Point/Counterpoint: Should Patients Share the Cost of MIGS Procedures?
Yes, they deserve an opportunity to consider all of their options.
By John Berdahl, MD

Patients already share the cost of their care, and they should—to a degree. The question is, how much should be borne by the patient? Currently in the United States, the financial incentives are incredibly misaligned. Payers are motivated to pay as little and as infrequently as possible for medical care. Doctors are financially incentivized to order more tests and perform more services (both to decrease the risk of litigation and potentially to increase revenue), and patients have little skin in the game, so to speak, when it comes to the cost of their care (especially when deductibles are met). Of course, doctors have taken an oath to put patients’ needs before their own, and the vast majority of doctors take this oath very seriously. I suspect few doctors actually perform unnecessary tests or procedures in order to line their pockets. Assuming that doctors are always trying to put the needs of their patients first allows a conversation about whether or not microinvasive glaucoma surgery should have a self-pay component for patients.

DISTINCTIONS IN REIMBURSEMENT
The first matter is to distinguish between on-label, off-label, and third-party reimbursement. On label simply means that the FDA and the manufacturer have used the available data to negotiate a label that describes indications, effectiveness, and safety parameters. Off label is when a drug or device is not used in strict adherence to the negotiated label. Many procedures and even approaches that are the standard of care are off label such as the use of antibiotics after cataract surgery. Third-party reimbursement does not depend on the FDA label. Third-party reimbursement is much more of a “black art” that occurs as companies and physicians reach out to the Centers for Medicare & Medicaid Services or third-party payers in an effort to convince them with the available data, experience, or standard of care that a particular product or service should be reimbursed. This process often takes years after the accumulation of well-established data or experience.

THE PHYSICIAN’S RESPONSIBILITY
Physicians’ primary job is to do the right thing for the patient in front of them. The most important question I ask myself in every encounter with patients is, “What would I do if this were my eye?” Considering this question helps me cut through the noise to focus on my responsibility to my patient and the oath that I took. I should note that what is best for a patient’s eye is not always what is best for his or her life. Many times, a patient simply cannot afford the ideal approach to care, which is unfortunate. My starting point is always the best thing for the eye, however, and then I see if that can fit in with the patient’s financial situation and other issues going on in his or her life.

A good example of this approach is the placement of a second iStent Trabecular Micro-Bypass Stent (Glaukos) in the setting of moderate to severe glaucoma. A reasonable amount of data suggests that a second iStent can incrementally lower IOP [Author: please provide reference 1]. If a person has a cataract and moderate to severe glaucoma
and is using two IOP-lowering medications, my preferred approach is cataract surgery plus the placement of two iStents. In fact, I almost always try to perform a microinvasive glaucoma surgical procedure prior to advancing to a tube or a trabeculectomy. Given the abysmal long-term outcomes reported in the Tube Versus Trabeculectomy (TVT) study [Au: please provide reference 2], if it were my eye, I would certainly want two stents plus or minus endocyclophotocoagulation prior to moving on to a much more invasive and risky surgical intervention.

PAYMENT

Because many (but not all) payers will not pay for a second iStent, should the patient have the option to cover the cost? Of course! Should doctors, ambulatory surgery centers, or hospitals bear the cost of a second iStent? I would argue no. We are providing a service to the patient. After receiving clear and transparent education on the risks, benefits, and alternatives, and after completing a strong financial informed consent with an Advanced Beneficiary Notice of Noncoverage, patients should be able to choose and pay for the treatment that they and their doctor agree is best for the patient’s eye. I feel that physicians are obligated to offer patients all of the options that are best for their eyes, with financial considerations being an important element of that discussion.

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