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National Panel Report: Surgeons Weigh In on Comanagement

Ophthalmologists have strong feelings about every facet of this issue, from the skills of optometrists to comanagement legislation.

Walter Bethke, Senior Editor

Few issues in ophthalmology stir up debate faster than the comanagement of surgical patients with optometrists. Some surgeons say it makes for more convenient care for patients in far-flung areas or keeps their referral sources viable, while others classify it as fee-splitting and object to it vehemently. In this month's National Panel Report, you can get an understanding of the proportion of surgeons who comanage patients, why they do it and what their colleagues think about it.

In this month's survey of 500 surgeons across the country, 86 panelists, or 17 percent of our sample, responded. Following are their experiences with comanagement, both good and bad. See how your opinions match up with theirs.

The Comanagement Stats

Twenty-nine percent of the surgeons say they comanage surgical patients with optometrists. Of these, 96 percent comanage cataract cases, and 42 percent comanage LASIK patients. Thirty-seven percent of the respondents say they comanage patients with other ophthalmologists.

Here are some general statistics from the survey:

- When comanaging cataract cases, 58 percent say they "release" the patients to their referring optometrist after a month of postop observation and visits, while the rest say they release them after the first postop visit.
- For those who comanage LASIK patients, 63 percent say their surgeon/optometrist fee arrangement is 80/20, making this the most popular arrangement for those surveyed.
- Sixteen percent use a 75/25 arrangement and 5 percent use a 60/40.

Surgeons Who Comanage

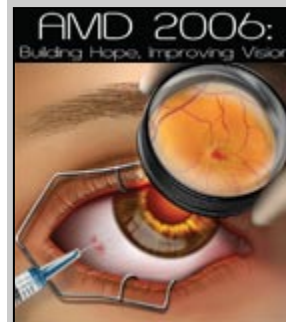
- *Why they do it. Reasons given for comanaging patients with optometrists range from convenience for the patient to survival of the ophthalmologist.*

One Nebraska surgeon says he comanages his surgical patients because "the

satellite office where I do my cataract surgery is two hours away from my main office." A Kansas surgeon concurs, saying he does it because of "concerns about travel distance."

A surgeon from Washington who thinks that, in general, "patients are better cared for by their

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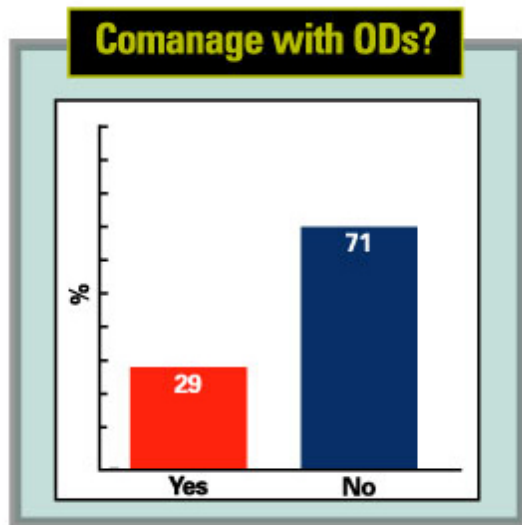
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surgeon,” concedes that he will comanage “only occasionally for patients who live far away.”

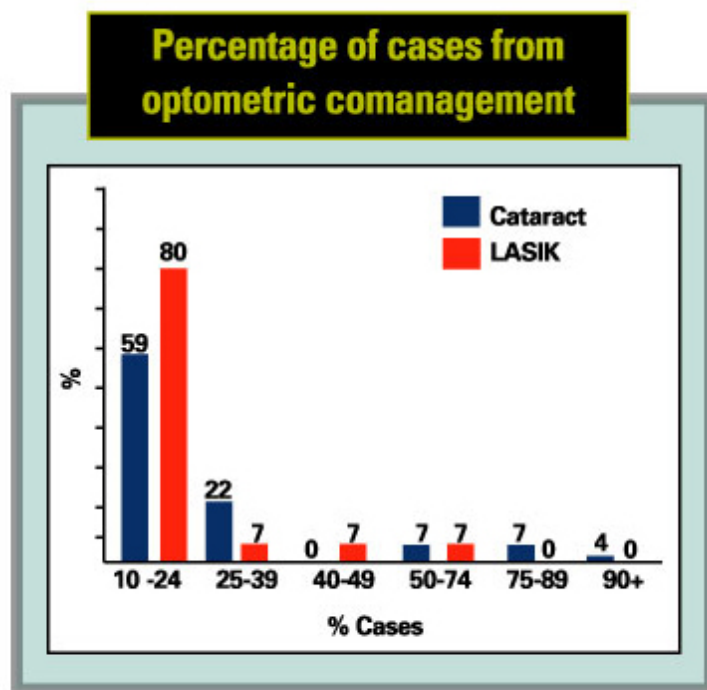
A surgeon from Minnesota puts his reasons for comanaging succinctly, saying, “Increased volume and decreased time.”

Though serving patients from remote areas may be a motivating factor behind comanagement, other surgeons point to a different, more pragmatic reason.

“For referrals, if I don’t comanage patients with optometrists, someone else will,” says an Ohio surgeon.

“I rely almost 100 percent on optometric referrals for surgical patients,” says a Michigan physician. “Most optometrists want to comanage. If I don’t, they will send patients elsewhere.”

• *Surgeon satisfaction.* Of the surgeons who comanage patients, 36 percent say they’re very satisfied with their arrangements. “We’ve trained or worked closely with every doctor we share patients with,” says Amir Arbisser, MD, of



Davenport, Iowa, who is among those very satisfied with his comanagement relationship. Another surgeon who feels similarly is Wilson Ko of Flushing, N.Y. “The relationship provides excellent care for the patient, and I have an excellent working relationship with the optometrist,” he says.

Another 26 percent are somewhat satisfied with their arrangements, but less effusive with their praise. “It relieves the burden of routine postop management,” says a Missouri surgeon in this group.

“It is sometimes difficult to explain to an optometrist that the patient wants to remain in my practice for the postop,” says one surgeon. “And it’s sometimes difficult for the

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patient to understand the arrangement.”

Surgeons Rate Optometrist's Skills					
	excellent = 1	good = 2	fair = 3	poor = 4	mean
Consistency of follow-up	29%	46%	17%	9%	2
Ability to recognize and manage complications	17%	28%	22%	33%	3
Handling patients' confusion regarding payments	12%	45%	21%	21%	3

Finally, 13 percent of those who comanage rate themselves somewhat unsatisfied with the arrangement. One surgeon, who only refers when it would be more convenient for patients who have to travel a far distance to see him, says, “Generally, I feel the best postoperative care is delivered by myself and my office.”

One Michigan surgeon thinks it's a moot point if he can keep the patient for a long enough time postop. “My cataract patients aren't released until they're seeing well,” he says. “There's little risk to the patient.”

• *Optometrists' skills.* As for the skills that optometrists bring to the comanagement arrangement, ophthalmologists who work with them give them good marks for consistency of follow-up. Three-quarters say that optometrists are either excellent or good in this area.

Fifty-eight percent say they're excellent or good in handling patients' confusion regarding separate payments to them and the surgeon. Marks aren't as high when it comes to recognizing and managing complications: 55 percent of surgeons responding say that optometrists are only fair or poor in this regard, with fully one-third saying the latter.

Just over half, 55 percent, of the surgeons say they take steps to confirm the training and abilities of their comanaging optometrists. These steps take various forms, with open lines of communication between surgeon and optometrist being common to each.

“We try to get them in to spend a day with us seeing postop patients,” says a Kansas surgeon. “We require follow-up forms be returned to us each visit and call the optometrist if we don't receive them.”

“I've known them, discerned their philosophy of care and kept in constant touch,” says Nalin Tolia, MD, of Odessa, Texas.

“I meet with the OD in my office once a week,” says a Beverly Hills, Calif., surgeon. Another, who keeps tabs on the optometrists' work constantly, says, “Observation is key. I review their postop notes as they are sent to me.” An Iowa surgeon agrees, saying he confirms his optometrists' skills with “reports on postop visits and by keeping open communication.”

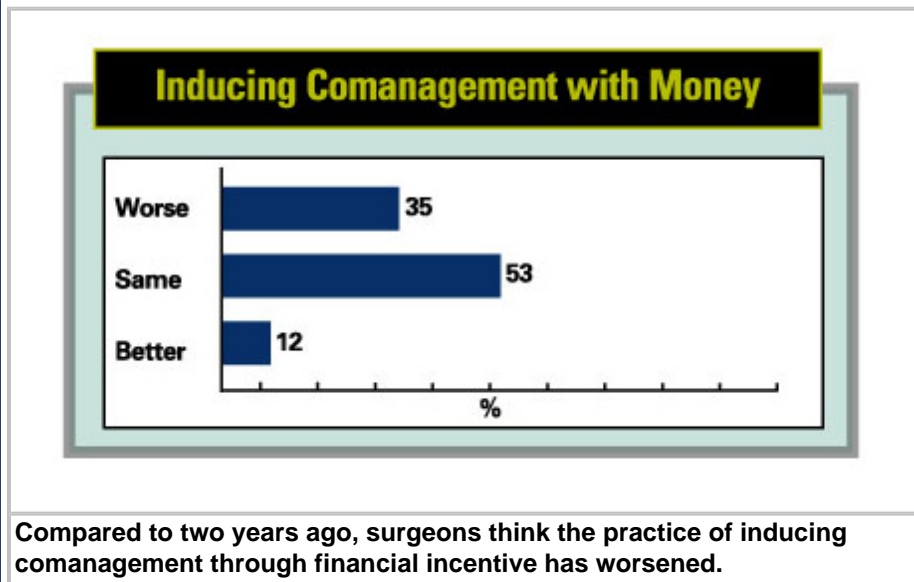
Michael Solomon, MD, of Warren, Mich., however, tried comanagement and says he got burned. Based on his experience, he rates optometrists' consistency of follow-up and handling of patients confusion over separate payments as poor. He says they do a fair job handling complications. “I had a very bad experience with an unethical and unscrupulous optom,” he says. As for proof of an optometrist's skills, he says, “Next

time, I want to see it in writing!"

The Vocal Majority

Though some of the respondents are making comanagement work in their particular practices, the bulk of them, 71 percent, don't comanage patients with optometrists. These physicians say their reasons center on quality-of-care issues and many view comanagement as unethical fee-splitting.

The respondents also say that the use of financial incentive to induce referrals is



worse than two years ago. Thirty-five percent say that it has worsened, and 54 percent think that it's the same. Only 12 percent think it's gotten better.

"It's wrong," says James Powell, MD, of Birmingham, Ala. "It's just a scheme to make money. Do you think an internist gets a fee for sending a gall bladder case to a surgeon? I think not."

"The practice I'm involved with has generally considered comanagement to not be in the best interest of the patient," says Jerry Tanner, MD, of Lincoln, Neb. "In practices that do comanage, there have been some suspect business relationships." He goes on to say that, "there are very few optometrists in my estimation capable of recognizing and/or sufficiently treating complications. Failure to recognize problems may delay timely treatment."

"Fee splitting is unethical and illegal," says Pittsburgh surgeon Arthur Fleming Jr. "Comanagement is just a euphemism for fee splitting."

"I've been asked and threatened by optometrists," says a New Mexico physician. "I've ignored their threats for 20 years and it's the best decision I've made. I do not look at patients as my patients or theirs, but as people whom I can help by treating or making appropriate referrals."

The Legislation Question

The trend toward more common use of financial incentive to induce comanagement may explain why, as the question of comanagement comes to a head in certain states, some state associations have turned to their legislatures for help. Surgeons are apparently not convinced of the wisdom of this approach: 80 percent of the respondents don't think lobbying for comanagement legislation is a good idea. The reasons they give center on fears that such legislation may actually legitimize a practice that many of them think is fee-splitting, as well as allow the government to further meddle with health care.

"No more government involvement is needed in Medicare," says a Pennsylvania surgeon. A physician from South Carolina agrees, saying, "Legislators should not be making these kinds of decisions."

The 20 percent that support legislation, however, do so with the condition that it limits comanagement.

An Ohio surgeon says no to comanagement legislation, “unless the lobbying is aimed at doing away with comanagement.”

One surgeon, who doesn’t want his name or location disclosed, says lobbying is a good idea if it “makes it a clean, no-hassle arrangement.” An Arizona surgeon feels the same, saying, “Lobbying is a good idea so there is consistency and guidelines to comanagement.”

One surgeon says he is “undecided” on the question of lobbying for legislation because doing so, he says, “puts those in the trenches in a difficult position.”

Comanaging surgeons were also asked if they had ever been approached by optometrists to support optometric-sponsored legislation, and how they responded. Most, 89 percent, say they haven’t been approached.

A surgeon from Kansas says he’s been approached, but that he “tried to avoid it without saying no.” Other ophthalmologists were more forthright when they were approached to support such legislation. “I would not support them,” says a Missouri physician.

In the end, some ophthalmologists may be looking for support on the comanagement issue to help them take a stand. Says one surgeon, “I wish the powers-that-be would force the issue one way or the other. To recommend no comanagement as the American Academy of Ophthalmology and the American Society of Cataract and Refractive Surgery did puts everyone in an awkward spot.”

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