At present, this option is not reimbursed, though topical therapy is.

BY VANCE THOMPSON, MD

For years, the need for postoperative topical medications has been the one downside of the otherwise elegant procedure that is modern cataract surgery. Many patients struggle with compliance issues, some so severe that administration of drops becomes impossible. Others grapple with the inconvenience of using drops for several weeks postoperatively. And all must deal with continually rising drug costs that can make obtaining these drops a hardship.

Injecting an antibiotic and steroid combination intravitreally, also known as dropless cataract surgery, minimizes all these concerns. Studies have demonstrated the safety and efficacy of injecting two compounded drug combinations: triamcinolone acetonide and moxifloxacin HCl (Tri-Moxi; Imprimis Pharmaceuticals); and triamcinolone, moxifloxacin, and vancomycin (Tri-Moxi-Vanc; Imprimis).1,2

We decided to implement this approach into our practice. Our center has performed more than 6,000 cataract surgeries using dropless therapy. Actually, we call it our “drop a day” program because we still like to have patients use a topical nonsteroidal antiinflammatory drug once a day to lessen the incidence of cystoid macular edema. To date, it is not possible to inject nonsteroidal antiinflammatory drugs intraocularly. It is notable that we still offer patients the option of traditional drop therapy, but the vast majority (more than 99%) choose the injection option.

POSITIVE IMPACT, NO REWARD

Of all the recent advancements in cataract surgery, this ranks at the top as far as positive impact from the patient’s perspective. This innovative approach also satisfies the triple aims of the Patient Protection and Affordable Care Act (ACA) as few other approaches do. The ACA, in its purest form, charges physicians to provide quality patient outcomes and high levels of patient satisfaction at reduced costs. Replacing weeks of inconvenient, difficult, and costly drops with one simple injection provides patients with wonderful outcomes and reduces costs to the system. It also brings peace of mind to surgeons, with the knowledge that they do not have to rely on patients to comply with antibiotic and steroid regimens.

However, at present, despite fulfilling these aims of the ACA, prophylactic therapy against infection and inflammation with dropless therapy administered once at the time of surgery is not given additional reimbursement by Medicare. By contrast, prophylactic therapy with drops administered hundreds of times after surgery is a covered drug benefit under Medicare Part D.

This is counterintuitive; the injection, like the drops, is an additional expense that as of now must be borne by the physician. This means that the best option for patients is one that raises costs for doctors. Permitting reimbursement or allowing patient payment for these injectables would be a forward-thinking development that could provide both a medical benefit to patients and economic benefit to the system.

SYSTEM-WIDE SAVINGS

Few medical advances both create better outcomes for patients and save them money. In fact, the opposite is more typically the case.

At present, the topical medications given after cataract surgery are either covered by Medicare or paid for by the patient. With costs sometimes reaching $650 per eye,3 many patients struggle to cover the expense. Medicare likewise incurs a significant expenditure for those prescriptions that fall under their coverage. The dropless approach, on the other hand, costs as little as $20 per eye, a significant savings.

Allowing dropless technology to be covered by insurance or by patients themselves would create tremendous savings.

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Patients who chose to pay for dropless therapy would save a total of approximately $1.4 billion in out-of-pocket copayments between 2016 and 2025, while Medicare and Medicaid would save approximately $7.1 billion, and state governments would save $124 million in Medicaid payments during this time frame.3

**PRECEDENTS SET**

In the past, other products in similar situations have been granted patient-pay options. In 2005, the Centers for Medicare and Medicaid (CMS) allowed patients to pay extra for presbyopia-correcting IOLs. CMS Deputy Administrator Leslie Norwalk was quoted in the *Wall Street Journal* at that time as saying, “This is a model we can continue to use and explore. … There may be other technologies that come down the road where this approach may make sense.” That time came in 2007 with the inclusion of astigmatism-correcting IOLs, and again with femtosecond laser treatments in 2012.

The time has come once again. Allowing injectable compounded medications to be either covered or paid for out of pocket would be advantageous for patients, doctors, and the system as a whole.

As noted above, in my experience, most patients presented with the options of dropless surgery or weeks of complicated and expensive drops will choose the dropless approach. The economic advantages of allowing this option to be covered by CMS or paid for out of pocket cannot be stressed enough. The possibility of saving the health care system billions of dollars is an exciting prospect and one that I hope will soon come to fruition.


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