Everyone knows you can’t make money doing Optometric Vision Therapy (OVT), just as everyone knows you must accept insurance in order to get patients to enroll in OVT.

These are the two most persistent comments heard, either from ODs who have tried and failed to make OVT work in their practices or from students and doctors who are hesitant to start offering therapy. As with much “conventional wisdom,” if believed, these two notions are likely to keep clinicians from enjoying a rich and rewarding life in developmental and behavioral optometry.

Not that there isn’t a grain of truth mixed in with these two overall false beliefs. In fact, it is possible to fiscally fail doing therapy or to have parents constantly ignore your therapy recommendations because insurance doesn’t cover it.

Mark Twain tells the story of a cat that made the mistake of jumping onto the top of a hot stove. After that, the cat stayed far away from the stove, until one bitterly cold night, it froze to death. That cat learned a lesson that was put into practice inappropriately.

What follows is a discussion of these myths and solutions to the issues that gave them birth.

Let’s start with myth one – profitability. The basic problem is that the doctor simply isn’t covering the actual cost of offering therapy from the fees collected. Chair time is the total of all costs of operating a practice divided by the number of hours the doctor is available to care for patients. In a small practice, total costs of say $250,000, divided by 1,500 patient care hours per year results in a chair cost of $167 per hour. In a larger practice, the figure may double.

Any doctor who delivers their own therapy who charges less than chair cost automatically loses money.

So in our simple example, in order for such a doctor to take home a modest $100 per hour, the fee would have to be about $300 per hour. Insurance barely begins to cover actual costs. By having just one employee and paring down all other expenses, a few doctors have boutique practices that produce an adequate living working with just 30-60 patients per year. Most offices need to be more productive than this.

The details are quite different in a combined primary care and OVT setting. In many such practices, potential therapy patients receive the same examination time allotment as primary care patients. Case presentation time is minimal and most patients just don’t have enough time to “get it” (to see the need for and value of therapy) which can result in few patients enrolling in a therapy program.

Determining potential OVT patients at the start of the first appointment call allows for booking extra time for both the evaluation and case presentation. It also allows a well educated and trained assistant to spend time helping the parent realize that the problem is vision function related and that the doctor likely has the solution. This well-prepared patient will have an idea of costs and insurance issues before the appointment is even made. This process almost always ensures that the doctor only sees patients who are already pre-qualified.

Parents who have issues that make them hesitant are invited to pass through an alternative intake process such as a seminar. This gives time for parents to become convinced that OVT is the solution. It also allows them the time to prepare for financial and scheduling considerations. Those who then schedule an appointment are much more likely to enroll in therapy. This will allow the doctor to invest precious
In practices where assistants deliver most of the therapy under doctor supervision, it is easier to generate profits from fees more in line with those charged by speech and language specialists, or physical or occupational therapists. In some states, the doctor must be in the therapy room, which argues for multiple therapists working with patients at the same time.

A number of offices have exceedingly well-educated and trained or certified therapists who require minimal supervision for typical OVT cases. Although some optometrists prefer a different way to conduct therapy, many others not only employ this methodology but prosper personally, professionally and fiscally by using it. It is helpful to apply a “management by exception system” so that any unusual behaviors or responses by the patient are called to the doctor’s attention quickly. Which therapy delivery format you use is your call, but the choice inevitably carries economic repercussions.

The essence of making therapy profitable enough to make it worth doing is to develop a delivery system that fits the doctor’s standards while empowering parents and patients to say yes to OVT regardless of money, time, or insurance considerations.

Now, let’s address the second myth: Must you accept insurance so that parents enroll their children in therapy? For a growing number of doctors, the answer is a resounding no. Consider this: OVT doctors now serve less than 3 percent of the patient base who need therapy. (See Maino D. The binocular vision dysfunction pandemic. Optom Vis Dev 2010;41(1):6-13 at http://www.covd.org/Portals/0/Editorial_BinocularPandemic.pdf.) By sustaining an active community outreach and internal marketing program, many ODs generate a reliable stream of private pay patients. They either accept no insurance or simply fill out paperwork to be submitted directly by the patient or parent for reimbursement.

This does not mean you cannot bill insurance for select tests and procedures. You can do this either as an in or out of network provider. Billing for two half-hour sessions for each hour provided and breaking out the orthoptics or covered procedures are common strategies. A major problem occurs when you must accept insurance as payment in full for therapy. Most such plans barely pay enough to cover actual cost. If you plan to offer therapy, calculate whether the third party plans you accept are financially workable. Drop any that are not.

One very common problem is that if insurance becomes a central topic of discussion during the case presentation, the patient may come to believe that if insurance doesn’t cover the therapy, then the problem isn’t important enough to justify paying for it out of pocket. When this occurs, the parent may believe they are getting the “hard sell” with the doctor or staff trying to push them into therapy.

How can you best handle these insurance pitfalls? Virtually all communication should center on what the parent is observing and experiencing as a result of the vision problem diagnosed. Every effort should be made to have the parent see for themselves the link between the vision problem and the difficulties they or their child are experiencing. Parents who “know” the problem is vision and that the doctor has the solution may need extra time to work out payment and other issues, but they will usually do their best to get help for their child. It is essential that cost and insurance questions be addressed early, preferably by an educated staff member, before consuming doctor time.

Many doctors consider their enrolling in various third party plans as a methodology to gain access to a plan’s patients. You may want to consider investing in hiring, training, and developing a marketing person to take your message out into the community instead. You can then actively seek those parents or patients who not only understand the need for therapy but also understand the value of the therapy fiscally. If you ask doctors who have taken this step, you will find they prefer this mode of practice.

Even those families who have low incomes or modest insurance coverage will understand the value of the therapy once explained to them in an appropriate fashion. An office with a profitable, balanced patient load will frequently establish “scholarships” for those truly in need as well.

If these myths are so far off the mark, why do they persist? Being passive about generating...
committed, private pay patients is at the heart of the answer. Insurance problems are really communication problems. Deliver premium, patient-centered communications and you can build a premium, patient-centered practice.

These two pernicious myths may start from the fear that the doctor will fail if they even try to start an OVT practice. Becoming educated about what works replaces frustration and fear with certainty about what it takes to establish a thriving optometric vision therapy practice.

The COVD, OEP, many optometric authors and even consultants can provide guidance or training to help you make optometric vision therapy a successful and satisfying part of your professional life.

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COVD 2010 Call for Posters and Papers

COVD 40th Annual Meeting
College of Optometrists in Vision Development
October 12-16, 2010
Rio Grande, Puerto Rico

The College of Optometrists in Vision Development is soliciting abstracts for papers and posters to be presented at the 2010 Annual Meeting. Any person wishing to make a presentation is invited to submit a proposal. All abstracts will be reviewed by the Research Committee and will be judged on the basis of overall quality, completion of required information, relevance to behavioral and functional vision, subject matter, innovation, and attention to key questions in the field. Proposals may include research results, case studies, or new and innovative diagnostic procedures or treatment techniques.

Deadline for submission of abstracts: June 11, 2010

Email info@covd.org or go to COVD website for application form and instructions.

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