

Coping with refractive comanagement

by Jan Beiting Contributing Editor

As many optometrists demand higher fees, physicians and legal experts ponder the line between comanagement and kickbacks.

Ophthalmologist Kevin M. Lorenz, MD, was shocked when an out-of-state patient's optometrist phoned to criticize him for "running a poor business" at The Eye Clinic of North Dakota. The optometrist, who hadn't referred the refractive surgery patient in the first place, expected to collect \$1,000 per eye for comanaging the case — far more than the \$200 discount that Lorenz had given his patient to pay for follow-up exams.

Around that time, Lorenz realized that local optometrists were referring patients to a laser surgery center 400 miles away, primarily, he suspects, to collect comanagement fees. "Call it whatever you like: fee splitting, buying referrals ... it all sounds the same to me. What does a guy do? Give in and offer the same thing?" he said.

With referral networks and standard comanagement fees of \$400 to \$500 per eye becoming more common, ophthalmologists across the country are asking the same question.

The Health Care Financing Administration (HCFA) set a precedent for comanagement with its acceptance of the 54 and 55 modifiers for cataract surgery. These modifiers split the cataract fee into 80% for the surgeon and 20% for the postop care provider.

Companies like TLC The Laser Center, which operates 48 excimer laser centers in North America, have embraced the 80/20-comanagement model. From the beginning, said Chief Executive Officer Elias Vamvakas, "We really wanted to be a surgical-only facility. If you do 30 to 50 cases a day, every day, it's impossible to follow all those patients."

Optometric referrals to TLC centers have climbed recently, but before this year represented less than 20% of total business, Vamvakas said. TLC bills patients \$2,000 per eye for the surgery and, on behalf of the comanaging optometrist, \$400 for pre- and postop care.

Vamvakas believes that having more than one doctor see the patient provides a built-in quality check, but others see it as a disservice.

"The bottom line must not be the bottom line, but what is best for the patient. As a rule, that translates into the surgeon providing the postoperative care whenever possible," said Los Angeles ophthalmologist Samuel Masket, MD. "We ascribe knowledge and training to our optometric colleagues that frankly I don't believe they have," he said.

Even assuming that optometrists do have the training to provide excellent postop care, opinions about

fair compensation for it are all over the map.

“A legitimate argument can be made that the person doing the pre- and postop work-up deserves 20% of the surgical fee,” said J. Trevor Woodhams, MD, an ophthalmologist in private practice in Atlanta. “But in most markets, a much larger percentage is changing hands,” he said, noting that comanaging optometrists are also getting 20% to 50% of the royalty and facility fees.

“The problem is that these comanagement fees, in some cases, have crossed the line to inducements for referrals,” said San Diego ophthalmologist James P. Pulaski, MD. Lawyers for the American Society of Cataract and Refractive Surgery (ASCRS) say Pulaski has a very good point.

“Comanaging arrangements should be based on fair-market value and should not be tied to the volume or value of referrals,” Jenner & Block attorney Robert M. Portman, of Washington, said. Although Medicare doesn’t cover refractive surgery, surgeons could be violating federal anti-kickback statutes if high refractive comanagement fees are seen as an inducement for referrals for Medicare-covered services.


Furthermore, “As soon as you cut a check to the optometrist, you have established a financial relationship under Stark II,” Portman said, advising refractive surgeons who also get referrals for Medicare-covered services to ensure that all comanagement arrangements are outlined in written contracts that meet the relevant exceptions.

Ophthalmologists who comanage must also keep medical malpractice risk in mind. “If the surgeon is negligent in selecting a comanaging physician or if the surgeon does not follow accepted standards for monitoring the patient’s pre- and postoperative care, the surgeon could be held responsible for injuries to the patient,” Portman said.

Finally, many states have blanket kickback and self-referral bans that apply to all medical services, not just those covered by Medicare and Medicaid. “Comanagement arrangements that involve above-market compensation run the risk of violating these state laws,” Portman said.

That is advice that Jim Pulaski is taking to heart: “After 19 years of refractive surgery, I say, take excellent care of the patients you see and stay away from the shady areas of our profession, even if you lose some market share.”

ASCRS/ASOA position on comanagement

 “Our mission is to educate, not to regulate. We believe that our members are fully committed to giving the best eyecare to the public and will do it in the best way possible under the circumstances in which they practice. For some, it will be in university settings, for others it will be in practices with referrals from closed panels, such as HMOs and PPOs. For others, it will be from optometric networks, some of which will require them to comanage. Each ophthalmologist must do that

which he feels is best for his patient and with which he feels most comfortable.

“We can advise and recommend, but regulation and enforcement are not a part of our mission or intent. Some may abuse the system, but things have a way of righting themselves with time and peer pressure.”

— Spencer P. Thornton, MD,

former president of the

American Society of Cataract and Refractive Surgery/ American Society of Ophthalmic Administrators.

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