OPHTHALMOLOGY/OPTOMETRY RELATIONSHIPS INVOLVED IN CATARACT SURGERY

OFFICE OF INSPECTOR GENERAL
OFFICE OF ANALYSIS AND INSPECTIONS

APRIL 1989

OPHTHALMOLOGY/OPTOMETRY RELATIONSHIPS INVOLVED IN CATARACT SURGERY

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EXECUTIVE SUMMARY

OBJECTIVES

This inspection focuses on issues involving optometrists' providing postoperative care to Medicare beneficiaries following cataract surgery. The overall objectives of the inspection were to determine:

- the extent and frequency of postoperative care by optometrists;
- the extent of referral arrangements between ophthalmologists and optometrists;
- the manner of billing by ophthalmologists and optometrists for cataract surgery when an optometrist provides postoperative care; and
- whether the practice of optometrists' providing cataract surgery postoperative care could lead to abusive referral arrangements, and possible duplicate billings.

BACKGROUND

This program inspection was requested by the Administrator of the Health Care Financing Administration (HCFA), who was concerned about the issue of optometrists' providing postoperative care to Medicare beneficiaries who had cataract surgery. This practice increased after Medicare coverage was expanded by the Omnibus Budget Reconciliation Act of 1986. This legislation permitted coverage of optometrists as physicians for any services they are legally authorized to perform in the State in which they practice. All 50 States permit optometrists to use diagnostic drugs. Further, 23 States have passed legislation allowing optometrists to use and prescribe therapeutic drugs, greatly expanding their scope of practice and ability to treat patients during the postoperative period following cataract surgery.

METHODOLOGY

Preinspection work included meetings and contacts with the American Academy of Ophthalmology, the American Optometric Association, State licensing boards, Medicare carriers, and HCFA staff.

A random sample of eight Medicare carriers was selected. Two carriers, who were randomly selected twice, provided two independent samples. One hundred claims "histories" for patients who had undergone cataract surgery were randomly selected for review from each sampled carrier (200 from those carriers which provided two samples). These histories were analyzed to determine the extent to which ophthalmologists delegate postoperative care to optometrists, and the extent to which optometrists are reimbursed for postoperative care already

billed by the ophthalmologists as part of a global fee covering both surgery and postoperative care.

The eight carriers also provided a separate sample of the names of 60 ophthalmologists who perform cataract surgery for Medicare beneficiaries. One-half of these surgeons were selected from among the highest-paid ophthalmologists at each carrier and the other half from those receiving the mid-range of payments. Fifty-eight of the 60 surgeons were interviewed regarding their practice. The surgeons were requested to provide a sample of names of optometrists handling aftercare, and a sample of names of cataract surgery patients. The optometrists and patients were interviewed to obtain their opinions on the issues of optometrists' providing cataract surgery referrals to ophthalmologists and optometrists' providing postoperative care.

In addition, peer review organizations (PROs) and State Boards of Optometry were contacted in each of the sampled States to discuss their experiences and opinions regarding these issues.

FINDINGS

Medicare May Be Paying Too Much For Postoperative Care Following Cataract Surgery

- The number of postoperative days encompassed by the global fee varies by carrier, as does the percentage of the global fee allocated to surgery versus postoperative care. As a result, in some cases Medicare is making additional payments for postoperative care which would be included in the global fee by other carriers.

- In 97 percent of cataract surgery cases reviewed, the ophthalmologists billed a global fee. In a small number of these cases, optometrists were paid inappropriately by Medicare for postoperative services during the period encompassed by the global fee.

There Is A Direct Correlation Between The Existence Of Referral Arrangements, Formal And Informal, And The Use Of Optometrists For Follow-up Care

- Thirteen (46 percent) of the highest-paid ophthalmologists sampled referred cataract surgery patients to optometrists for postoperative care, in contrast to 3 (10 percent) of the ophthalmologists receiving mid-range payments.

- Ophthalmologists who refer cataract surgery patients to optometrists for postoperative care receive a higher percentage of their surgical referrals from optometrists than do ophthalmologists who do all postoperative care themselves (32 percent versus 7 percent). States that allow optometrists to prescribe therapeutic drugs had a higher overall percentage of optometric referrals.

The Inspection Did Not Examine Quality Of Care; However, Some Potential Vulnerabilities Were Noted

- There is no consensus regarding the division of responsibility following cataract surgery when the surgeon does not provide all such care. This lack of standards for treatment means that there are no standards for review of such care.

- Ophthalmologists who refer their patients to optometrists for postoperative care, compared to those who perform their own postoperative care, generally follow their patients for a shorter postoperative period. However, most optometrists said that although they provide postoperative care, they only treat routine complaints, and would refer patients back to ophthalmologists for treatment of serious complications.

- More than half the ophthalmologists stated they had provided Medicare patients with second opinions regarding the necessity for cataract surgery. However, only 20 percent of the sample patients said they had received a second opinion before undergoing surgery.

RECOMMENDATIONS

To Improve Medicare Payments For Cataract Surgery

- The HCFA should develop national guidelines covering the number of postoperative days included in a global fee for cataract surgery, and the percentage allocation of a global fee to surgery and postoperative care.

- The HCFA should require all carriers to instruct optometrists and ophthalmologists in the use of procedure code modifiers, and to establish screens for duplicate billing within the global-fee period. The HCFA should also identify ophthalmologists most likely to refer cataract surgery patients to optometrists for postoperative care. Such referrals would provide for a focused postpayment review of cataract surgery patient records to insure appropriate billings.

To address referral arrangements that may violate the anti-kickback provisions

- The HCFA should require carriers to refer any potentially abusive arrangements between ophthalmologists and optometrists, which the carrier identifies, to the Office of Inspector General for investigation.

To Improve Quality Of Care For Cataract Surgery Patients

- The HCFA should require PROs, including local ophthalmologists, to work with their State Boards of Optometry to establish protocols for postoperative cataract surgical care.

Such protocols should address the minimum number and frequency of postoperative visits, the necessity for 24-hour availability of emergency care, and the presence of written agreements between referring practitioners regarding the division of responsibilities. These protocols should become part of the PROs' review of cataract surgery in both inpatient and ambulatory settings.

- The HCFA should require mandatory second surgical opinions for elective surgeries, such as cataract surgery, paid under Medicare.

COMMENTS

The HCFA agreed with the recommendations with the exception of a second surgical opinion for cataract surgery. We continue to believe that the requirement of a second opinion for cataract surgeries is essential, particularly when this surgery is generally performed in other than an acute care facility.

The OIG issued the draft inspection report on "Ophthalmology/Optometry Relationships Involved in Cataract Surgery" for comments to the American Academy of Ophthalmology and the American Optometric Association. Neither organization disagreed strongly with the findings. Their comments presented their opposing positions regarding the use of optometrists to provide postoperative care.

The complete text of the comments by HCFA and the Academy and Association are included in appendix III.

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INTRODUCTION

OBJECTIVES

This inspection focuses on issues involving postoperative care rendered by optometrists to Medicare beneficiaries following cataract surgery. The overall objectives of the inspection were to determine:

- the extent and frequency of postoperative care by optometrists;
- the extent of referral arrangements between ophthalmologists and optometrists;
- the manner of billing by ophthalmologists for cataract surgery when an optometrist performs postoperative care; and
- whether the practice of optometrists' providing cataract surgery postoperative care could lead to abusive referral arrangements, and possible duplicate billings.

BACKGROUND

This program inspection was requested by the Administrator of the Health Care Financing Administration (HCFA) who was concerned about ophthalmologists' referring cataract patients to optometrists for postoperative care after performing cataract surgery. The concern stemmed from a statement by the American Academy of Ophthalmology regarding adherence to professional ethical standards. According to the Academy, operating surgeons are responsible for providing postoperative care to their patients. Further, surgeons who turn over their responsibility for postoperative care to someone else do not fulfill their responsibilities to the patient. In addition, the bylaws of the American College of Surgeons state that it is unethical to turn over postoperative care of a patient to another physician who is not as well qualified to undertake it. Their concern is that the quality of postoperative care provided by someone other than the surgeon may be poor and result in placing the patient at greater risk.

Nature of Surgery

Cataracts of the eye occur when the natural crystalline lens inside the eye becomes cloudy. Cataracts can occur at any age, but are more prevalent in the elderly population. Due to the aging process, the natural lens becomes hard and unable to focus. This progressive process may eventually result in blurred vision or even blindness. Surgery is the only effective way to remove a cataract. Vision can be restored after the natural lens of the eye is removed and a permanent intraocular lens (IOL) is implanted inside the eye. Cataract glasses or contact lenses are used for candidates not suitable for IOL implants, although even those with an IOL implant usually require eyeglasses for reading, sewing, or other activities.

Due to technological advances over the last 10 years, cataract surgery is highly successful; the patient's vision can be restored in up to 90 percent of all cataract cases. However, according to medical studies, increasing patient age, surgical problems, postoperative complications, and adverse reactions are among the factors which could reduce visual acuity after cataract surgery. It is estimated that medical complications following cataract surgery may occur in about 3 to 5 percent of the cases but would not necessarily result in a loss of vision if recognized and treated properly. The postoperative recovery period usually lasts 6 to 12 weeks, during which time the eye heals and visual rehabilitation takes place.

Medicare Coverage

Under Medicare, vision care services are limited to those necessary to treat eye diseases such as cataracts. Cataract surgery, as well as preoperative and postoperative care, are covered by Medicare when medically necessary. Cataract surgery is considered major eye surgery with a potential for complications and is one of the most frequently performed procedures in the Medicare population. Over one million cataract surgeries were performed in 1987, with more than $1 billion paid to surgeons.

Cataract surgical care for Medicare beneficiaries is covered by a global fee that includes surgery and postoperative care. The Medicare carrier establishes the global-fee period using criteria developed from medical practice in the carrier's service area. The surgeon provides all the services during the global-fee period, e.g. 90 days, when a global fee is billed. When the surgeon provides some of the services, e.g. surgery only, and the postoperative care is provided by another physician, the two-digit modifier "54" should be used on the bill to indicate surgical care only. When only postoperative care is provided, the modifier "55" should be used to show postoperative management only. Carriers are required to screen bills for eye care services within the global-fee period to avoid inappropriate or duplicate payments.

In 1980, the Omnibus Reconciliation Act authorized Medicare payments to optometrists for services related to cataract surgery (Section 937 of Public Law 96-499). Until March 31, 1987, optometrists were covered by Medicare for examination services related to aphakia (the absence of the natural lens in the eye). Optometrists could only bill Medicare for determining visual acuity, prescribing glasses, and dispensing optical devices to patients who had had cataracts removed, although the State may have allowed them to perform a wider range of services.

Effective April 1, 1987, Medicare coverage of optometrists' services was expanded with Section 9336 of Public Law 99-509 (the Omnibus Budget Reconciliation Act of 1986, known as OBRA 86). This expansion allowed Medicare coverage of optometrists as physicians (as defined in the Social Security Act governing Medicare) in providing cataract surgery postoperative care, within the legal authorizations of the States in which they practice. However, this expansion of coverage raises questions about the division of responsibility between the ophthalmologists and optometrists regarding appropriate patient care and billing to the Medicare program.

Licensure Issues

There is no uniform set of optometric services covered by Medicare, since State licensure laws vary widely. Qualifications, training requirements, and the scope of practice for optometrists are established under State law. In this regard, 50 States permit optometrists to use diagnostic drugs. Twenty-three of the States also permit optometrists to prescribe therapeutic pharmaceutical agents, which significantly expands the optometric scope of practice and the ability to treat some postoperative complications. Postoperative cataract care was within the scope of practice of an optometrist in the seven States included in the inspection sample. All seven States permit optometrists to use diagnostic drugs, and three of the seven also allow the use of therapeutic drugs.

OIG Concerns

The Office of Inspector General (OIG) is concerned with situations in which abusive referral arrangements result in Medicare overpayments and kickbacks. Postoperative care by someone other than the surgeon raises concerns over global reimbursement to surgeons who perform only cataract surgery and not postoperative care. In addition, patient referrals between optometrists and ophthalmologists (so-called networking) could result in improper payments. The OIG has identified potential vulnerabilities, including coercion to refer patients and failure to adequately provide preoperative and postoperative care. Instances of these potential vulnerabilities have been identified in complaints to the OIG and/or to the Senate Select Committee on Aging.

METHODOLOGY

A sample of Medicare carriers was selected at random proportional to size (in terms of numbers of IOL surgeries in 1985). Two carriers were randomly selected twice and provided two independent samples. Selected carriers processed claims for beneficiaries in Northern and Southern California, Louisiana, Montana, Western Missouri, Upper New York State, North Carolina, and Oregon. (See appendix I.) Each carrier was requested to identify all beneficiaries who received one of four specified cataract services during the period April 1, 1987 through March 31, 1988. Each carrier then provided beneficiary payment histories for a random sample of 100 of the identified beneficiaries (200 for those carriers which provided two samples). The total sample of 1,000 beneficiaries who had cataract surgery represented 1,062 procedures, since some beneficiaries received surgery on both eyes.

In addition, the eight carriers provided the OIG with the names of a sample of three (six at two carriers) ophthalmologists from each of two groups: (1) those who received the highest Medicare payments in that specialty; and (2) those who were paid in the mid-range of payments during fiscal year 1987. Of the 60 names of ophthalmologists provided by the carriers, 58 were contacted. We were unable to contact the remaining two.

The ophthalmologists we talked to provided us with the names of 49 patients who had received cataract surgery. Those who refer their cataract surgery patients to optometrists for

postoperative care also provided us with the names of 28 of these optometrists.
The ophthalmologists, optometrists, and patients were contacted in person or by phone and interviewed using discussion guides. Opinions were obtained regarding the issue of optometrists' providing referrals and postoperative care following cataract surgery, second opinions for cataract surgery, and the effect of cataract surgery on the patient's life.

Peer review organizations (PROs) and the State Boards of Optometry were contacted in each of the sampled States. The organizations were queried on the extent of postoperative care by optometrists after cataract surgery in their States, and whether they were aware of positive or negative outcomes of this practice.

FINDINGS

Medicare May Be Paying Too Much For Postoperative Care Following Cataract Surgery

A. Variance In Postoperative Days and Global Fees

There are no specific HCFA guidelines regarding:

- the number of postoperative days covered by a global fee; and
- the percentage or amount of the global fee allocated for the surgery and postoperative care.

This leads to nationwide variances in postoperative days covered by Medicare and in the amounts allocated to surgery and postoperative care. Through our contacts with the eight Medicare carriers included in this inspection, we found that the global fee covered postoperative periods ranging from 10 to 120 days, with a median of 90 days.

We asked the 58 ophthalmologists their opinions about the appropriate length of the postoperative period of recovery following cataract surgery. The median number of postoperative days identified in these interviews was 86, ranging from 10 to 365 days.

Where the carrier's global-fee postoperative period is 10 days, both ophthalmologists and optometrists can begin billing for services rendered on the 11th day, 1 day following the end of the carrier-established global-fee postoperative period. This very short global-fee postoperative period allows additional program payments. These payments could be avoided if national guidelines on the number of postoperative days in a global fee were developed which included a greater number of days in the postoperative period.

We also found the portion of the global fee allocated for postoperative care varied among carriers. Three of the 8 carriers utilized a 70/30 global-fee split between the surgical procedure (70 percent) and postoperative care (30 percent). Other carriers based postoperative allocations on specific procedure codes, made adjustments after a review of the charges, or used no modifier or global-fee split at all.

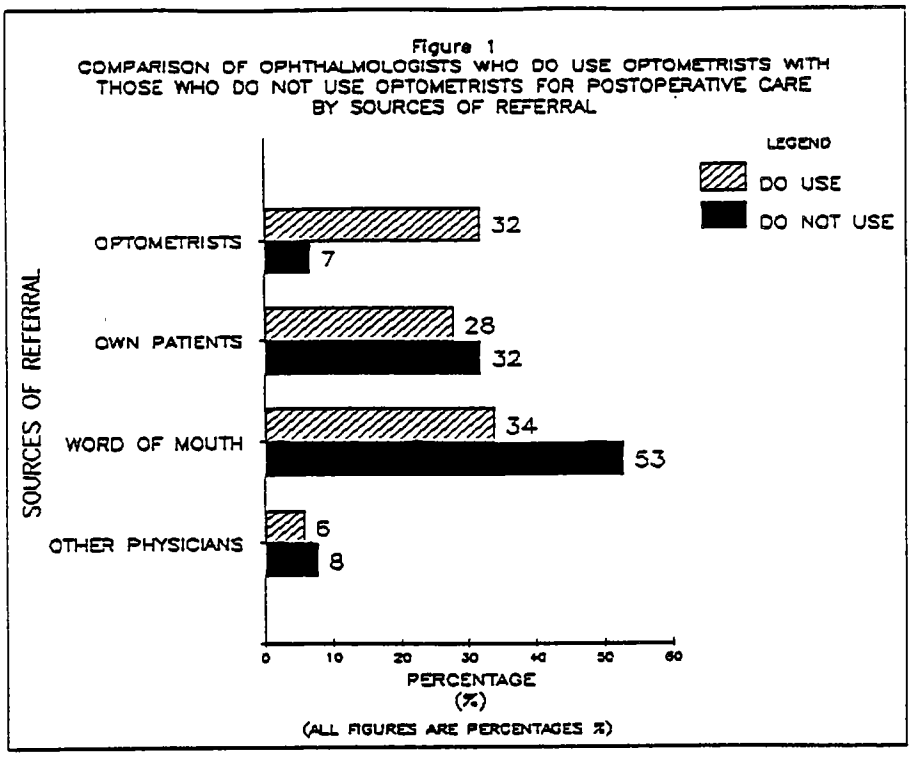
B. Optometry Services Billed During the Global-Fee Period

Ophthalmologists billed Medicare a global fee for cataract surgery in over 97 percent of the 1,062 cataract surgery cases reviewed. The global fee covers both the surgical procedure and postoperative care. In 25 of the cases covered by a global fee, optometrists also billed Medicare. In 10 of these cases, the services provided by the optometrists were outside the global-fee period. However, in the remaining 15 cases, the services were performed within the global-fee period. These services represent a potential overpayment of $826 because carriers did not deny these services even though a global fee was billed by the ophthalmologists. The HCFA requires that Medicare carriers establish a screening mechanism that will allow for identification of inappropriate or duplicate services.

There Is A Direct Correlation Between The Existence Of Referral Arrangements, Formal And Informal, And The Use Of Optometrists For Follow-up Care

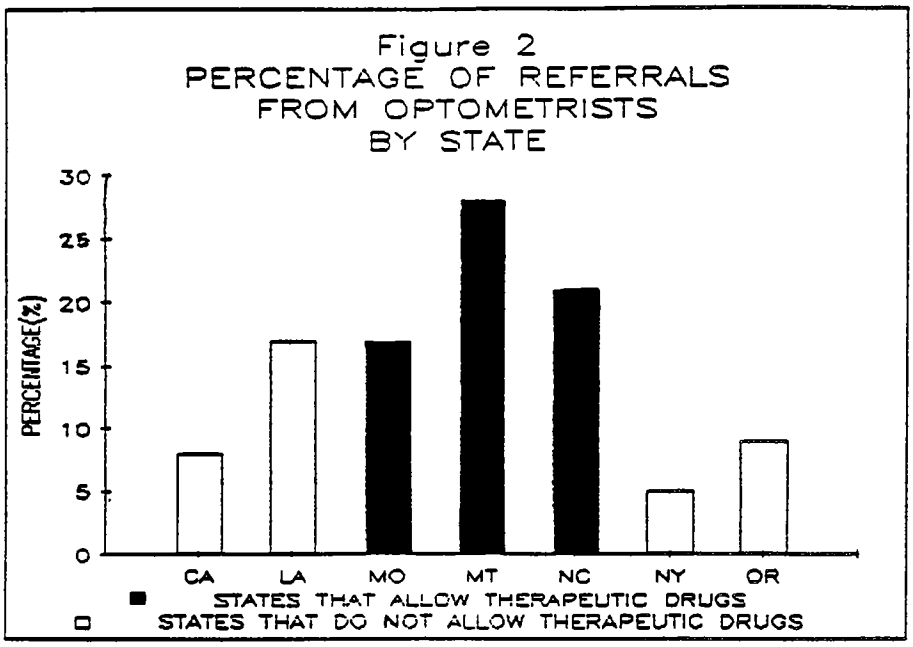
A. Optometric Referrals For Cataract Surgery

The inspection found that 13 or 46 percent of the highest-paid ophthalmologists sampled allow optometrists to provide postoperative care to their cataract surgery patients, in contrast to 3 or 10 percent of those in the mid-range of payments. We also found that sampled ophthalmologists who allowed optometrists to provide their cataract surgery patients with postoperative care received 32 percent of their cataract surgery patients through referrals from optometrists. Ophthalmologists who did not refer their patients to optometrists for postoperative care received only 7 percent of their cataract surgery referrals from optometrists.



We identified two examples of contractual agreements between ophthalmologists and optometrists. The first involved an employment agreement between an ophthalmologist and optometrist. It was determined by Office of General Counsel to represent a bona-fide employment contract, exempt from criminality under the law. The second involved a lease arrangement. It was not developed by the Office of Investigations because of the minimal payments involved.

The average percentage of optometric referrals to the sampled ophthalmologists varied by State, ranging from 5 to 28 percent. The highest percentages of optometric referrals occurred in those States that permit optometrists to provide therapeutic drugs.



B. Postoperative Care by Optometrists

An examination of three sources of data revealed that:

- sixteen of 58 ophthalmologists interviewed (nearly 28 percent) allow optometrists to provide postoperative care to their cataract surgery patients;

- in 15 of 1062 cases reviewed, payments were made inappropriately for postoperative care that should have been denied, because the surgeon had already been paid a global fee (without modifers) that includes postoperative care; and

- eighteen of 49 patients interviewed (nearly 37 percent) stated they saw a doctor other than the surgeon for postoperative care. In some instances the patients were not certain if the doctor was an ophthalmologist or an optometrist.

A comparison of data between the 16 ophthalmologists who allow optometrists to provide postoperative care and the 42 who do not is shown in appendix II.

Ophthalmologists reported the major reason patients returned to an optometrist for postoperative care was the distance involved in traveling back to the operating surgeon. Optometrists stated that patients preferred to return to their local physician for care; this was confirmed by

almost half of the patients who received cataract surgery. They stated that travel was required to receive cataract surgery since it was not available in their communities.

All 28 optometrists interviewed stated they provide cataract surgery postoperative care, and feel confident in monitoring these patients for the detection of complications that would require the patients' return to the ophthalmologist. However, 17 (61 percent) said they only treat routine complaints and complications such as blurred vision, redness of the eye, and a slight increase in intraocular pressure. Thirteen of the 17 are in States that allow optometrists to provide therapeutic drugs to treat eye conditions, but only 1 of the 13 said he would attempt treating a serious complication, and then only after conferring with the operating ophthalmologist. The remaining 11 would provide only routine eye exams and refractions, and monitor the eye for increases in pressure and other indications of complications. These 11 optometrists indicated that patients with any indication of a complication would be referred back to the ophthalmologist for treatment.

The ophthalmologists interviewed were significantly divided on the issue of optometrists providing cataract surgery postoperative care. We found that the majority (42) of those ophthalmologists interviewed believed that optometrists are not qualified to provide postoperative care. A minority of (16) ophthalmologists interviewed approve of optometrists providing their patients with postoperative care. The majority also stated that the services provided by an optometrist during postoperative care are not as comprehensive as the services provided by an ophthalmologist.

The Inspection Did Not Examine Quality Of Care; However, Some Potential Vulnerabilities Were Noted

A. Potential Causes of Poor Quality Care

While a medical peer review of patient records was not performed, interviews with sampled ophthalmologists indicated the following potential vulnerabilities in cases where an optometrist would provide the follow-up care to cataract surgery.

- Twelve percent of the ophthalmologists do not always examine the patient prior to the date of surgery.

- Twelve percent of the ophthalmologists do not always examine the patient the day after surgery.
- Ophthalmologists who refer their patients to optometrists for postoperative care, compared to those who perform their own postoperative care, were found to follow their patients for a shorter postoperative period.

Our review did not find an existing national professional standard for cataract surgery follow-up care provided by an optometrist. In the absence of a standard for treatment, "sub-standard"

care cannot be identified during peer review with the degree of precision possible when reviewing postoperative care rendered by the surgeon.

Most optometrists interviewed said that although they provide postoperative care, they only treat routine complaints, and would refer patients with evidence of a serious complication back to ophthalmologists for treatment. This, however, does not constitute a standard for care, and may place patients at risk if a rare surgical complication is not identified by an optometrist.

B. Second Opinion For Cataract Surgery

The physicians interviewed stated that second opinions were requested as a requirement for private insurance. Thirty of 58 ophthalmologists (52 percent) stated they received requests for second opinions, and 11 of 28 of the optometrists (39 percent) said they had provided Medicare patients with second opinions regarding cataract surgery. Ten of the 49 Medicare patients (20 percent) we interviewed stated they sought a second opinion before undergoing cataract surgery. Six of the 10 patients sought a second opinion from an ophthalmologist, and the remaining 4 saw an optometrist for the second opinion. This study did not attempt to determine the medical necessity of the 1,062 surgeries reviewed. However, cataracts develop slowly, and surgery may be avoided for many years if the patient so desires. Additionally, cataract surgery should not be performed unless eyesight is expected to improve.

The OIG has previously recommended that legislation be adopted to require a mandatory second opinion program for elective surgeries for Medicare patients.

RECOMMENDATIONS AND AGENCY COMMENTS

RECOMMENDATION

The HCFA should develop national guidelines covering the number of postoperative days (e.g., 60 to 90 days) that should be included in global fees, and the percentage allocation of global fees to surgery and postoperative care (e.g., 80/20). These guidelines should allow sufficient postoperative time to complete all necessary postoperative exams and procedures, with the exception of complicated cases.

AGENCY COMMENTS - The HCFA generally concurs with our recommendations. It indicates that efforts are also being made to implement and develop uniform definitions of services. As part of that effort, it is considering establishment of a uniform reduction in the global charge where postoperative services are not performed by the operating surgeon.

OIG RESPONSE - We are pleased with the HCFA response. We believe the development of national guidelines is the best approach to resolving the inconsistencies in the number of postoperative days and the percentage allocation of global fees among Medicare carriers.

RECOMMENDATION

The HCFA should require all carriers to instruct both optometrists and ophthalmologists in the use of modifiers when cataract surgery postoperative care is shared with or provided by an optometrist.

AGENCY COMMENTS - The HCFA concurs and states that a reminder is being made to all carriers as part of the 1989 Common Procedure Code System update.

OIG RESPONSE - We are pleased that HCFA concurs and that HCFA is reminding carriers of the use of modifiers. However, we believe HCFA should also ask carriers to include a reminder on the importance and use of modifiers in the next newsletter/bulletin issued to the physician community.

RECOMMENDATION

The HCFA should require all carriers to identify ophthalmologists most likely to permit postoperative care by optometrists. (The inspection found the highest-paid ophthalmologists to be most likely to share cataract surgery care with optometrists.)

AGENCY COMMENTS - The HCFA agrees with this recommendation. Instructions were recently issued to carriers requiring detection of those physicians with unusually high increases in payment. These ophthalmologists or ophthalmologists and optometrists will be subjected to an intensified review.

OIG RESPONSE - We are pleased that HCFA has issued instructions to carriers to identify physicians for review who have had high increases. We believe that HCFA should also issue instructions to carriers that require a review of total payments to ophthalmologists in order to identify the highest paid ophthalmologists. Our study found that the highest paid ophthalmologists were those most likely to share cataract surgery follow up care with optometrists.

RECOMMENDATION

The HCFA should require all carriers to have the necessary screens in place to detect services billed within a global-fee period.

AGENCY COMMENTS - The HCFA concurs with this recommendation, but believes that the present claims review requirements provides for such detection.

OIG RESPONSE - The OIG supports the sections in the Medicare Carriers Manual that require carriers' systems to conduct comparisons to ensure proper payment. However, we also believe that HCFA should expand the manual so that the comparisons also include a physician-to-physician review to assess payment when one physician, e.g. an ophthalmologist, bills a global fee for cataract surgery and a optometrist bills for a postoperative service during the global fee postoperative period.

RECOMMENDATION

The HCFA should require all carriers to conduct postpayment reviews of cataract surgery to determine:

- if physicians are correctly billing and using modifiers;

- if optometrists are being paid for services already paid to the ophthalmologist in the global fee; and

- the possible existence of arrangements which might violate anti-kickback statutes.

AGENCY COMMENTS - The HCFA concurs with this recommendation, and will enhance the present Medicare Carriers Manual postpayment review and alert list to address these vulnerabilities. The HCFA will consider asking several carriers to conduct pilot postpayment studies in this area.

OIG RESPONSE - We support HCFA's current efforts to direct and focus postpayment review. However, we believe the areas for postpayment alerts should also be amended to include duplicate payments to physicians when they bill for services that already have been paid to another physician as part of a global fee.

RECOMMENDATION

The HCFA should require carriers to refer any potentially abusive arrangements between ophthalmologists and optometrists, which the carrier identifies, to the Office of Inspector General for investigations.

AGENCY COMMENTS - The HCFA agrees with this recommendation and is emphasizing the detection and referral of fraudulent or abusive situations through Manual guidance and training, and monitoring of the carriers activity and effectiveness.

RECOMMENDATION

The HCFA should require mandatory second surgical opinions for elective surgeries paid under Medicare. Cataract surgeries, which are basically elective, would be included for mandatory second opinions by another ophthalmologist.

AGENCY COMMENTS - The HCFA does not agree with this recommendation. They believe that the present preprocedural review by the PROs will function as a second opinion and that pending regulations will mandate a PRO second opinion to resolve outstanding uncertainties as to the medical necessity of the procedure.

OIG RESPONSE - In cataract surgery, the accepted indications for surgery are based on the impact of the cataract on the beneficiaries' quality of life as well as on a uniform set of clinical measures. Since the preprocedure review program concentrates on review of relatively simple clinical indications, this program will not be as effective as the visual inspection and consultation contemplated in our second opinion recommendation.

RECOMMENDATION

The HCFA should require PROs, including local ophthalmologists, to work with their State Boards of Optometry to establish review procedures for postoperative cataract surgical care. Such review procedures should address the minimum number and frequency of postoperative visits, the necessity for 24-hour availability of emergency care, and the presence of written agreements between referring practitioners regarding the division of responsibilities.

AGENCY COMMENTS - While HCFA agreed in principle, they indicated that this requirement currently is beyond the scope of the PRO program because PROs do not review care provided in practitioners' offices.

OIG RESPONSE - We have recommended PRO involvement based upon their role as arbiters of medical practice in their respective States. We feel that the division of responsibility allowed by OBRA 86 requires involvement by HCFA and its contractors in ensuring quality of care for Medicare patients, who account for the majority of cases in which such divided care will be rendered.

HEALTH ORGANIZATION COMMENTS

The OIG issued the draft inspection report on "Ophthalmology/Optometry Relationships Involved in Cataract Surgery" for comments to the American Academy of Ophthalmology and the American Optometric Association. Copies of the comments are included in appendix III. The following is a summary of the responses received from these organizations.

The American Academy of Ophthalmology stated that in general they were pleased with the findings and recommendations in the report. However, they urged that we drop the recommendation that HCFA develop national guidelines for splitting the global fee and the recommendation that PROs work with the State Boards of Optometry to establish review procedures for postoperative cataract surgical care. The Academy commented regarding the rationale for referrals of cataract surgical patients to optometrists for care. They stated that ophthalmologists' services are widely available in urban and rural areas and that the travel distance to an ophthalmologist, for the majority of patients, should never exceed an hour's drive. The Academy also recommended a 90-day postoperative period for cataract surgery.
The American Optometric Association provided current figures on the number of States that permit optometrists to use diagnostic and therapeutic drugs. They also noted one inconsistency in the report regarding the services that can be provided by optometrists following an expansion of coverage.

OIG RESPONSE - We have reviewed the comments of these organizations but believe that changes to the basic recommendations in the report are not warranted. We feel that the findings establish the requirement for definitive guidelines and the need for a medical review presence to ensure the medical necessity and quality of care when services are performed.

In response to the comment by the American Academy of Ophthalmology regarding the geographic dispersion of ophthalmologists, some of the beneficiaries whom we contacted in our study and who had seen an optometrist for postoperative care stated that there was not an ophthalmologist that they were aware of in their immediate community. Our report accordingly has included this information as a conclusion of those beneficiaries.

The Academy's recommendation of a 90-day postoperative period coincides exactly with the median period used by the Medicare carriers sampled in this review.

APPENDIX I

OPHTHALMOLOGY/OPTOMETRY SAMPLE

CARRIER	STATE
Arkansas Blue Shield, processing claims for	Louisiana
Blue Shield of California	California (Northern)
Transamerica Occidental of California*	California (Southern)
Blue Shield of Kansas City	Missouri (Western)
Blue Shield of Western New York, Inc.	New York (Does not include New York City)
Prudential of North Carolina*	North Carolina
Aetna of Oregon	Oregon
Blue Shield of Montana	Montana

*Two separate samples of 100 each

APPENDIX II

OPHTHALMOLOGISTS COMPARISON DATA

The inspection found that of the 58 interviewed ophthalmologists who perform cataract surgery, 16 (28 percent) said they approved of optometrists providing their patients with cataract surgery postoperative care. The remaining 42 (72 percent) felt that optometrists were not qualified to provide postoperative care. The comparison of data between both groups is outlined below. The comments address ophthalmologists who allow postoperative care by optometrists.

Data	Allow Postop Care (16)	Do Not Allow Postop Care (42)	Comments
Average number of years in practice	13	18	Averaged fewer years in practice
Percentage of practice with Medicare patients	79%	59%	Had a higher Medicare patient population
Percentage of surgery performed at:			Performed a higher cataract surgery percentage of their surgeries in an ambulatory center (ASC)
(a) Hospital surgical Outpatient	26%	71%	
(b) ASC	74%	28%	
Percentage of cataract surgery referrals from optometrists	32%	7%	Received a higher percentage (25% higher) of optometric referrals
Patients always examined by the ophthalmologist prior to the day of surgery	14 (88%)	41 (98%)	

Continued

Data	Allow Postop Care (16)	Do Not Allow Postop Care (42)	Comments
Patients examined by the ophthalmologists the day after surgery (24 hr. exam)	14 (88%)	41 (98%)	
Length of follow-up by the ophthalmologists:			Follow their patients for a shorter time after surgery
(a) one week or less	3 (19%)	0	
(b) 2-4 weeks	2 (13%)	0	
(c) 5-7 weeks	2 (13%)	4 (10%)	
(d) 8 weeks	9 (56%)	38(90%)	
Dollars paid to the sampled ophthalmologists during FY 1987	$30,627,042	$39,155,850	28% of the physicians collected 44% of the total Medicare payments for physicians sampled.
Average payment	$ 1,914,190	$ 932,282	

Total: $69,782,892 paid to the 58 sampled physicians

APPENDIX III

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

DEC 30 1988

Memorandum

Date

From William L. Roper, M.D.
Administrator

Subject OIG Draft Report: Ophthalmology/Optometry Relationships in Cataract Surgery - OAI-07-88-00460

To The Inspector General
Office of the Secretary

We have reviewed your draft report which addressed the interrelationship of ophthalmologists and optometrists in cataract surgeries and the resultant effects on Medicare reimbursement.

In the interest of clarity, we are including our response to your recommendations as an attachment.

Thank you for giving us the opportunity to comment on this draft report.

Attachment

Health Care Financing Administration
Comments on OIG Draft Report
"Ophthalmology/Optometry Relationships
Involved in Cataract Surgery"
OAI-07-88-00460

Recommendation 1:

The HCFA should develop national guidelines covering the number of postoperative days included in a global fee for cataract surgery, and the percentage allocation of a global fee to surgery and postoperative care.

HCFA Comments:

We generally agree with the recommendation. Our Bureau of Quality Control has conducted a study of cataract surgery and associated pre- and postoperative services. The study included all carriers and indicated variances in global fee structures as well as variances in billing payment practices. We are currently completing the cataract study and we plan to address the issue of carrier variances in the structure and payment of global packages. As part of our effort to implement and develop uniform definitions of services as required by section 4055(a)(2) of the Omnibus Budget Reconciliation Act of 1987, we are considering establishing a uniform reduction in the global charge where postoperative services are not performed by the operating surgeon.

Recommendation 2:

The HCFA should require all carriers to instruct optometrists and ophthalmologists in the use of procedure code modifiers.

HCFA Comments:

We are reminding carriers of the use of all CPT-4 modifiers as part of the 1989 HCFA Common Procedure Coding System update.

Recommendation 3:

The HCFA should require all carriers to identify ophthalmologists most likely to permit postoperative care by optometrists.

HCFA Comments:

We recently issued instructions requiring carriers to calculate the percentage of increase in total Medicare payments to physicians in order to detect those with unusually high increases. Physicians with significant increases, such as the ophthalmologists operating in tandem with optometrists, will be detected by this analysis and subjected to more intensified review.

Recommendation 4:

The HCFA should require all carriers to have the necessary screens in place to detect services billed within a global fee period.

HCFA Comments:

Section 7527 of the Medicare Carriers Manual currently requires that a procedure-to-procedure review be done of each claim submitted for payment to identify all individual procedures which are normally part of surgical packages.

Recommendation 5:

The HCFA should require all carriers to conduct postpayment reviews of cataract surgery to evaluate use of modifiers, excess or duplicative payments to optometrists, or the existence of kickback schemes.

HCFA Comments:

The Postpayment Alert List (section 7514 E of the Medicare Carriers Manual) lists areas of previously detected program vulnerability that carriers should consider when selecting cases for postpayment review. It currently includes "cataracts - excessive preoperative visual acuity testing" and "pre- and post-operative care - not included in global fee, as applicable, regardless of the place of service." We will add a reference to use of the modifiers. The existence of kickback schemes would hopefully be detected as a by-product of an intensified postpayment review. In addition, we will consider asking several carriers to do pilot postpayment studies in this area.

Recommendation 6:

The HCFA should require carriers to refer any potentially abusive arrangements between ophthalmologists and optometrists, which the carrier identifies, to the OIG for investigation.

HCFA Comments:

The Medicare Carriers Manual contains numerous references to the requirement that all apparent fraud or abuse cases and uncorrected misbilling cases be referred to OIG, regardless of specialty. We have also instructed the carriers to periodically contact OIG to determine the status of referred cases. In addition, section 11000, the fraud and abuse chapter undergoing final changes prior to final publication, stresses the same requirements. We also devoted much time to this subject during recent carrier medical review training. We will be monitoring the number of FY 89 referrals to determine whether this new emphasis has been effective.

Recommendation 7:

The HCFA should require mandatory second surgical opinions for elective surgeries paid under Medicare. Cataract surgeries, which are basically elective, would be included for mandatory second opinions by another ophthalmologist.

HCFA Comments:

We do not believe it is necessary to mandate second opinions for all cataract surgeries for the following reasons:

- Under the third Scope of Work, Utilization and Quality Control Peer Review Organizations (PROs) are required to review 10 procedures on a preadmission/preprocedure basis and deny payment for any procedure which is not medically necessary or is proposed to be delivered in a setting which is not appropriate. In effect, the PRO will render a second opinion on the necessity and appropriateness of the surgery.

- The impending implementation of section 9401 of the Consolidated Omnibus Budget Reconciliation Act will extend preadmission/preprocedure review to also require the PRO to mandate a second opinion to resolve outstanding uncertainties as to the medical necessity of the procedure. This provision is being implemented through the regulatory process.

Recommendation 8:

The HCFA should require PROs to work with their State Boards of Optometry to establish review procedures for postoperative cataract surgical care. Such review procedures should address

the minimum number and frequency of postoperative visits, the necessity for 24-hour availability of emergency care, and the presence of written agreements between referring practitioners regarding the division of responsibilities.

HCFA Comments:

Such a requirement currently is beyond the scope of the PRO program as PROs do not review care provided in practitioners' offices. If and when PROs begin reviewing these services, we will take this recommendation under consideration.

AMERICAN ACADEMY OF OPHTHALMOLOGY

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February 28, 1989

Mr. Barry Steeley
Office of Analysis and Inspections
Office of Inspector General
Department of Health and Human
Services
330 Independence Avenue, S.W.
Washington, DC 20201

Dear Mr. Steeley:

Thank you for the opportunity to review your draft report entitled, Ophthalmology/Optometry Relationships Involved in Cataract Surgery. The report provides some new documentation of the arrangements about which the Academy has expressed concern. While its methodology and findings appear valid, we would urge you to strengthen some of the recommendations and to attempt to re-verify some of the findings.

Recommendations. The information you have gathered should permit you to reach the conclusion that optometrists should NOT be providing post-operative care following cataract surgery and should NOT be reimbursed for services provided prior to the end of the post-operative period. We urge you to delete the draft recommendation which would require HCFA to develop guidelines for splitting the global fee. The Academy has recommended a 90-day post-operative period for cataract surgery.

Quality of Care. The issue of quality is mentioned, but not defined or explored. We would refer you to the October, 1988 report by the Office of Technology Assessment comparing some measures of quality and training. For example, in your draft, you quote optometrists as saying that they only provide "routine" follow up care, and would refer any "significant" complications to the operating surgeon.

The OTA report explains how this situation could lead to serious complications based on the optometrist not being qualified to clearly diagnose the significance of post-operative symptoms, and the crucial delays when the patient is referred from the optometrist back to the operating surgeon. This type of situation, as you are aware, was the subject last year of a hearing conducted by the Senate Aging Committee.

Further, your draft report does not indicate whether both the optometrist and the operating surgeon bill Medicare for these instances when a patient must be referred back to the surgeon, and how much of a potential additional expense to Medicare this practice could represent.

More emphasis on findings needed. We were generally pleased with the findings and recommendations made by the report; however, there are some areas that should be strengthened to more accurately portray the results. In the executive summary, "no direct evidence of poor quality," is a misleading title, since later in the report, there are direct statements that the OIG has identified: "coercion to refer patients and failure to adequately provide preoperative and postopertive care." (p. 4)

Emphasis in the executive summary and more attention in the body of the report should be given to the findings on surgeons who do not see the patient prior to the surgery (12%, see p. 14) and who do not see the patient the day after surgery (12%, see p. 15). The OTA report's strongest recommendation regards the necessity for a pre-operative examination by the operating ophthalmologist.

For example, in North Carolina, where optometrists have been most successful in expanding their scope of license through legislative fiat, the Medicare carrier nonetheless requires that the operating surgeon examine the patient before cataract surgery, and the day after surgery. Anything less would be a dereliction of responsibility to the patient's welfare.

Another "vulnerability" which should be included in the executive summary for emphasis is cited on page 6: a 60 percent rate of overbilling by optometrists who submitted claims for services during the global fee period.

Also, in your sampling of cases, you uncovered two contractual arrangements which appear to be highly questionable, yet these are only noted in passing (p. 7), and not given any acknowledgement in the executive summary.

Definition of optometric post-op care. The draft report incorrectly assumes that state licensure to use certain drugs also permits optometrists to provide medical treatment to post-surgical cataract patients (see p. 3). There are very important differences between the permission to prescribe medications and the ability to decide on post-operative treatment.

Just because some of the drugs that some optometrists are permitted to use happen to include some of the medications prescribed by ophthalmologists post-operatively, does not grant ability to make a medical determination regarding the appropriate use of the drugs during surgically-related treatment.

Even if you should conclude, contrary to our view, that optometrists may be qualified to perform some post-operative care in states where they are permitted to use and prescribe certain therapeutic drugs, such a conclusion clearly does not support the notion that optometrists are qualified to provide post-operative care in states where they are not authorized to prescribe therapeutic drugs.

These are key points, and must be corrected in the report. Of the eight states studied, only three permit optometrists to prescribe a short list of "therapeutic" drugs. All exclude surgery from the optometrist's scope of practice. Only Colorado addresses the question of post-operative care. The state legislatures passed these laws generally to allow optometrists to care for minor eye irritations, such as red eye, not for the treatment of post-surgical patients.

Comprises in post-operative eye care may have been encouraged by the Medicare payment policy begun in 1986 of permitting operating surgeons and referring optometrists to split the global surgical fee simply by using designated modifiers on Medicare claims forms. As a result, the Medicare program in essence, has singled out eye care patients for inadequate post-operative care in the hands of persons other than medical doctors.

Licensing Boards. It is our general understanding that the Boards of Medical Examiners in all the states consider surgical care, including post-operative care, to be part of the care and treatment for which they license medical doctors. Optometrists are licensed under an independent Board of Optometry, not subject to the same licensing requirements as ophthalmologists or other medical doctors. This raises two points which must be addressed in the report:

(1) That any statewide decision on the practice of medicine must include the Board of Medical Examiners. The recommendation for the Board of Optometry to decide on the division of post-op care (see p. 12) is probably not lawful, and certainly insufficient, undesirable, and unnecessary. This recommendation should be deleted from the report.

(2) The ability to prescribe certain drugs is not synonymous with the ability to treat a post-operative patient. The surgeon must choose from a wide array of medications and other interventions, as well as deciding when not to add or change medications. The optometrist's prescribing authority is strictly limited in every state, which prevents the wide choice of treatments necessary to ensure appropriate care of the patient.

Reason for Referral. The draft report states that: "the major reason patients returned to an optometrist for postoperative care was the distance involved in traveling back to the operating surgeon." This has always been an unsupported assertion which must be documented.

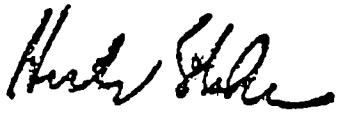
We wonder whether the OIG field researchers checked on the location of the patient's home, the distance traveled to the optometrist, the distance traveled to the operating ophthalmologist. We wonder whether the field researchers documented that there were no closer ophthalmologists from whom the patient could receive both surgical and post-operative cataract care. We wonder whether the researchers compared the travel distances for patients of those ophthalmologists who had a high volume of cataract referrals from optometrists with travel distances for patients of ophthalmologists who had only a small number of optometric referrals.

Based on zip code studies of ophthalmologists, the Academy has concluded that ophthalmologists are widely distributed among urban and rural areas, and that only a tiny fraction of the population is more than an hour's drive from an ophthalmologist. We strongly suggest that before this report is finalized, your field researchers go back and verify the assertion that referrals are "necessary" because of the unavailability of ophthalmologists.

If other local ophthalmologists are available, then it is clear that referral patterns which result in optometrists sending patients to surgeons who are too far away to provide postoperative care are patterns which should be investigated for Medicare anti-kickback violations.

Thank you for the opportunity to comment on this draft report.

Sincerely,



Hunter Stokes, MD
Secretary

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January 31, 1989

Mr. Mike Mangano
Assistant Inspector General
for Analysis and Inspection
Department of Health and Human Services
330 Independence Avenue, S.W., Room 5660
Washington, D. C. 20201

Dear Mr. Mangano:

The American Optometric Association appreciates the opportunity to review the draft document Ophthalmology/Optometry Relationships Involved in Cataract Surgery and would like to offer the following comments for consideration.

Executive Summary

Page i -- The correct number of states permitting optometrists to use diagnostic and therapeutic drugs is 50 and 23, respectively (see attached). It is important to note that post-operative care coordinated between optometrists and ophthalmic surgeons is not dependent on the use of therapeutic drugs.

Page iii -- We are unclear how the two comments under the heading of quality of care relate to "vulnerabilities", and we believe, based on the study findings, that vulnerabilities is not the proper word for this heading.

It is not surprising that ophthalmologists who comanage patients with optometrists generally follow their patients for a shorter period, since two providers are involved in the post-operative episode. The number of visits in this case will be consistent with other models of care, and as the draft points out, optometrists continue to communicate and consult with the ophthalmic surgeon on possible complications. This passage would appear to point out a strength inherent in comanagement, not a vulnerability.

The reference to second opinions appears out of place. While the possible use of second opinions may address questions of volume and overutilization, it does not represent a potential vulnerability to the rendering of quality post-operative care.

Page iv -- We believe the reference to minimum number and frequency of visits should relate to uncomplicated cases.

Introduction

Page 1 -- The reference to the American Academy of Ophthalmology's ethical standards regarding post-operative care is not correct. The post-operative section of the AAO Code of Ethics, conditionally approved by the Federal Trade Commission, states that the ophthalmologist should provide "those aspects of eye care within the unique competence of the ophthalmologist (which do not include those permitted by law to be performed by auxiliaries.)." The FTC opinion conditionally approving the AAO Code states specifically that "the rule would not prevent ophthalmologists from arramging for optometrists to provide post-operative eye care services consistent with state law" (opinion enclosed).

Page 3 -- The last sentence of the first paragraph implies that the 1980 Omnibus Reconciliation Act amendment allowed optometrists to bill Medicare only for determining visual acuity, prescribing glasses, and dispensing optical devices. This is not correct. The law provided for payment for all examination services related to aphakia consistent with state law, which include office examinations during the post-operative period. The HCFA regulations implementing this change confirmed this intent and provided examples of such services. Again, the correct reference to diagnostic and therapeutic states is 50 and 23.

The description of the expanded coverage of optometrists' services provided under the Omnibus Budget Reconciliation Act of 1986 (OBRA 1986) is not entirely accurate. It suggests that the expansion is narrowly applicable to the post-operative period in a cataract patient. Page i of the draft report more accurately notes that OBRA 1986 authorized Medicare coverage for vision care services furnished by an optometrist, to all Medicare eligible patients, if the services are among those covered under Medicare and if the optometrist is legally authorized under state scope of practice law to perform the service.

Findings

Page 6 -- The first paragraph describes an overpayment situation and implies that it was the optometrist who billed and was paid inappropriately. Similarly, on page ii of the summary it is stated that "...optometrists also billed Medicare inappropriately for services during the period encompassed by the global fee." In fact, it is the ophthalmologist who billed inappropriately for services he or she did not provide, and, in such cases, it is the ophthalmologist who is overpaid, not the optometrist. We believe the report should state clearly that a physician billing a global fee should provide all the services covered under the global fee or use a modifier to note that some of the package of services will be provided by another practitioner.

Page 9 -- The report notes that the ophthalmologists interviewed were significantly divided on the issue of optometrists providing post-operative care, however only the majority opinion is stated. We assume that the 28 percent who comanage with optometrists did not agree with their colleagues on the quality of optometric post-operative care and believe this should be highlighted.

Again, we question the appropriateness of the word "vulnerabilities" and the relevance of the second opinion discussion to this section. See comment on executive summary page iii.

Page 10 -- We would suggest that the heading for 10b be changed to "Quality Considerations", since the report has stated there is no direct evidence of poor quality care. We again question the comment on ophthalmologists who refer to optometrists following their patients for a shorter period of time as in executive summary page iii.

Recommendations

Page 11 -- We believe the third recommendation should read "identify ophthalmologists most likely to permit post-operative care by other providers," so as to include referrals to other ophthalmologists for post-operative care. We are also concerned that the reference in this recommendation to "highest paid" could be interpreted to mean that these ophthalmologists charge more per procedure, which does not seem to be the case. They receive more payments because they provide a greater volume of service.

Page 12 -- The reference to second opinions should state "by another ophthalmologist or optometrist". Optometrists are clearly qualified to render an opinion on the necessity of cataract surgery and as the report notes earlier on page 10, are asked to do so on occasion.

As stated before in executive summary page iv, we believe the reference to minimum number and frequency of visits should relate to uncomplicated cases.

Thank you for the opportunity to review and comment on this draft. We would be happy to meet with you to discuss our comments and the report.

Sincerely,

Jeffrey G. Mays
Washington Office Director

Attachment
JGM/N. Goff
0191F