,601.44	$1,265,442.78	$306,884.89	$92,940.03	$35,621.06
	$0.00	$0.00	$0.00	$0.00	$0.00	$711,589.98	$1,696,949.96	$258,400.36	$59,399.47
	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$979,582.39	$1,361,381.62	$229,786.51
	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,177,202.75	$1,759,666.13
	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$918,423.59
Grand Total	**$2,699.635.96**	**$2,692,619.79**	**$2,692,553.79**	**$2,442,226.80**	**$2,751,277.12**	**$2,276,605.85**	**$3,077,787.49**	**$2,936,587.88**	**$3,032.991.87**

Figure 4. The SQL-based reporting can also calculate revenues by age. All names and data are fictional and for illustrative purposes only.

We then expanded the SQL program beyond scheduling to identify coding and insurance-related issues. This includes claims submitted to the incorrect Medicare jurisdiction, insurance plans that would not recognize certain code sets such as eye codes or consultation codes, and instances where patients who had not been seen in 3 years were inadvertently scheduled and billed as established patients.

On the financial side, we started to monitor reimbursement activity for intravitreal injections. Our revenue cycle management (RCM) staff received automated reports that identified payment variances, denials, or recoupments related to medications. Because these reports were reviewed daily, changes in payor allowables were flagged almost immediately.

BY COMBINING OPERATIONAL ANALYTICS WITH THE INSIGHTS OF FRONTLINE STAFF AND REAL-WORLD WORKFLOW EXPERIENCE, PRACTICES CAN CREATE MEANINGFUL SAFETY NETS THAT SUPPORT BOTH PATIENT CARE AND FINANCIAL STABILITY.

The SQL reporting process extended into revenue cycle workflows beyond traditional coding and billing audits. For example, one staff member identified a recurring issue involving claims that processed to patient deductibles or generated coordination-of-benefits denials. In many cases, these balances would be automatically transferred to the guarantor account and remain unresolved until the next patient statement was generated. To address this, we created an automated report that notified staff whenever these situations occurred (Figure 2). This allowed team members to proactively contact patients, verify insurance information, resolve coordination-of-benefits issues, and discuss outstanding balances before the normal statement cycle. In addition, the process helped improve communication with patients and reduced the likelihood of unresolved balances lingering in accounts receivable.

CASE EXAMPLE

Recently, a payer unexpectedly changed the allowable reimbursement for aflibercept 8 mg (Eylea HD, Regeneron) to less than $50 per injection (Figure 3). The day after the first remittance was posted, our RCM team received an email that showed the discrepancy and immediately notified administration and providers. We temporarily halted use of the medication for patients covered by that payer until the issue was investigated further. This was our "canary in the coal mine" moment, as the reporting process allowed us to identify the issue before significant additional underpayments occurred. We also notified the company of the issue so they could work directly with the payer and alert other retina practices in the state to the problem.

WHAT THE SYSTEM OFFERS

We further enhanced our reporting capabilities to provide more actionable financial data for leadership and the RCM team. While most PM/EHR systems provide standard reporting tools, we found that extracting data directly from our SQL database allowed for significantly greater flexibility and faster operational analysis. This approach made it easier to identify reimbursement trends, evaluate payment timelines, and answer operational questions that were difficult to address through standard system reports alone.

Using SQL-based reporting, we can evaluate revenue according to the original date of service, allowing us to better understand the true aging of incoming reimbursements (Figure 4). This complements traditional accounts receivable aging buckets and provides a more detailed view of payment timelines and reimbursement trends. With this approach, we can evaluate actual drug profitability at a more granular level than traditional financial reporting alone. By linking acquisition costs, reimbursements, and dates of service, we can calculate true net cost recovery and margin performance for individual medications over specific periods. This visibility helps identify reimbursement trends, evaluate the financial effect of payer policy changes, and make informed decisions regarding high-cost medications.

As biosimilars, drug pricing, and payer policies continue to evolve, this level of detail has become increasingly important for evaluating both operational efficiency and long-term financial sustainability.

HARNESS YOUR DATA

Your practice's data can provide far more value than standard reporting alone. When used proactively, it can help identify scheduling errors, reimbursement discrepancies, workflow gaps, and revenue cycle issues before they create larger consequences. By combining operational analytics with the insights of frontline staff and real-world workflow experience, practices can create meaningful safety nets that support both patient care and financial stability. ■

Author's note: Patient privacy and data security were a primary consideration throughout the preparation of this article, and no identifiable or proprietary practice information was disclosed.

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THE BIGGEST FINANCIAL DECISION: SELLING A PRACTICE



The sale price gets all the attention. How much wealth you keep depends on something else entirely: whether the experts around you are working from the same playbook.

BY DAVID B. MANDELL, JD, MBA

When a retina specialist sells a practice, the instinct is to fixate on one number: the sale price. That's understandable, as it represents decades of clinical excellence, business ownership, and personal sacrifice. But the price is only part of the financial outcome. The larger question is: After the transaction closes, how much of those proceeds become lasting wealth? The answer depends on the planning that takes place well before a buyer ever appears.

Most successful physician-owners have a capable team: a certified public accountant (CPA) who prepares the tax return, a wealth advisor who manages investments, an attorney who handles contracts, a banker, and—once a sale is on the horizon—a broker or investment banker running the transaction. Each brings valuable expertise. However, these advisors often work independently, although the decisions they're making are closely connected.

GOOD ADVICE DOESN'T ALWAYS ADD UP TO GOOD PLANNING

When the largest financial event of a physician's career arrives, fragmentation can quietly become expensive. The broker focuses on valuation. The attorney negotiates terms. The CPA, often brought into the conversation after a letter of intent (LOI) has been signed, reports the tax consequences of a transaction they had little opportunity to shape.

None of these advisors are doing anything wrong. In fact, they're optimizing within their own discipline. The challenge is that no one is necessarily responsible for optimizing across the various teams. For example, the CPA could help structure the treatment of goodwill, the timing of cash payments in an installment sale, and the tax treatment of rollover equity, if any. Investment decisions frequently begin only after the proceeds arrive.

That's where coordinated planning creates value. Rather than treating taxes, investments, legal structure, and retirement planning as separate conversations, a coordinated plan brings each expert together around a common objective. The goal isn't simply to execute each decision well; it's to ensure each decision reinforces the others.

WHAT THE SALE OF A PRACTICE REALLY MEANS

The sale of a practice changes more than who owns the business. It changes how a physician earns income, pays taxes, invests assets, and plans for retirement. All those decisions usually happen simultaneously. This makes a practice transition one of the highest-leverage moments in a physician's financial life because choices in one area inevitably affect outcomes somewhere else. The structure of the transaction influences taxes, while tax planning affects how much capital remains available to invest. Investment decisions shape retirement income, which in turn influences estate and legacy planning.

Viewed separately, these are individual financial decisions. Viewed together, they're one planning process.

PLANNING CREATES OPTIONS

Many physicians assume planning begins once they receive an LOI. In reality, the most meaningful opportunities exist well before a buyer enters the picture.

Investment accounts may need years, not months, to accumulate assets that can support future tax strategies, such as tax loss harvesting—accelerated versions of which can be ideal loss-creators in preparation of a practice sale. Retirement plans can play a role, but changes within 1 to 2 years of sale only affect deductible contributions for those years; the earlier changes are made, the better. Entity structures, succession planning, and even the timing of a transaction can influence after-tax outcomes long before negotiations begin.

The objective when deciding when and how to sell a practice is to build flexibility so that when the opportunity arrives, more options remain available.

A CASE STUDY IN COORDINATION

One longtime client, a practice owner in California approaching retirement, illustrates what coordinated planning can make possible. They planned to sell a private practice for approximately $1.6 million after decades of ownership. Rather than waiting until the transaction was underway, planning began several years in advance, allowing their tax, investment, and long-term financial strategies to be developed together.

Nearly $1.7 million had already been invested in a taxable portfolio before the sale, with an additional $1.1 million invested afterward. Because the strategy was designed with the anticipated liquidity event in mind, realized tax losses offset approximately $1.4 million of capital gains from the sale, reducing that year's tax liability by roughly $420,000.

The lesson isn't that every practice owner should pursue this same investment strategy. Individual circumstances vary, and tax-aware investing involves risks. The durable takeaway is that opportunities often emerge when planning begins early and tax, investment, and transition decisions are made as part of a coordinated strategy rather than in isolation.

THE STRATEGY IS COORDINATION

Tax-loss harvesting, direct indexing, and other tax-aware investment strategies have become increasingly sophisticated in recent years. Under the right circumstances, they can improve after-tax outcomes while allowing investors to remain aligned with their long-term investment objectives.

But the tools themselves aren't the strategy.

An investment portfolio can't prepare for a practice sale it doesn't know is coming. Likewise, a CPA has limited ability to improve the outcome of a transaction after the documents have been signed. Sophisticated strategies create the greatest value when they're part of a broader planning process.

That's why coordination matters. The investment strategy should inform the tax strategy. The tax strategy should support retirement planning. The transaction itself should fit within a broader vision for a physician's financial future.

THE BEST TIME TO PLAN IS BEFORE YOU SELL

It's natural to judge a practice sale by the purchase price. But that's only the starting point. The more useful questions come later. How much of the proceeds remain after taxes? How should those assets support retirement? How do today's decisions affect a family's long-term financial security? Those answers rarely come from any single advisor because they rarely belong to a single discipline.

A successful practice sale is about ensuring that years of work translate into lasting financial flexibility and peace of mind. That begins long before the sale itself with a coordinated approach that treats taxes, investments, legal strategy, and long-term planning as parts of the same conversation. The key is building a team of relevant advisors early and communicating with all of them about a possible sale, ideally 3 to 5 years prior to seriously considering any transaction, so that planning can begin. Key professionals include a CPA, financial advisor, retirement plan specialist, attorney, and, possibly, an investment banker when 1-2 years out. ■

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TAX-LOSS HARVESTING: A TIMELY STRATEGY

Here's how to leverage market downturns to your advantage.

READ NOW

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PRACTICE MANAGEMENT

REAL ESTATE: INVEST IN THE FUTURE OF YOUR PRACTICE



These financial, operational, and strategic considerations can help you make the right decision between renting and owning.

BY JEFFEREY T. BROCKETTE, MSHA

For most retina specialists, investing in real estate is a major decision. However, the question isn't whether it makes sense—it's how to approach it in a way that fits your practice. It's important to recognize that real estate decisions don't sit in one lane; they touch operations, finances, strategy, and even culture. Without a carefully constructed strategy to go about purchasing real estate, it may become easier to over-analyze every deal or put it off entirely.

When making important real estate decisions, start by focusing on three crucial areas: strategy, financial structure, and operations. Within each of these three areas, explore at least three options, rather than relying on one perspective.

KEY TAKEAWAYS

- Real estate decisions don't sit in one lane; they touch operations, finance, strategy, and even culture.
- Talking through different real estate structures with multiple advisors–rather than relying on input from a single source–often reveals options that make the path forward feel more manageable.
- Hybrid real estate structures can take several forms, including physician ownership alongside outside capital partners, joint ventures with developers or health systems, or staggered buy-in models that allow newer partners to participate over time.

PRACTICE CULTURE

Ownership tends to create a stronger sense of alignment and long-term commitment among physicians, particularly when they are participating in both the practice and the real estate entity. It supports a practice's legacy and can provide greater control over the clinical environment, which, in turn, affects workflow, efficiency, and patient experience. Leasing, on the other hand, can offer more flexibility—particularly in early-stage growth or when entering new markets.

Each approach can support a healthy culture, but ownership reinforces stability and long-term planning, while leasing lends itself better to supporting adaptability.

DEVELOPING A STRATEGY

Before getting into numbers or deal terms, it's worthwhile to step back and think about where your practice is headed. Rather than locking yourself into a single direction early in the growth of your business, consider a few different paths:

- A leasing option
- An ownership option
- A hybrid or partnership structure

Leasing offers flexibility, lower upfront capital requirements, and can be a good fit when entering new markets or during periods of uncertainty. Ownership provides long-term control, equity creation, and alignment with a long-term growth strategy. Hybrid structures—such as partial ownership, joint ventures, or partnerships—can allow practices to participate in real estate, while sharing risk and capital requirements. The choice between these three models typically depends on the practice's growth trajectory, capital availability, and appetite for long-term investment.

In most cases, there isn't just one solution—and this is exactly where it's helpful to get multiple perspectives. Talking

through these scenarios with a few different advisors—rather than relying on input from a single source—often reveals options that make the path forward feel much more manageable. Advisors typically include commercial real estate brokers, attorneys who specialize in health care, lenders, architects, and, sometimes, development partners. In addition, many physicians find it valuable to speak with peers who have gone through similar transactions. The goal is to gather multiple perspectives across both the clinical and real estate sides of the decision.

As an example, we had a project that started as a retail building—about 40,000 square feet, right along a major interstate. Although it wasn't originally built for health care, it had the right fundamentals: strong access, great visibility, and enough flexibility to rethink the layout.

The key takeaway here is that viable health care real estate opportunities do not always start as traditional medical office spaces. In this case, the decision was driven by location—visibility, access, and adaptability—rather than original use. Evaluating multiple types of properties and engaging different perspectives helped us find a real estate opportunity that may have been overlooked under a more traditional approach.

THE FINANCIAL SIDE

Practice owners and managers are often overwhelmed by the perceived complexity around the structure of various real estate decisions, particularly buy-ins, buy-outs, and how to handle partners at different stages. These are important to consider carefully, but they shouldn't impose a barrier.

Common considerations include how physicians enter and exit the investment, how ownership is allocated, and how risk is shared. Hybrid structures can take several forms, including physician ownership alongside outside capital partners, joint ventures with developers or health systems, or staggered buy-in models that allow newer partners to participate over time. These structures are often customized based on the size and goals of the practice.

There are multiple ways to approach real estate strategy and ownership structure, such as bringing in capital partners, which may include other physicians, developers, health systems, or institutional investors. Most structures involve more traditional real estate partnership rather than private equity. Other approaches include structuring staggered buy-ins or designing ownership models that evolve over time.

When considering the financial aspects of real estate, consult with at least three lenders before signing onto a loan, compare multiple term structures, and understand the different guarantee requirements and risk profiles available. Project owners are typically comparing interest rates, loan terms, amortization schedules, prepayment flexibility, guarantee requirements, and overall risk exposure. The goal is to align financing with the intended hold period and long-term strategy of the asset.

"Physician ownership of real estate creates a powerful, parallel path to wealth alongside clinical income," said Andrew Laverghetta, MBA, CEO of Southeastern Retina Associates in Knoxville, Tennessee, regarding his experience with the practice. "Because rent is an unavoidable cost of operating a practice, directing those payments toward an entity you own allows you to capture the long-term value through equity and appreciation rather than surrendering it to a third party. Just as importantly, developing and owning property strengthens relationships with lenders, which can translate into broader financial advantages for physicians beyond the practice itself."

The key takeaway is that owning real estate can serve as a complementary financial strategy alongside clinical income, while also strengthening long-term relationships with financial institutions.

OPERATIONS

Operations in this context refers to execution—how the project is actually implemented. This process generally includes selecting and managing brokers, architects, contractors, and development partners. Key considerations include experience with health care projects, understanding of clinical workflows, cost discipline, and alignment with the practice's goals. These considerations apply to both ownership and leasing, although ownership typically involves a broader scope of decision making.

BUILDING WITH THE FUTURE IN MIND

"Owning our real estate gives us control over our future—operationally and financially. It turns a fixed expense into a strategic asset, supports long-term planning, and ensures that the space we practice in evolves with our physicians and patients," said Stephanie Collins, MBA, CEO of Austin Retina in Austin.

There's no single path when it comes to leasing, ownership, and hybrid approaches to real estate. Regardless of your ultimate decision, when your strategy aligns with how care is delivered, how your teams operate, and how your practice grows, you will be equipped to create an environment that better supports physicians, staff, and, most importantly, patients. ■

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- Founder and Principal, Vue Realty, Dallas
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- AI disclosure: The author used ChatGPT to support drafting and editing of this article. All concepts, opinions, and content are the author's own.

PRACTICE MANAGEMENT

DESIGNING A SUCCESSFUL FRONT OFFICE

Thoughtful planning is essential.

BY ALAN WINIG

Opening an independent practice brings the freedom to shape it according to your vision, values, and standards of care. Ownership also expands your role beyond that of a clinician to that of an entrepreneur and CEO, and it creates opportunities to build long-term wealth. The primary asset is the ophthalmology practice itself, and a second potential asset is the real estate the practice occupies. Choosing to purchase your office building rather than lease space creates an additional investment and a future source of passive income. Owner-occupied real estate is common in our industry and can be a smart financial strategy when feasible.

Once you have selected a location, thoughtful space planning becomes essential. One of the most important elements of office design is patient flow (ie, how patients move through the space and how efficiently they can complete their visit). Maximizing throughput without making your patients feel rushed creates a better experience for both them and your staff.

Ophthalmology practices serve a large elderly population, and many of these individuals have mobility limitations or move slowly. The office layout should be intuitive, easy to navigate, and designed to minimize unnecessary walking. Clear circulation patterns and efficient adjacencies maintain operational efficiency while allowing patients to move comfortably.

After the foundational planning is complete, the front office becomes a critical area in the practice. This article focuses on the principles that define an effective and welcoming front office design.

ENTRY VESTIBULES AND PATIENT COMFORT

The greater the seasonal changes are or the more extreme the climate is in your region, the more advantageous an entry vestibule may be. These vestibules help regulate indoor temperature, reduce dirt and debris in the clinic, and create a transitional space. Glass vestibules can be especially effective because they maintain visibility and openness.

You may provide a coat closet near the entrance to your practice, although some patients may prefer to keep their coats with them. Consult a practice designer who can anticipate this behavior when planning seating and circulation.

FIRST IMPRESSIONS

When patients enter, check-in is their priority. Your reception desk should be immediately visible and clearly identifiable. Equally important, your front desk staff should be able to maintain visual awareness of everyone entering and leaving the office.

RECEPTION DESK DESIGN

Reception desks typically accommodate both check-in and check-out functions. A general guideline is to allow approximately 4 feet of desk space per staff member. Some desks may also include a lowered section for wheelchair users in compliance with the Americans with Disabilities Act.

The primary work surface for staff is 30 inches high, and a transaction counter for writing and processing payments is 42 inches high. The higher counter can conceal computer equipment and clutter. Proper wire management, grommets, and integrated power are essential to maintain a clean, professional appearance.

Enclosed glass reception barriers, once common, are no longer preferred. Plexiglass partitions became common during the COVID-19 pandemic but have largely disappeared because of their impersonal feel.

Minimizing clutter at the front desk is critical. Promotional materials and vendor samples should not be permitted to accumulate here, because visual clutter detracts from both design and patient comprehension.

WAITING AREA CAPACITY AND LAYOUT

A common design question is how many chairs the front waiting area requires. The answer depends on several factors:

- The number of providers seeing patients simultaneously;
- Your practice's efficiency in moving patients to examination rooms;

- The presence of family or caregivers accompanying patients; and
- The availability of a secondary waiting area in the clinical area.

Consider how many of your patients tend to arrive with spouses or caregivers. If secondary waiting areas exist near examination rooms, your front waiting area may require fewer chairs. Ultimately, the goal is not to create a large waiting room but to minimize waiting altogether. Patients should be moving comfortably and efficiently through your practice.

Long visit times frustrate patients and have a negative impact on practice revenue.

On that note, the waiting area should be adjacent to both the reception desk and, if applicable, the optical dispensary (Figure). The proximity can help make browsing feel like a natural extension of the visit. Seating within or near the optical is useful for spouses or companions waiting during frame selection.

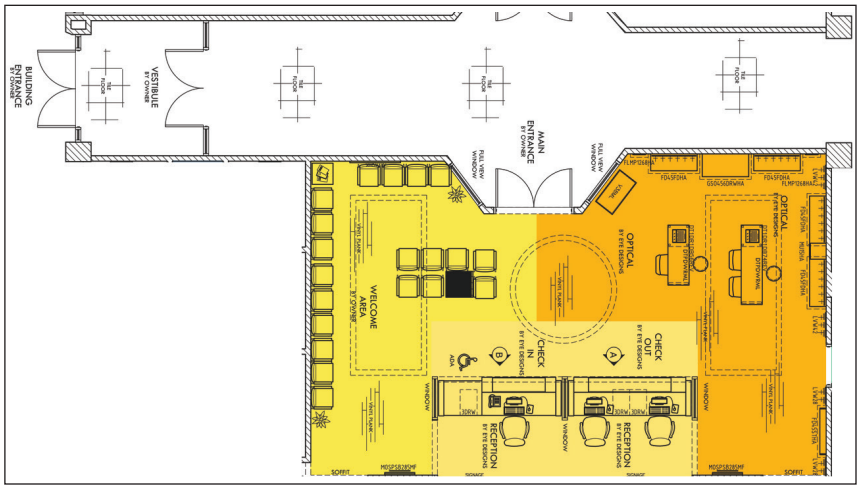


Figure. Sample floor plan.

SEATING DESIGN AND MATERIALS

Aesthetics

All waiting area furniture must be commercial-grade, never residential. Different upholstery colors or textures can add visual interest. Upholstery should be durable and suitable for a health care environment, including resistance to wear and staining from incontinence accidents. Worn or outdated furniture sends the wrong message about the quality of care your practice provides.

Some manufacturers offer wall-saver chair designs with extended rear legs that prevent contact with walls, eliminating the need for chair rails and reducing wall damage.

If your practice includes pediatric services, a separate children's waiting area is highly recommended. This space can be visually defined with unique flooring, ceiling treatments, or wall finishes. Carpeted steps, integrated toy storage, and child-focused entertainment options can appeal to young patients while improving the experience of their parents and others in the waiting area.

Practical Considerations

An effective waiting area offers a variety of seating options rather than repeating a single type of chair.

Sofas and loveseats can look attractive, but they present challenges. For example, since the COVID-19 pandemic, many patients have felt uncomfortable sitting directly next to strangers. Elderly patients, moreover, often struggle to rise from low, soft seating, whereas chairs with armrests can help them sit and stand more easily. Compared with sofas and loveseats, individual chairs are also far easier to reconfigure as needs change.

High-top café tables may look modern, but most elderly patients avoid them due to stability concerns. If used, the number of these tables should be limited. Features such as integrated charging stations can add value.

PATIENT AMENITIES

Restrooms

Patient restrooms should be located near the waiting area to accommodate elderly patients with limited mobility. The restrooms should be finished to the same standard as all public spaces.

Refreshments

Water fountains are required. Coffee stations are a popular amenity that does not need to be elaborate. These areas should be easy to clean and consistently maintained by staff.

Media and Entertainment

Televisions and magazines are generally discouraged. Televised content can cause patients anxiety or make them hungry, and magazines quickly become worn and unsanitary. Most patients prefer their own mobile devices to office-provided entertainment.

Signage

Clear signage is essential. Service boards explaining provider roles and offerings are useful. Many patients cannot distinguish between ophthalmologists, optometrists, and opticians. Informative signage educates them and promotes your practice's services.

FINISHING TOUCHES

Branding

Behind reception, an accent wall with your practice's logo—ideally in raised lettering with targeted lighting—can create a strong visual anchor and reinforce branding.

(Continued on page 15)

CODING ADVISOR
A Collaboration Between *Retina Today* and AMERICAN ACADEMY™ OF OPHTHALMOLOGY Protecting Sight. Empowering Lives.

RETINA IMAGING: HOW TO AVOID DENIALS AND AUDIT RISKS



This article reviews common reasons why retina imaging claims may be denied or audited and documentation best practices to help reduce these risks.

BY MATTHEW BAUGH, MHA, COT, OCS, OCSR

Retina imaging such as OCT, fluorescein angiography (FA), fundus photography, and diagnostic ultrasound are essential to guide diagnosis, treatment decisions, and long-term monitoring for a wide range of conditions. As the use of imaging has increased, so has payer scrutiny. Retina imaging services are frequently targeted for denials, audits, and recoupment requests. In many cases, the issue is not an incorrect Current Procedural Terminology (CPT) code selection, but the failure to provide adequate documentation.

Repeat testing frequency, multiple imaging studies performed on the same day, standing orders, and missing documentation are common payer concerns. Understanding these risks can help practices strengthen compliance and reduce reimbursement challenges. This article reviews several common denial reasons and audit risks involving retina imaging services and practical strategies to help avoid them.

COMMON REASONS FOR DENIALS

Documentation Does Not Support Medical Necessity

Imaging is reimbursable only when it is reasonable and necessary for diagnosing or managing a patient's condition—not simply because the practice routinely performs the test for a particular condition or visit type. Payers increasingly scrutinize imaging that appears repetitive or protocol driven. This is especially true when testing is performed before the physician evaluates the patient and determines the need for imaging at that encounter. For example, performing OCT at every injection visit without documenting a specific clinical reason may trigger denials or audit scrutiny. Similarly, fundus photography for a patient with stable disease may not support payment if the record does not explain why photography was necessary. Strong documentation for imaging should include:[1]

- A physician order
- The patient's diagnosis, symptoms, or clinical findings
- Whether the condition was new, worsening, or under active monitoring
- Why the imaging modality was selected
- How the findings affected treatment decisions

Practices should identify the payer before services are performed. Although many payers follow National Correct Coding Initiative (NCCI) edits, coverage requirements, payable diagnoses, and frequency limitations may differ between Medicare Administrative Contractors, Medicare Advantage plans, and commercial insurers.

A service payable under one payer's policy may be denied by another if documentation, diagnosis coding, or use requirements are not met. Retina practices should regularly review payer-specific and related coverage articles applicable to ophthalmic imaging services. A list of Medicare requirements for these testing services can be found at aao.org/lcds.

Testing Frequency Is Not Justified

Even when repeat imaging is clinically appropriate, the documentation must explain why testing was necessary at

that visit. Stable disease alone may not justify repeat testing over short intervals, and payer policies have frequency limitations.

Documentation such as "follow-up AMD" or "continue injections" often does not sufficiently explain why imaging was repeated. Stronger documentation connects the test directly to the physician's clinical concern or management decision. Examples of justification for repeat OCT imaging may include:

- Assessing for recurrent intraretinal or subretinal fluid
- Evaluating response to anti-VEGF therapy
- Monitoring progression of diabetic macular edema
- Determining whether treatment intervals can safely be extended

Similarly, FA claims may face scrutiny when angiography is repeated without documentation explaining why prior imaging was insufficient or why additional vascular evaluation was necessary.

Frequency expectations, called *frequency edits,* may differ by payer. Some insurers apply stricter use edits or require additional documentation when imaging studies are repeated frequently. For example, Novitas allows OCT to be performed monthly (ie, every 28 days) with active treatment but only every 2 months when monitoring disease.

Practices should also avoid using templated documentation across multiple visits. Individualized charting better demonstrates clinical decision making and helps support medical necessity during payer review.

Multiple Imaging Studies Appear Duplicative

Retina patients often require multiple imaging studies during the same encounter. However, performing several tests does not automatically mean all services are separately payable. One common denial trigger occurs when documentation does not distinguish the purpose of each imaging modality. Fundus photography (CPT 92250), for example, is frequently denied when billed with OCT because they are bundled together.[2] NCCI bundling edits and payer-specific policies help determine which imaging combinations may be reported together. Although many imaging combinations are allowable under NCCI guidance, payment still depends on whether each test was medically necessary, what the specific payer policy allows, and whether it provided distinct diagnostic information.[3]

Some commercial payers may apply stricter bundling edits than standard NCCI policy. When multiple imaging studies are performed on the same day, the record should clearly establish 1) why each test was ordered, 2) what unique information each study provided, and 3) how each study contributed to patient management. Without this distinction, payers may determine the tests were redundant or unnecessary. In addition, if a payer bundles two imaging services and it is inappropriate to unbundle with modifier -59, practices should ensure the billed test best reflects the imaging study that provided the most clinically relevant information for diagnosis or treatment decisions.

STABLE DISEASE ALONE MAY NOT JUSTIFY REPEAT TESTING OVER SHORT INTERVALS, AND PAYER POLICIES HAVE FREQUENCY LIMITATIONS.

COMMON AUDIT RISKS

Documentation Does Not Support the Test Performed

Again, to avoid triggering an audit, the medical record must adequately support why a specific imaging modality was selected. This is particularly important with diagnostic ultrasound. B-scan ultrasound (CPT 76512) is typically performed when the posterior segment cannot be adequately visualized; thus, simply documenting "B-scan performed" is unlikely to support reimbursement during an audit. Instead, the record should explain why visualization was limited with other imaging modalities, and what clinical question the ultrasound was intended to answer. Examples include:

- Dense vitreous hemorrhage obscuring retinal view
- No posterior view due to mature cataract
- Evaluate for retinal detachment in the setting of vitreous opacity

Similarly, FA documentation should clearly explain why angiography was needed beyond OCT or clinical examination findings—for example, the evaluation of vascular leakage, ischemia, neovascularization, or another specific clinical concern.

In general, the more invasive or resource-intensive the test, the greater the expectation that the documentation clearly supports why it was necessary.

Missing or Insufficient Interpretation and Report

An image alone is not sufficient for reimbursement. The interpretation should document clinically relevant findings, comparison with prior studies when appropriate, and the effect on diagnosis or treatment decisions. Examples of clinically relevant findings may include intraretinal or subretinal fluid, pigment epithelial detachment, vitreomacular traction, retinal nonperfusion, vascular leakage, or

disease progression compared with prior imaging.

Brief statements such as "reviewed," "stable," or "see scan" generally do not meet documentation requirements. Interpretation and report deficiencies are particularly problematic during audits because the imaging may appear clinically appropriate yet still fail to meet billing requirements due to incomplete physician documentation.

No Written Order for Delegated Tests

Another frequent audit deficiency involves the absence of a documented physician order for delegated diagnostic testing. Under the Code of Federal Regulations (42 CFR §410.32), diagnostic tests may only be ordered by the treating physician. Delegated tests performed without an appropriate physician order may be considered not reasonable and necessary and, therefore, nonbillable. When diagnostic testing is delegated to clinical staff, the medical record should contain a clear physician order before the test is performed. The order should include:

- The specific test being ordered
- The eye or site being tested
- When the test is scheduled for
- Documentation supporting medical necessity

Payers also require that delegated orders include a compliant physician signature; unsigned or incomplete orders may not support payment during audit review. However, when the physician does personally perform the test rather than delegating it to staff, the documentation should clearly reflect this, so an outside reviewer is not expecting a separate physician order in the record.

SHOW YOUR WORK

Retina imaging denials and recoupment requests are often preventable. In many cases, the imaging itself was clinically appropriate, but the documentation failed to clearly explain why the test was performed, how it contributed to management, or why multiple studies were needed. Practices can reduce denial and audit risk by implementing consistent documentation workflows. Imaging should support—not replace—clinical decision making, and the medical record should clearly demonstrate that connection. ■

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(Continued from page 12)

Technology

If yours is a high-volume practice, you may wish to incorporate self–check-in kiosks to improve efficiency. These systems must provide visual privacy, comply with HIPAA requirements, and include adequate power and data infrastructure.

Flooring

Front office flooring typically combines carpet, luxury vinyl plank, and ceramic tile. Carpet tiles are preferable to broadloom carpet because the replacement of the former is easier and more cost-effective. The rotation of carpet tiles, moreover, can extend their wear. All flooring must be commercial-grade and slip-resistant.

Ceilings and Lighting

High (approximately 10 feet) ceilings can improve the front office's brightness. Architectural or exposed ceilings require careful lighting design. Quality lighting such as Lum Lighting (Eye Designs) can enhance both patient comfort and retail presentation.

Longevity and Maintenance

Design choices should favor timeless materials and natural finishes to avoid rapid obsolescence. White remains popular in optical design, and it is often balanced with warm wood tones and muted accent colors.

Waiting areas require periodic updates. In the short term, this may include cleaning, repairs, and touch-up paint. Every 7 to 10 years, seating, lighting, and finishes should be refreshed. Existing chairs can often be moved to examination rooms where wear is less noticeable.

FINAL THOUGHTS

The front office is both the first and last impression a patient has of your practice. A well-designed space can enhance their comfort and their confidence in the care they are receiving in addition to improving practice efficiency.

Careful planning and budgeting are required to achieve these goals. Engaging a design firm that specializes in eye care environments can help ensure results that are functional, welcoming, modern, profitable, and compliant with HIPAA guidelines and the Americans with Disabilities Act. ■

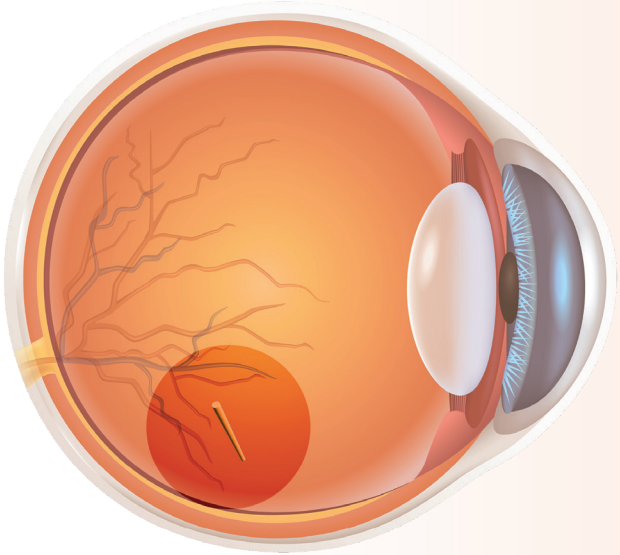
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