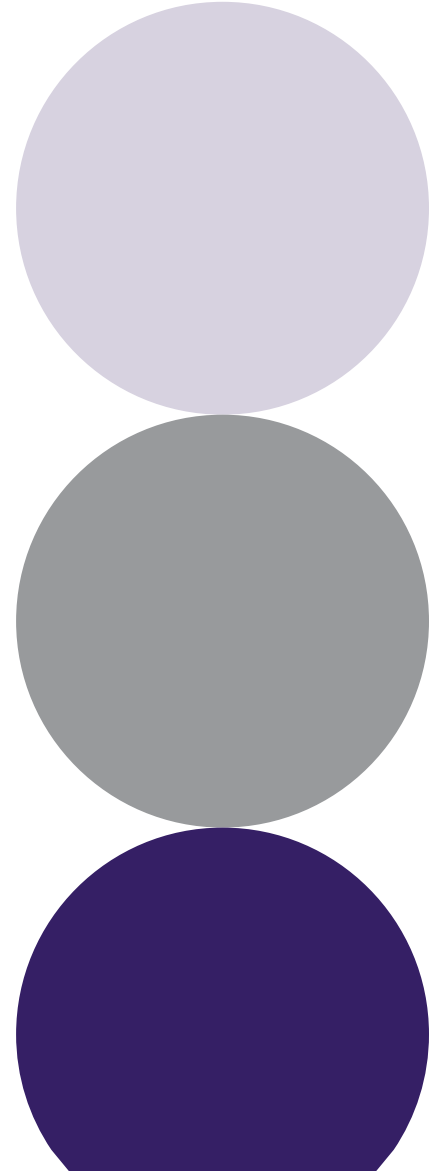


Practice Management 2026: How to run a high-performing ophthalmology practice in today's environment

Ravi D. Goel, MD
Instructor, Wills Eye Hospital
Regional Eye Associates, Cherry Hill, NJ

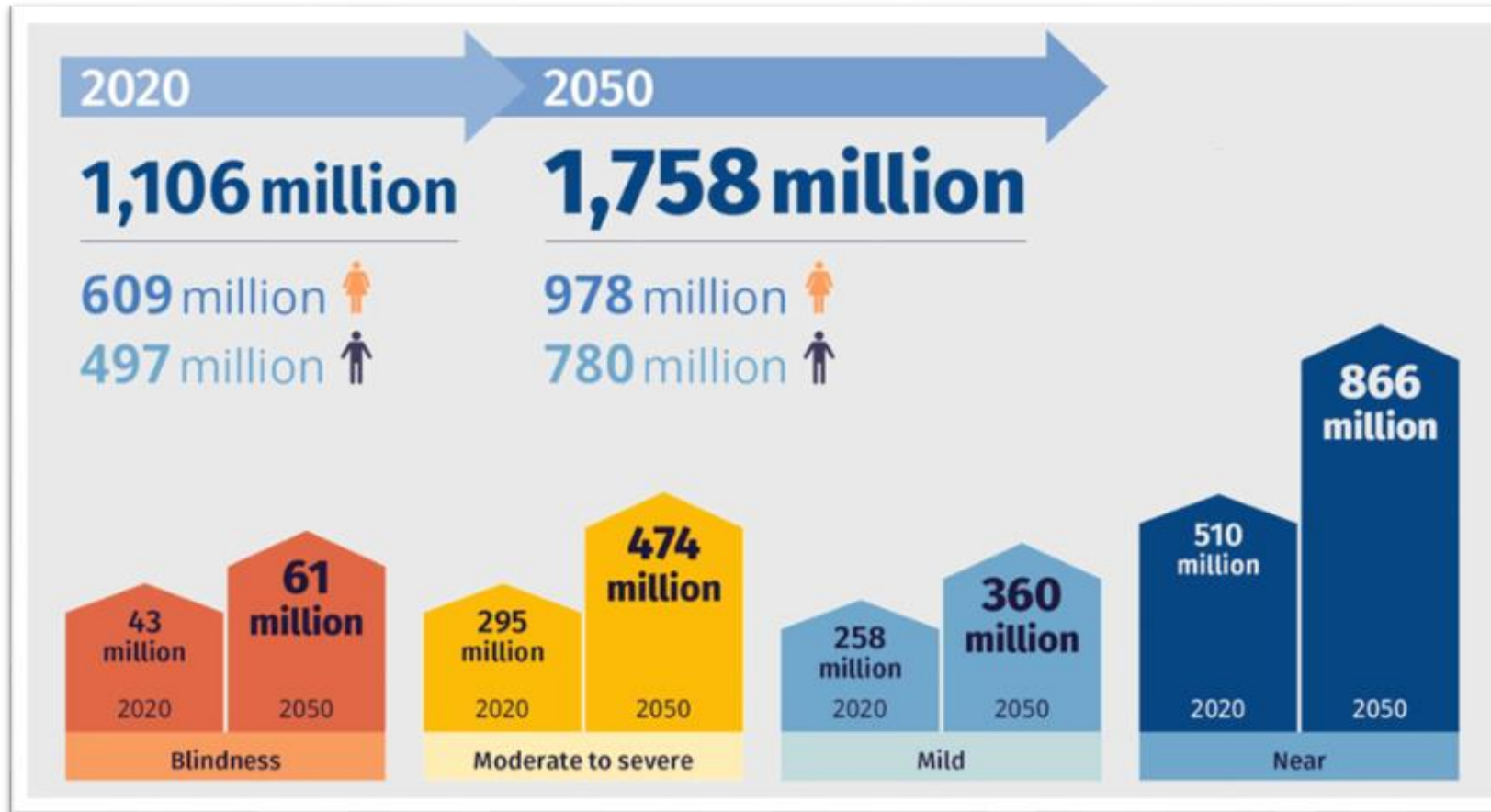


Financial Disclosure

- I have the following financial interests or relationships to disclose:
 - DORC, LLC: Lecture Fees/Speakers Bureau
 - iVeena Delivery Systems Inc.: Equity / Stock Holder

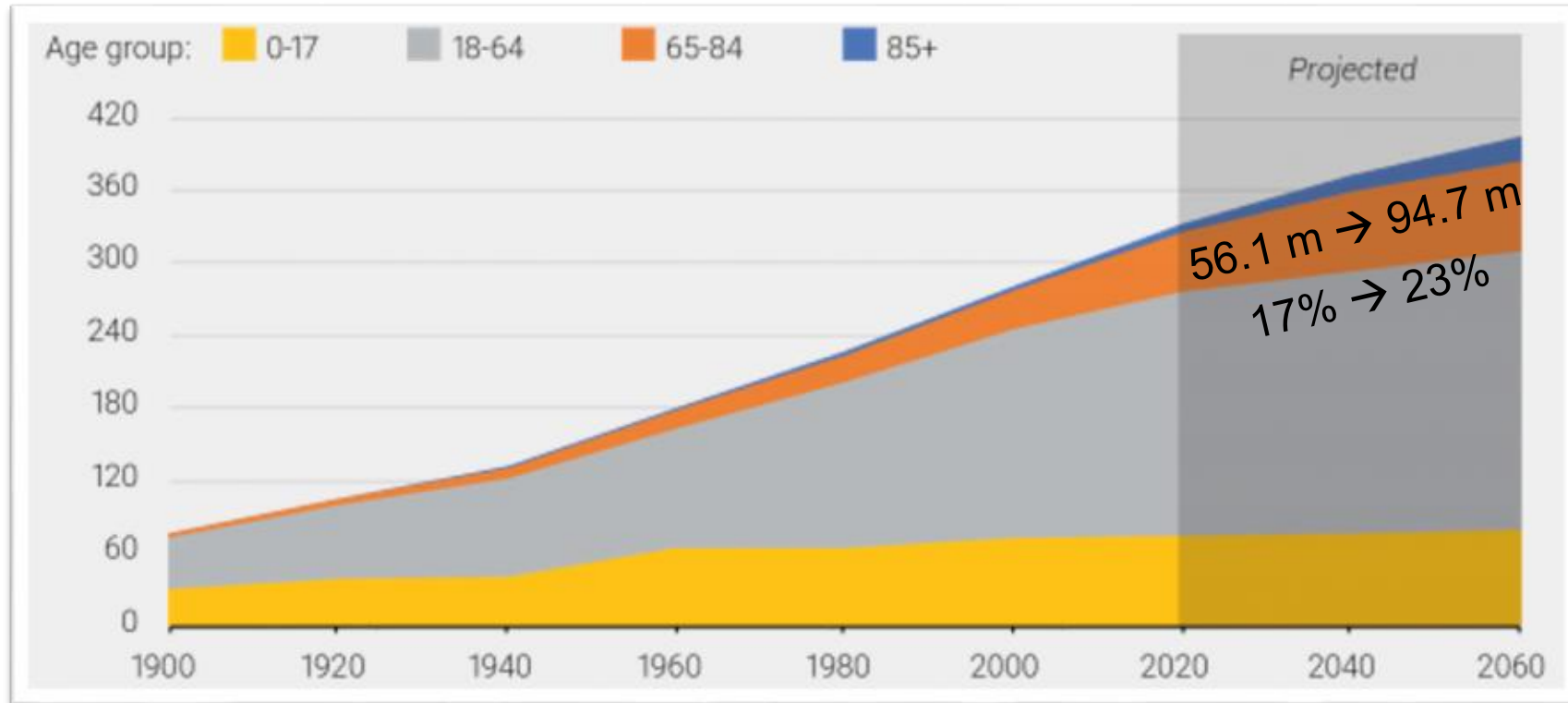


Projected Vision Loss: 2020 vs. 2050





U.S. Population by Age Group, 1900 to 2060



Source: U.S. Census Bureau, decennial censuses and vintage 2017 population projections (2020-2060, in millions).



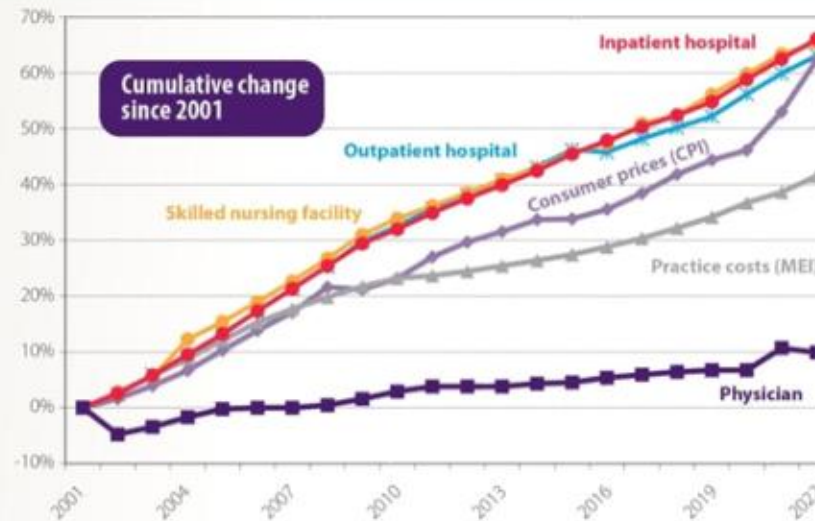


Medicare Payment Decline

Medicare physician payment is **not** keeping up with inflation. Why are physician services taking a backseat?

Medicare updates compared to inflation (2001–2022)

Adjusted for inflation in practice costs, Medicare physician payment declined 22% from 2001 to 2022.



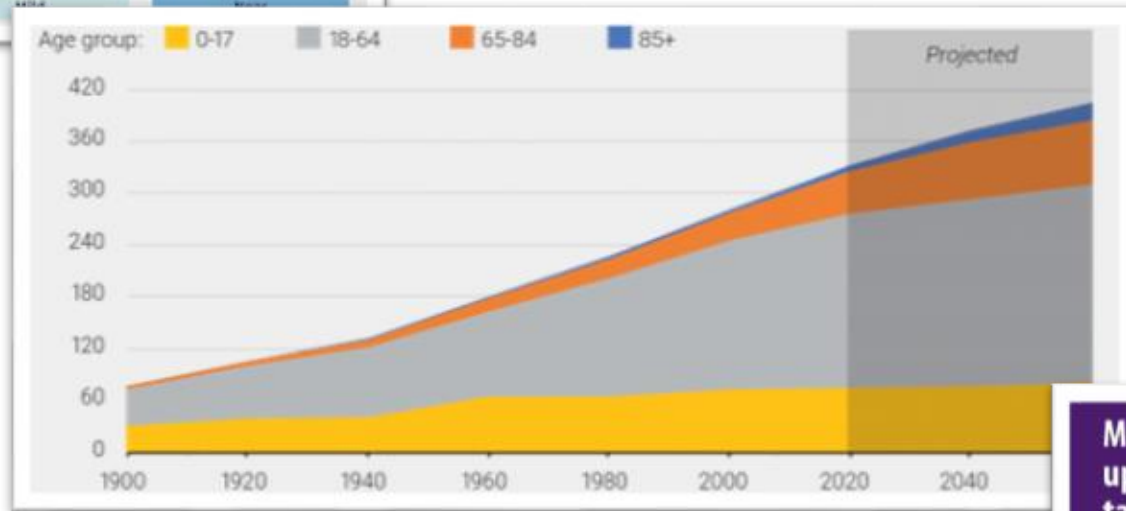
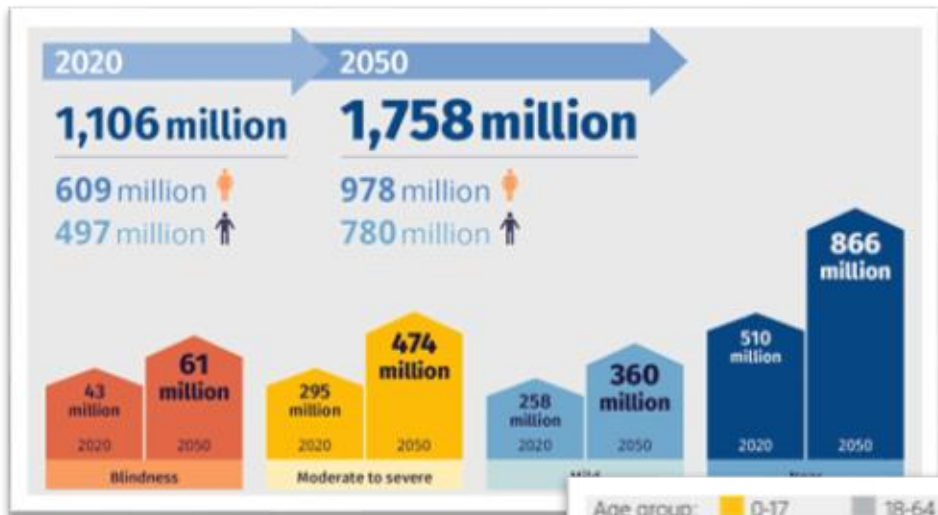
Sources: Federal Register, Medicare Trustees Reports and U.S. Bureau of Labor Statistics, American Medical Association, Economic and Health Policy Research, September 2022.





Medicare Payment Decline





Medicare physician payment is **not** keeping up with inflation. Why are physician services taking a backseat?

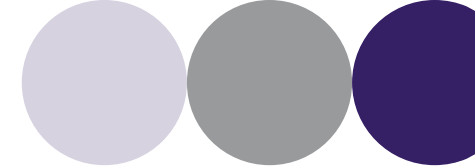
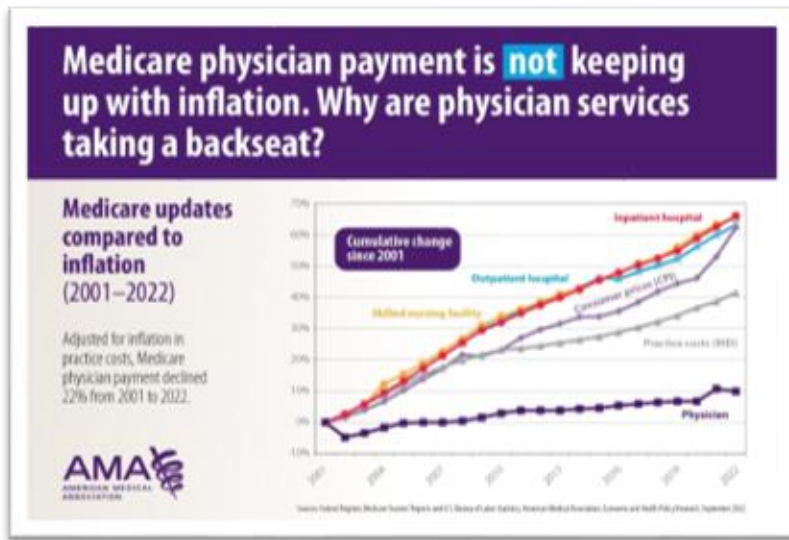
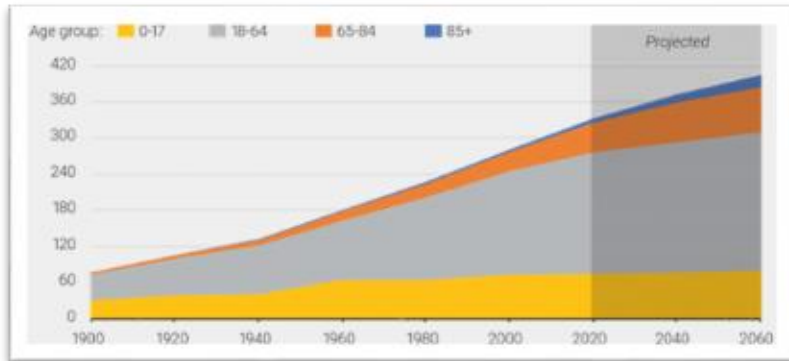
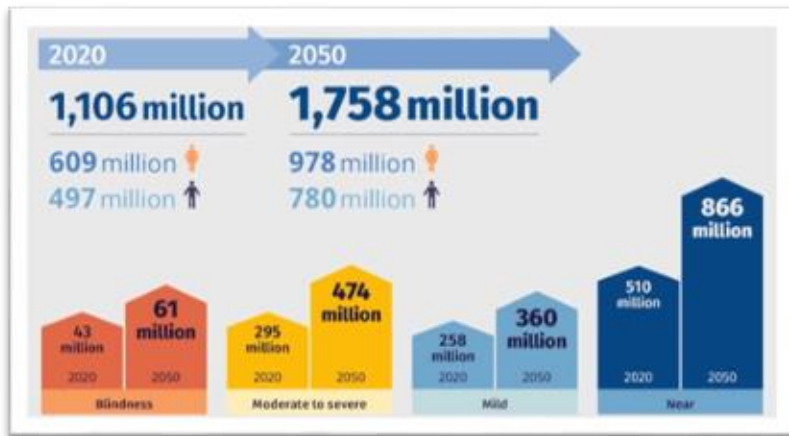
Medicare updates compared to inflation (2001–2022)

Adjusted for inflation in practice costs, Medicare physician payment declined 22% from 2001 to 2022.

Category	2001	2022
Inpatient hospital	100%	~150%
Outpatient hospital	100%	~130%
Skilled nursing facility	100%	~110%
Consumer prices (CPI)	100%	~120%
Private sector (BLS)	100%	~110%
Physician	100%	~78%

AMA
AMERICAN MEDICAL ASSOCIATION

Source: Federal Reserve, Medical Trend Report, and U.S. Bureau of Labor Statistics, Health and Retirement Income and Health Care, December 2022



The Reality

THE ENVIRONMENT OUR PRACTICES FACE



Demand

Patients need us more than ever



Payment

Reimbursement continues to decline



Complexity

Operations, staffing, and admin burden are rising



Success in 2026 isn't about seeing more patients— it's about running a **better practice.**

@RaviGoelMD





The Reality

THE ENVIRONMENT OUR PRACTICES FACE



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Success in 2026 isn't about seeing more patients—it's about running a **better practice**.

Threats

California legislators considering reducing requirements to perform eye surgery

August 29, 2022

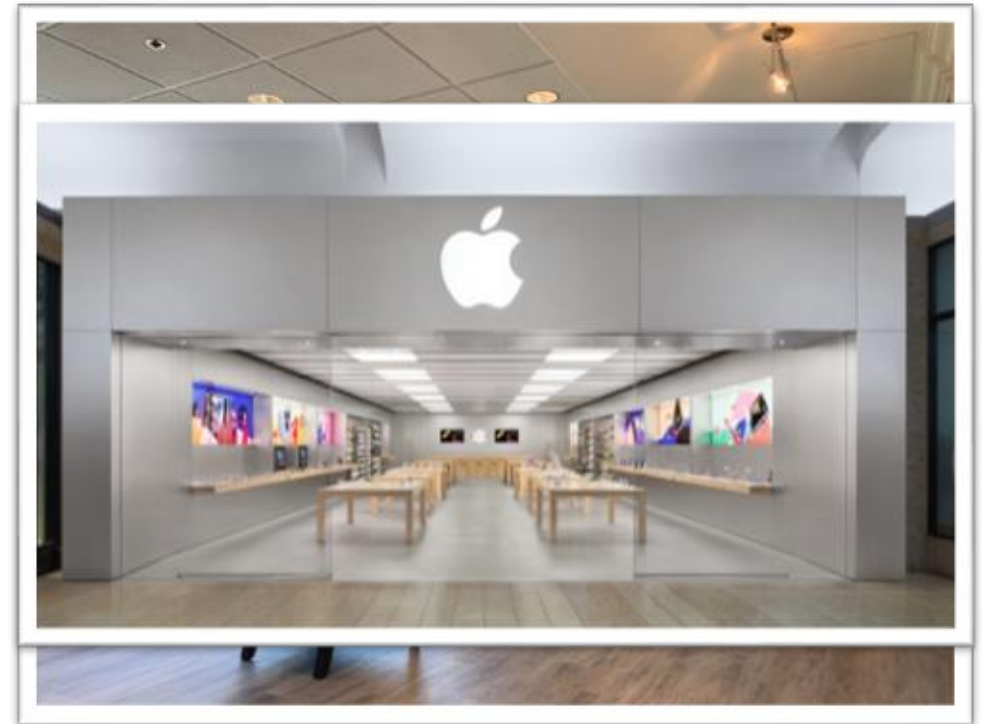
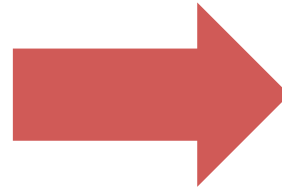
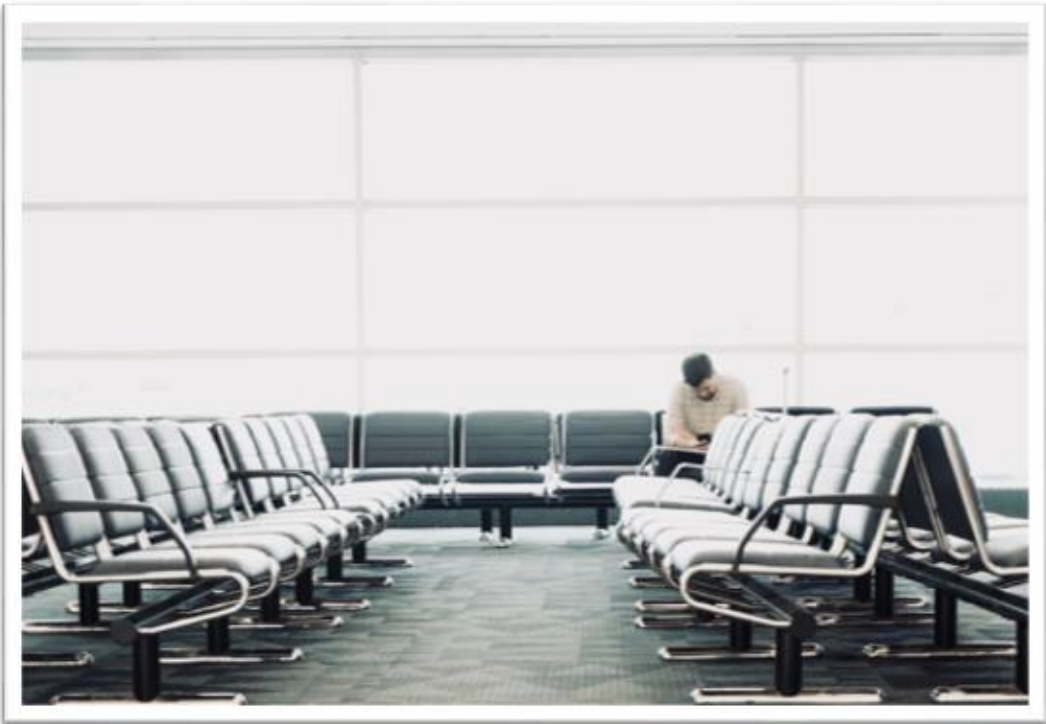
David Hutton



AB 2236, which would reduce the medical education, clinical, and surgical training requirements to become licensed in California to perform eye surgery. Trade organizations and other groups are stepping up to oppose the measure.

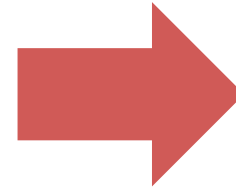


The Patient Experience



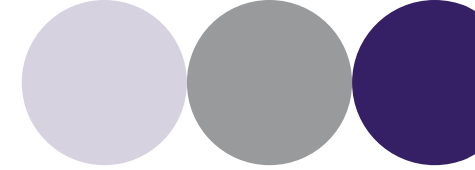


Principles to Improve the Patient Experience



1. Patients Are Consumers
2. Experience > Technology
3. Processes Drive Outcomes





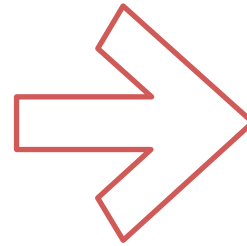
“It takes 20 years to build a reputation and five minutes to ruin it.”

Warren Buffett

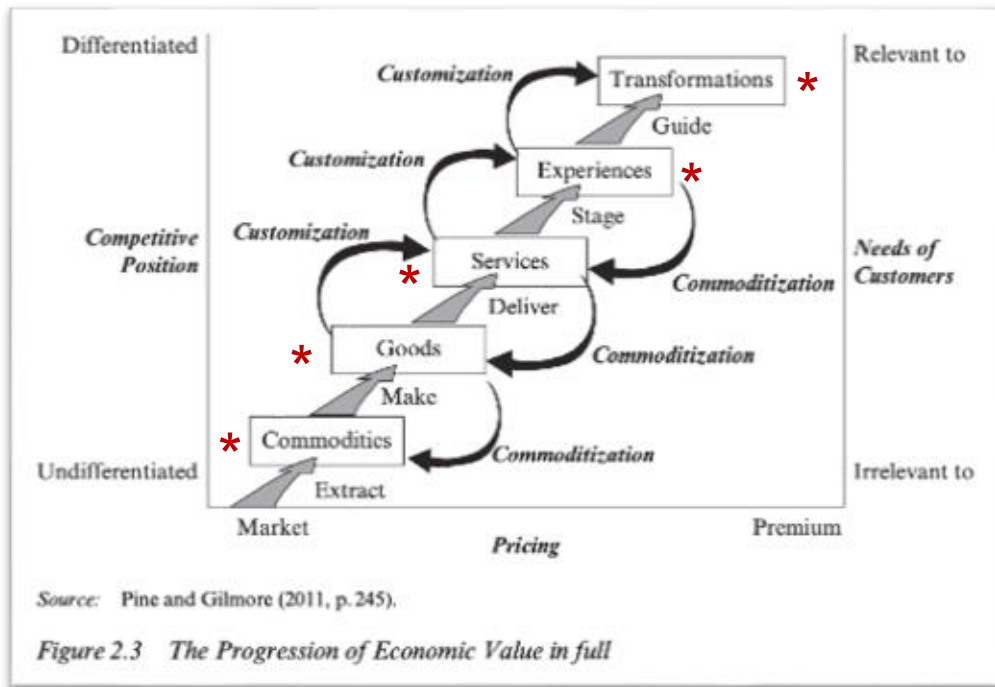




One Bad Experience Scales



The Progression of Economic Value



\$0.05 / cup



\$0.15 / cup



\$1.50 / cup

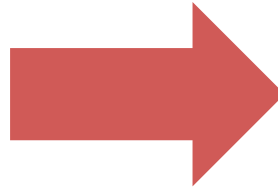


\$3-6 / cup



\$75 / cup

The Progression of Ophthalmic Value



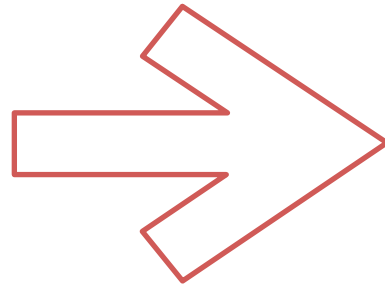
Images from Unsplash

@RaviGoelMD

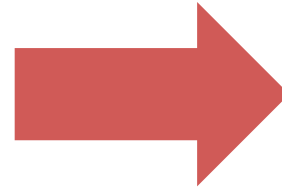
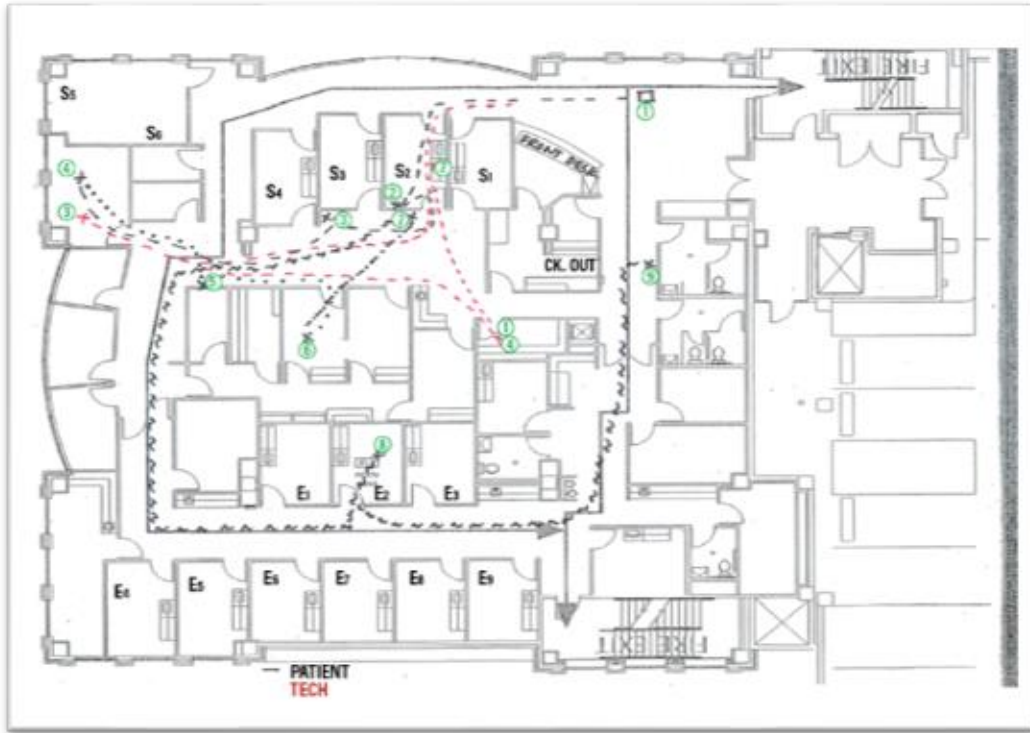


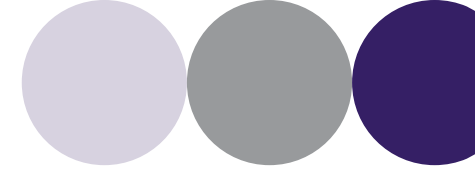


Patients Choose Brands



Patient Flow Redesign





Where Practices Actually Lose Money (Operationally)



Inefficient Staffing



Physician Idle Time



Poor Clinic Flow



Supply Waste



Underutilized OR Time



Most practices have a **cost control problem.**





Top 5 Cost Levers



Staffing
model



Clinic
throughput



OR
utilization



Supply
standardization



Vendor
negotiation



Most practices have a **cost control problem.**





If You Fix Only 3 Things




- 1 No-show rate
- 2 Technician utilization
- 3 Physician idle time

Focus here first—**high ROI.**





The Risk You Don't See

-  Happens in every specialty
-  Small amounts over time
-  Long-term accumulation
-  Trusted employees





Regional Eye Associates

Unsplash

@RaviGoelMD



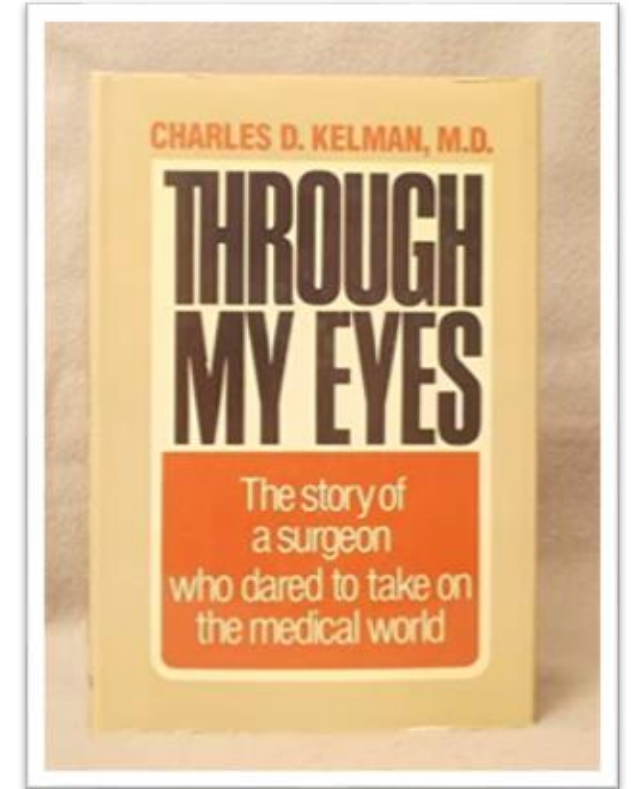
Case Study



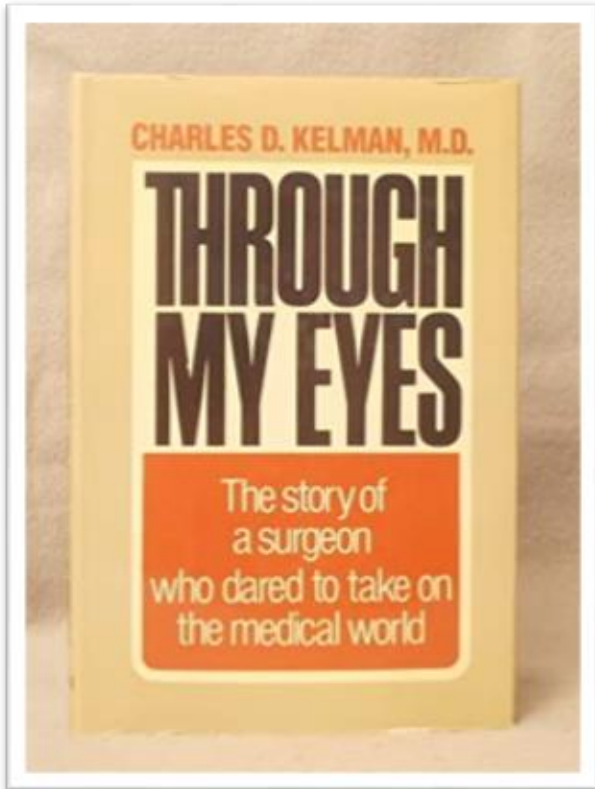
1. "I trusted her implicitly."
2. "You're so busy, let me make the deposits."
3. Checks were deposited & cash was not.
4. No bank statement to computer reconciliation.
5. Accountant denied responsibility.
6. "I didn't know the passwords."
7. "I didn't check background references."



Charles D. Kelman, M.D.



“Nearly responsible for my downfall”



THROUGH MY EYES

With Cheryl so occupied, I needed someone else in the office, and after interviewing many, chose Marcia to take on some of Cheryl's duties, including typing up my confidential operative reports on the phacoemulsification patients.

Marcia, who had a warm, southern drawl; Marcia who had a wonderful sense of humor; Marcia who would soon nearly be responsible for my downfall. . . .

One evening, with Cheryl and Marcia gone for the day, the phone rang; it was a patient requesting a receipt. I remembered examining him that day, but when I looked at Marcia's daily sheet, his name was not there. He said that he had paid in cash. It could mean only one thing: Marcia had pocketed the sixty dollars and had made the records correspond to the theft by omitting his name. There was no way of knowing how much she had taken prior to that day. The next day I confronted her. She admitted the theft, pleading dire financial straits because of an ailing mother. But I had no choice, I had to let her go. I told her to leave as soon as Cheryl came back from the lab; I left her alone in the office.

My remaining staff consisted of Otto, my German engineer, and Joe, my office administrator.



“You have blinded four people.”

I left the hospital and returned to my office to find Joe anxiously waiting for me. Anguish, like a silk-stocking mask, deformed his face. It had been two weeks since I'd fired Marcia. "Charley, Tom Wurtz telephoned," Joe said, as if announcing a funeral. "We got a problem, buddy; we got a real problem." Joe shook his head up and down, as if to impress me with the gravity of the situation.

Wurtz was head of anesthesia at Mid-Cities and chairman of the medical board. He had always been friendly to me since we shared a common love, flying. He and his son owned an airplane, and I had always been interested in piloting and even took some lessons. I called him on the telephone.

"Dr. Kelman"—he was now formal—"someone has informed the hospital directors that you are doing experimental surgery and that you have blinded four people." I was stunned. "The board is going to hold an inquiry. If the charges are true, if this experimental surgery has caused patients to lose their vision, you must be dropped from the staff of the hospital." He said all of this as if hoping the accusations were false but believing that they were true.

The hearing was to be in two days; I could, if I wished,

“The board is going to hold an inquiry.”



Regional Eye Associates

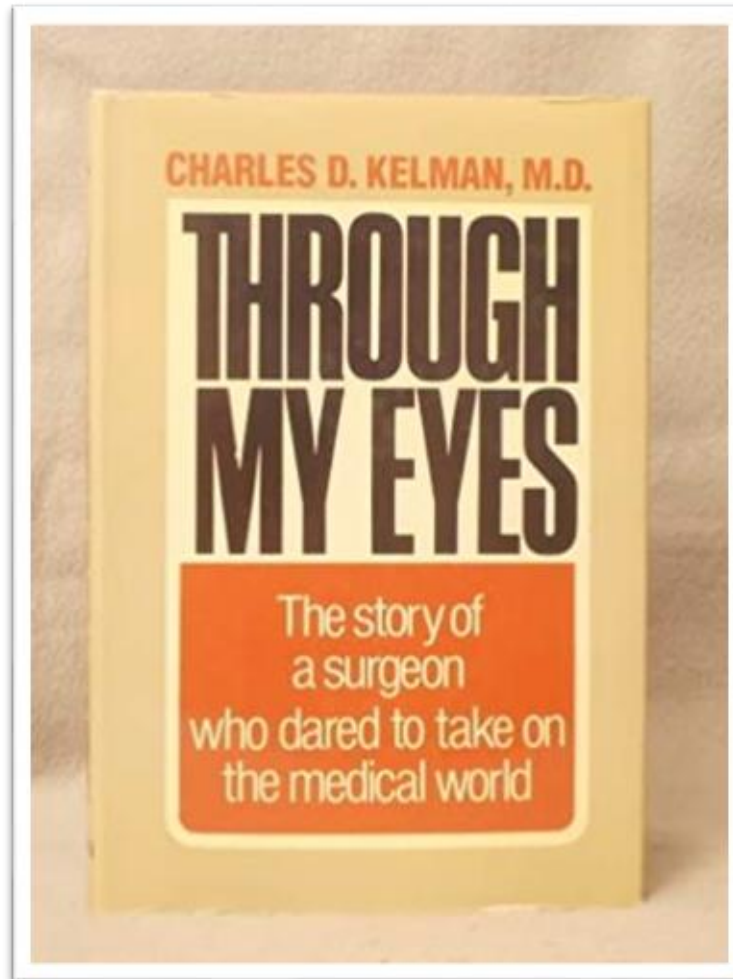


Photo: Kevin Balingit, You X Ventures (Unsplash)

the charges would be dropped. No one, after all, had the right to dictate to me what type of operation I could do—as long as I was getting good results.

I rushed to my files for the records of those four patients. The first one I sought was missing—probably misfiled, I thought. The second file I sought was missing; the third and the fourth were not there either. My records were gone. Oh my God! Marcia! I had left her alone in the office after I'd fired her. The pieces suddenly fell into place.

Lying on my back in the lonely den that night, watching the reflections of passing headlights bounce off the ceiling, I had a lot to think about. Abe Levin's operation that day had been a triumph: When I had examined him before I came home, his eye looked really good, better, in fact, than any cataract operation I had ever done by the usual method. His cornea had no swelling, his eye had no redness, and there was no sign of infection. Looking at him from two feet away, it was impossible to tell that Abe had had surgery. Had I not had to worry about the inquest, I would have been drinking champagne.

The phone rang in the middle of the night. I was still

“Oh my God! Marcia!”

@RaviGoelMD





the charges would be dropped. No one, after all, had the right to dictate to me what type of operation I could do—as long as I was getting good results.

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“Oh my God! Marcia!”



Regional Eye Associates

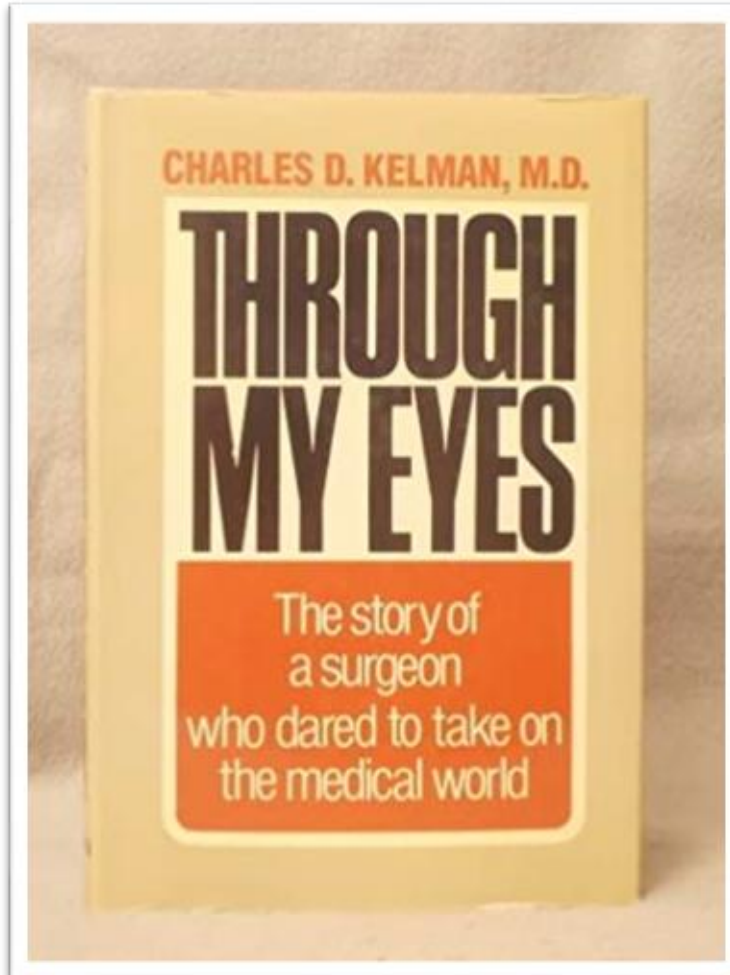


Photo: Kevin Balingit, You X Ventures (Unsplash)



“Marcia, Marcia, Marcia!”

@RaviGoelMD



Red Flags

1. No vacations
2. Defensive behavior
3. Financial inconsistencies
4. Lifestyle mismatch



Simple Safeguards

1. Separate duties
2. Daily reconciliation
3. Random audits
4. Physician oversight



Financial Controls

1. Patient revenue transactions
2. Petty cash
3. Purchasing and payment functions
4. Bank accounts
5. Corporate credit cards
6. Payroll
7. Inventory
8. Practice vehicles, cell phones and computer equipment.

APR 09, 2018

Protecting Your Practice from Embezzlement

By Sara Burns Rapuano, MBA, OCS

+ Add to My Bookmarks ▾

Comments

Views

Embezzlement poses a real threat to physician practices. If you do not have well-defined financial controls or monitor them closely, your staff may be able to pocket co-payments or other revenue, divert credit card payments to their own bank account, overpay themselves or their friends, take inventory of medications, glasses or contact lenses or use the corporate credit card for personal items.

Even if you think your staff would never steal from you, checks and balances protect you from sloppy practices that can lead to poor charge capture and overpayment for supplies and services. To reduce the opportunity for theft and maximize your bottom line, it is critical that you have a strong system of financial controls





Dr. Neil S. Srinivasan, MD, FACS

CONTROLLING HIDDEN COSTS

TO IMPROVE YOUR BOTTOM LINE

When physicians talk about improving profitability, the conversation often jumps straight to adding new services, performing more procedures, or increasing patient volume. While these strategies can generate revenue, they overlook the single greatest and most controllable driver of profitability: reducing the hidden, internal costs of running a medical practice.

My own thinking on cost control has long been shaped by lessons from great entrepreneurs. At the turn of the 19th century, Andrew Carnegie became one of the wealthiest individuals on earth not by selling more steel, but by obsessively lowering the cost of production. He famously advised, "Watch the costs and the profits will take care of themselves." He understood that disciplined cost management

creates resilience in downturns and magnifies profits during periods of growth.

Modern leaders from Elon Musk to Jeff Bezos follow this same philosophy, scaling their enterprises by relentlessly improving efficiency. For ophthalmologists, the principle is no different. Before expanding OR blocks or opening additional clinic sessions, we should examine how to reduce the cost per patient encounter. Even small efficiencies, multiplied across thousands of visits, can substantially improve the bottom line.

In my own practice, I have identified four categories of hidden costs that threaten profitability.

1. Loss of Cash (Including Embezzlement)

Cash leakage, especially through embezzlement, is more common in medical practices than many realize. One estimate suggests up to 80% of practices will experience embezzlement within five years.

Pearls include:

- Segregate financial duties so that no one employee controls collections, deposits, and reconciliations.
- Perform routine and surprise audits, including reviewing bank statements personally each month.
- Remove signature stamps and require dual signatures on checks.
- Create a culture where transparency and verification are expected, not viewed as mistrust.
- A single point of failure can eliminate the revenue from dozens of cataract surgeries—and the emotional cost of betrayal can be equally damaging.

2. Loss of Time

Time is one of the most undervalued assets in medical practice. Hours are lost daily to prior authorizations, inefficient processes, and staff who are physically present but not contributing productive work.

Strategies include:

- Standardize common workflows
- Streamline DRG templates
- Track time-based productivity
- Outsource administrative bottlenecks, such as prior authorizations or insurance verification
- Build a culture where time is treated as currency
- Even modest improvements in throughput boost profitability across a full clinic schedule.

3. Loss of Product

Inventory mismanagement is a quiet but costly drain, especially with high-cost products such as retinal injection medications. A lost, expired, or mishandled vial can cost thousands.

Pearls include:

- Implement supervisory approval for all purchasing
- Set purchase limits
- Conduct quarterly inventory audits
- Separate ordering, receiving, and reconciliation responsibilities
- Track expiration dates with a simple shared log or digital tool
- Small, repeated product losses compound quickly.

4. Loss Due to Meretricious Relationships

Inappropriate relationships with vendors, whether staff receiving personal benefits or colleagues entering into biased agreements, can significantly inflate practice expenses. These arrangements are unethical, potentially illegal, and harmful to profitability.

Safeguards include:

- Competitive bidding
- Transparent procurement processes
- Clear conflict-of-interest policies
- Vendor rotation and documented price comparisons

Improving the bottom line does not require radical changes. It requires vigilance, discipline, and a willingness to examine the silent financial leaks that erode profitability. Channeling Carnegie's wisdom, practices that watch their costs every day, in every corner of operations will position themselves for long-term financial strength and growth.





Top Pearls to Implement **Monday Morning**

Create a High Performing Ophthalmology Practice



Start On Time



Communicate Clearly



Focus on Efficiency



Engage Your Team



Enhance Patient Experience



Follow Up on Action Items



Pearl #1 – Augmented Intelligence (AI)



RAVI
This is my cataract surgery dictation below. Optimize the language to make most efficient and clear.

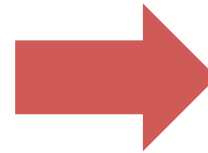
CHATGPT
Of course, please provide the dictation for your cataract surgery, and I'll help optimize the language for efficiency and clarity.

RAVI
PREOPERATIVE DIAGNOSES:
POSTOPERATIVE DIAGNOSES: SAME
PROCEDURE PERFORMED: Phacoemulsification, right eye with insertion of a posterior chamber lens.
INTRAOCULAR LENS:
ANESTHESIA: Topical with intracameral lidocaine. Monitored anesthesia care (MAC).
COMPLICATIONS: None.
INDICATION FOR SURGERY:

DESCRIPTION OF PROCEDURE: The patient was brought to the operating room and was positively identified by the attending surgeon, Ravi Goel, M.D. A time out was called and the patient's name, operative eye and planned intraocular lens selection were confirmed. The patient was prepped in a standard sterile fashion.

Attention was turned to the operative eye. A lid drape was placed, incision made with drape scissors, and a lid speculum was then placed to expose the operative eye. Tetracaine and balanced salt solution were placed on the eye. A side-port incision was created at 11 o'clock. Non-preserved lidocaine with epinephrine was injected into the anterior chamber. Viscoat and Provisc were placed using the soft-shell technique. The main wound incision was fashioned at the 9 o'clock position using a 2.75-mm phaco knife. A continuous tear capsulorrhexis was then performed. Hydrodissection and hydrodelineation were used to loosen the nucleus within the capsular bag. The nucleus was removed by phacoemulsification using the stop-and-chop technique. Residual cortical material was removed using irrigation and aspiration.

The lens bag was filled with viscoelastic. A foldable acrylic implant was then placed within the capsular bag. Residual viscoelastic was removed. The eye was re-pressurized with balanced salt solution. Moxifloxacin was injected into the anterior chamber. The wound was checked with Weck-cel sponges and was found to be secure and watertight. The lens was centered. The lid speculum was removed. Antibiotic and anti-glaucoma medications were placed in the eye. The patient left the operating room having tolerated the procedure well.

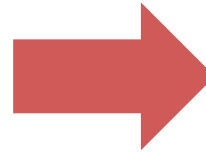
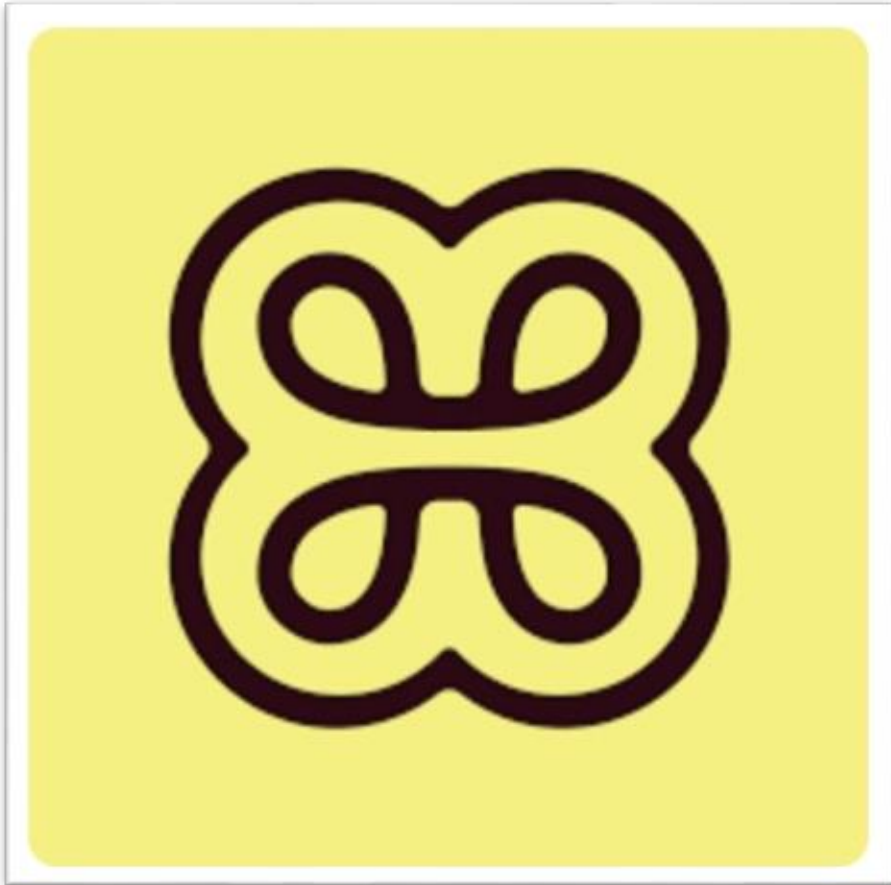


CHATGPT
Preoperative Diagnosis: Cataract, right eye
Postoperative Diagnosis: Cataract, right eye
Procedure: Phacoemulsification with posterior chamber lens insertion
Intraocular Lens: [Specify lens type, if applicable]
Anesthesia: Topical with intracameral lidocaine; Monitored anesthesia care (MAC)
Complications: None
Indication for Surgery: [Provide specific indication, if available]
Procedure Description:

1. Patient identification was confirmed, and a time-out was conducted, verifying patient's name, operative eye, and planned intraocular lens.
2. Standard sterile preparation was performed.
3. The operative eye was exposed using a lid speculum after making an incision with drape scissors.
4. Tetracaine and balanced salt solution were applied to the eye.
5. A side-port incision was made at 11 o'clock.
6. Non-preserved lidocaine with epinephrine was injected into the anterior chamber.
7. Viscoat and Provisc were applied using the soft-shell technique.
8. The main wound incision was created at the 9 o'clock position with a 2.75-mm phaco knife.
9. A continuous tear capsulorrhexis was performed.
10. Hydrodissection and hydrodelineation were used to facilitate nucleus loosening within the capsular bag.
11. The nucleus was removed via phacoemulsification using the stop-and-chop technique.
12. Residual cortical material was removed using irrigation and aspiration.
13. The lens bag was filled with viscoelastic.
14. A foldable acrylic implant was placed within the capsular bag.
15. Residual viscoelastic was removed.
16. The eye was re-pressurized with balanced salt solution.
17. Moxifloxacin was injected into the anterior chamber.
18. The wound was assessed and found to be secure and watertight using Weck-cel sponges.
19. The lens was centered.
20. The lid speculum was removed.
21. Antibiotic and anti-glaucoma medications were instilled.
22. The patient left the operating room having tolerated the procedure well.



Pearl #1 – AI scribe



Bilateral CNevi
03/23/2026 1:20pm 5:02

Ophthalmology Note

Context

Subjective:

- Reports vision is okay but did not read the chart well today.
- Past ocular history:
 - Left eye cataract surgery on 02/22/2022.
 - Right eye cataract surgery on 02/22/2022.
- Family history of eye diseases or inherited ocular conditions:
 - Father had a freckle in the eye.
 - Mother also had a freckle in the eye.
- Social history including tobacco and alcohol use, and occupational hazards:
 - Husband is a non-smoker.

Objective:

- Intraocular pressure measurement method and values (OD, OS):
 - OD: 18 mmHg
 - OS: 21 mmHg
- Findings from anterior segment examination including slit-lamp assessment:
 - OD: Post-cataract surgery, +2.00 to +3.00 correction.
 - OS: Post-cataract surgery, +2.00 to +3.00 correction.
- Findings from posterior segment examination including dilated fundus exam:
 - OD: Choroidal nevus noted. Retina appears normal. Macula is good.
 - OS: Choroidal nevus noted. Retina appears normal. Macula is good.

Assessment:

- Choroidal nevi, bilateral. Discussed that approximately 5% of patients have these and they can grow, but current findings are stable.

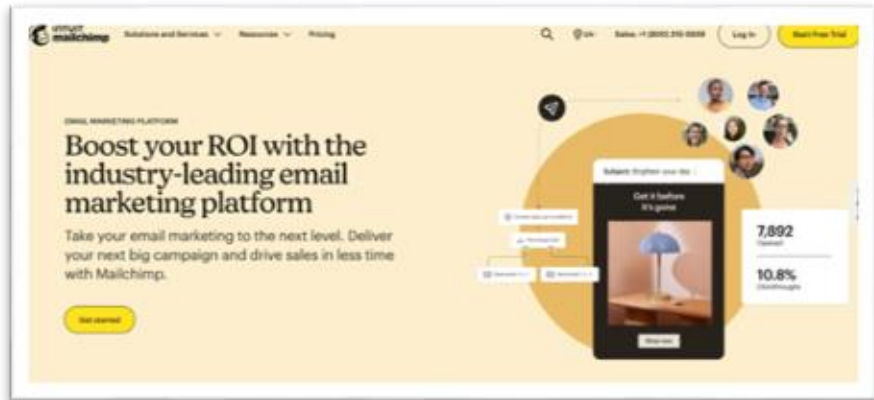
Plan:

- Follow-up in 6 months.
- Discussed right eye cataract, which is not currently bothersome. No intervention planned at this time.


Provide feedback

Resume

Pearl #2 – Email marketing



Eye Health Observances
January - Glaucoma Awareness Month
February - Age-Related Macular Degeneration Awareness Month
March - Workplace Eye Wellness Month
April - Sports Eye Safety Month
May - Healthy Vision Month
June - Fireworks Eye Safety & Cataract Awareness Month
July - UV Safety Month
August - Children's Eye Health/Safety Month
September - Healthy Aging Month
October - Halloween Safety Month
November - Diabetic Eye Disease Awareness Month
December - Safe Toys and Celebrations Month



Regional Eye Associates

Seven Myths About Sunglasses That Could Damage Your Vision




Did you know that too much sun on unprotected eyes increases the risk of eye disease? The good news is that prevention is simple: Wear sunglasses that block 99 to 100 percent of UVA and UVB radiation. But there are a lot of common myths about sunglasses and eye health. That's why Regional Eye Associates and the American Academy of Ophthalmology are working to debunk the myths and offer tips to promote smart eye health choices.


(**No financial interest)

@RaviGoelMD

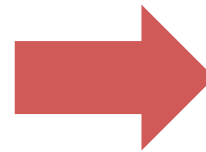





Regional Eye Associates
[View this email in your browser](#)



Dear Ravi,
Happy Birthday from the team at Regional Eye Associates!
Wishing you a day filled with joy!
Cordially,
Ravi D. Goel, MD
Michele A. Miano, MD



Happy Birthday!

Sending Last sent Today, 6:06 AM

Subject	Happy Birthday from Regional Eye Associates!
Audience	Regional Eye Associates
URL	http://jeepurl.com/in7MmE

Engagement

684 Unique opens	▲ 56.3%
57 Unique clicks	▲ 4.7%

Performance

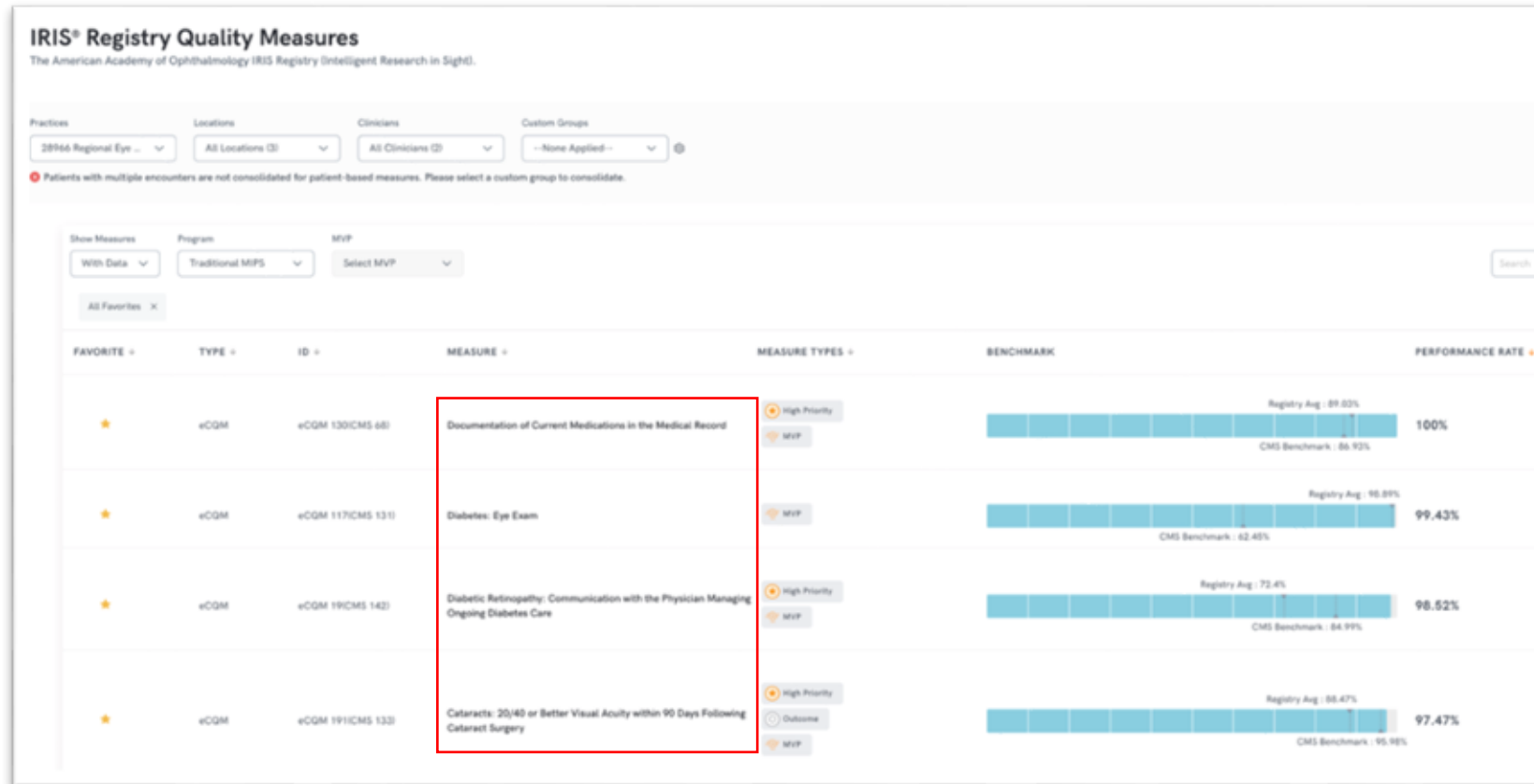
Abuse reports	1
Recipients	1,244
Unsubscribes	8
Successful deliveries	1,215
Bounced	29
Total opens	1,156
Total clicks	90
Forwarded	0
Forwarded opens	0

Pearl #3: Big Data

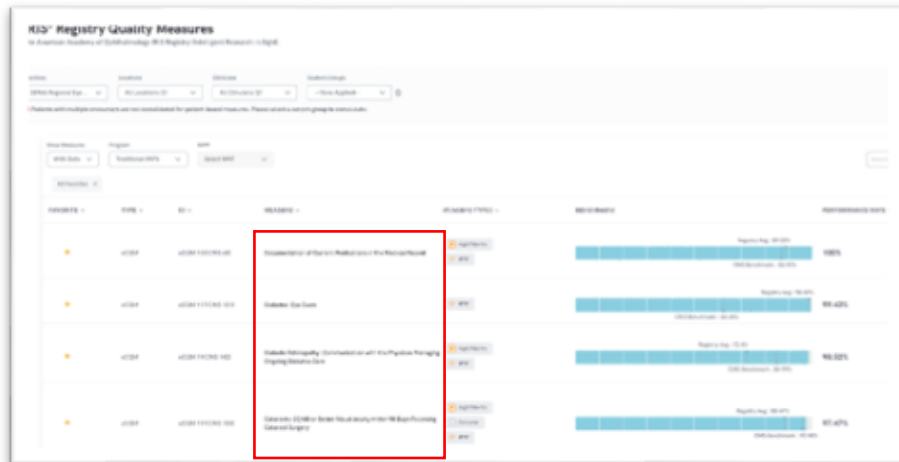
1. Identify Blind Spots
2. Improve Decisions



IRIS Registry



IRIS Registry



Documentation of Current Medications in the Medical Record

Diabetes: Eye Exam


Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery



Pearl #4 – Collaboration

Benefits of AAOE Membership	
AAOE-Talk	Join the members-only online community to connect throughout the day with supportive peers, have questions answered and share opinions about issues that matter right now.
Video Education Library	An expanding online resource with coding courses, practice management instruction, select Annual Meeting sessions and popular webinars that explore a multitude of topics.
Practice Forms Library	A comprehensive collection of ophthalmic medical practice forms supplied and shared by your colleagues.



AAOE-Talk
1453 group members

Members Resources Events

AAOE Members-Only Website	Find valuable practice management resources including personalized answers to your mission-critical coding questions.
EyeNet® Magazine	Ophthalmology's premiere monthly magazine includes essential features like "The Savvy Coder" and "Practice Perfect."
Academy educational meetings and courses	Receive significant savings on registration to all Academy educational meetings and courses.
Practice Management Express	The popular weekly email newsletter includes essential information and the trusted advice coding and practice management professionals need most. Find valuable tips and current updates covering a variety of topics.





Insurance Benefits and Surgery

We schedule surgery and check the patients' eligibility/benefits that day, then discuss with patient an expected amount of what their insurance will cover and what is the patients responsibility. My question is, if any of you do this, also, and if so, how do you handle it for those that are scheduled for the next month or two out? Such as verifying that their insurance is still active prior to surgery. We work ahead probably like 6 weeks out, and we have had a couple of surgeries deny recently due to termination of policy. The patient did not inform us the day of surgery therefore we are "stuck" with the patient's large balance and the trying to collect from the patient after surgery has been done. I would like to be more proactive so that doesn't happen, we begin surgery at 5:45am so trying to verify insurance on the 1st is going to be a challenge. I would appreciate any ideas or suggestions.

1 appreciated this Seen by 500

5 comments Private Reply

Humana Step Therapy

We received notice of Humana's Step Therapy policy, as of January 2024. I didn't see specific notation regarding patients *already on* "preferred" or "non-preferred" drugs, other than Avastin, as to whether those will bypass the Avastin step & be grandfathered therapy. Does anyone else know more? Also, I'm assuming that after Avastin is tried, there's no particular requirement for what "preferred" drug can be utilized next. For instance, we're able to jump to Vabysmo or Eylea after Avastin failure, correct? Just want to make sure we understand appropriately. Thanks for your eyes!

Humana Step Th...
2 MB · 19 downloads

Be the first to appreciate this Seen by 90

Virtual credit cards

Has anyone has success in stopping virtual credit cards permanently with a carrier? We call the number they instruct us to and it stops for a few months and starts up again. It's causing more administrative burden than any practice needs at this time. And if you do nothing, and wait for the paper check it takes forever to receive. Physician owners do not want to pay fees on declining reimbursement, it's almost principal at this point. Now granted those fees may be nothing compared to handling a paper check, getting to the bank or even running thru check machine, but again principal.



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The Resilient Practice





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