The Optometric-Ophthalmic Kickback Scheme: the Demise of American Eye Medicine

Robert P. Gervais, M.D.

The Cost of Abolishing Free-Market Prices

Disconnecting the natural regulatory mechanism of the free market—prices agreed upon by buyer and seller—has resulted in economic chaos and the likely extinction of honest medical practitioners.

Free-market economists teach us that the expenditure explosion in medical care results from the abolition of real prices by employer-provided medical insurance, Medicaid, and Medicare. If real prices cannot perform their resource-allocating or rationing function, because they have been abolished by government intervention, then we are left with government performing that function. However, the government's tools are blunt and can never match the free market's pricing system. This is why government intervention always does more harm than good.

In its attempt to allocate and ration medical resources, while controlling costs, government has mandated managed care, Professional Standards Review Organizations, Professional Review Organizations, certificates of need, and numerous other control schemes. These measures have failed. Government, however, never admits error. It continues to search for ways to make central planning and price controls work. That explains the genesis of Medicare's sustainable growth rate (SGR) formula, the resource-based relative value scale (RBRVS), Medicare's Correct Coding Initiative, "pay for performance," and other supposed cost-containment measures.

Some of government's cost-containment schemes have affected certain specialties more than others, and in the case of optometry/ophthalmology, government has implemented an optometric-ophthalmic "kickback" scheme that has not only exacerbated the expenditure problem, but corrupted eye-care professionals.

How Ophthalmologic Fee-Splitting Works

Although fee-splitting was once universally condemned as unethical, the government-sanctioned "optometric-ophthalmic co-management," permits the splitting of the fee for performing cataract surgery. Ophthalmologists retain 80 percent of the government-approved fee, and optometrists receive 20 percent. The result is that whenever the optometrist refers a patient for cataract surgery, the optometrist receives the equivalent of a kickback from the ophthalmologist for postoperative management. Government has rationalized this arrangement on the grounds that optometrists are qualified to provide postoperative care and merit 20 percent of the surgeon's fee for doing so. However, the reality is quite different. Optometrists are paid 20 percent of the surgeon's fee for referring a patient to a relatively small group of ophthalmologists willing to participate in the kickback scheme. This represents a generous government-provided stipend to optometrists for making a telephone call and prescribing a pair of glasses. Not all optometrists expect such a kickback, but many do participate very willingly in this arrangement.

The Rationalization

How optometrists persuaded legislators to legalize this kickback demands an explanation. They posited, with the approval of a few business-savvy ophthalmologists, the following arguments to justify the splitting of the cataract surgery fee:

First, optometrists convinced legislators that they are doctors who are qualified to diagnose the cause of blurred vision, to recommend surgery, and to assume the postoperative care of patients. According to a small cadre of ophthalmologists, optometric schooling was a sufficient prerequisite for "surgery free" ophthalmology fellowships. After all, if some ophthalmologists agreed with optometric claims, why shouldn't legislators? The possibility that these fellowships were intended to attract referrals to ophthalmologists willing to offer such training was not considered.

It was a great optometric coup to convince legislators that the mental process whereby a physician arrives at a diagnosis could be inculcated without the rigors of medical school. What the lay public and legislators failed to comprehend was that exposure to family medicine, cardiology, neurology, general surgery, and other specialties in the standard medical school curriculum is necessary for learning the art and science of diagnosis and the basics of patient management. Only when skilled in the medical way of thinking is a physician prepared to tackle the demands of specialty training, which refines his skills in his chosen field.

Abstract concepts like medical thought processes were of much less concern to legislators than cost arguments. Optometrists stressed the fact that many of their members serve smaller communities. Allowing them to provide postoperative care would save cataract patients the trouble and expense of having to travel to large metropolitan centers where ophthalmologists congregate. But above all, optometrists persuaded legislators that as the efficient, low-cost providers of eye care they would save the medical system millions of dollars.

The Consequences: Costs, Corruption, and Compromised Care

The savings failed to materialize for several reasons.

First, because the diagnosis of a clinically relevant cataract is subjective, eye-care professionals—technicians, optometrists, and ophthalmologists—have a strong incentive under the government's scheme to "find" cataracts allegedly needing surgery so as to maximize profit. This is easily accomplished by performing less-than-accurate refractions, by aggressive reliance on preoperative glare testing, and by conveniently overlooking other causes of blurred vision, such as subtle macular pucker and early macular degeneration. Second, evidence from the "crime scene" is destroyed in the process of performing surgery: Pathologists cannot confirm the diagnosis because cataracts are liquefied by sophisticated equipment during surgery.

Third, the propensity to err on the side of surgery is greatly facilitated by the third-party payment system because it short-circuits the economizing or rationing function of prices that occurs in a system where buyers and sellers interact directly.

The propensity to order excessive services is also seen on the medical side. One patient who did *not* have glaucoma ended up paying about $300 for a glaucoma work-up to optometrists accustomed to third-party payments. The optometrists had an incentive to feel unsure about the diagnosis of non-glaucoma. All of the insecurity evaporated when the second optometrist, who

worked for an ophthalmologist participating in the kickback scheme, learned that the patient was paying out of pocket.

Fourth, optometrists have few reservations about aggressively recommending cataract surgery because they have no reason to fear litigation. Surgeons are ultimately responsible for all aspects of cataract care including its proper diagnosis. But optometrists send them patients who are primed to accept surgery—and indeed expect it.

Fifth, if surgical complications occur, most surgeons, together with their own staff, assume postoperative care in order to quell litigation and camouflage the real incidence of complications from referring optometrists. This fact gives optometrists a huge incentive to refer patients for the flimsiest of indications, secure in the knowledge that they will get the 20 percent kickback fee to care for patients who do not need meaningful postoperative care.

These five reasons not only explain the expenditure explosion but also how optometrists are corrupted by the scheme.

That the scheme also corrupts ophthalmologists is an even worse effect. They have a strong incentive to overlook misdiagnoses and to perform surgery prematurely because they can ill afford to alienate their stable of loyal, referring optometrists. Ophthalmologists who routinely override optometric diagnoses, cancel surgery, and deprive optometrists of their 20 percent kickback fee soon find that optometrists are sending patients to less discriminating or less ethical ophthalmologists so as to ensure their revenue stream.

The scheme's corrupting incentives have also led to the creation of medicine's version of "pinball"—unnecessary re-testing. For example, a solo optometrist examines a patient and diagnoses cataracts. The patient is referred to an ophthalmic mega-clinic and is subjected to a second optometric eye exam to confirm the diagnosis. The second optometrist orders a series of preoperative tests and schedules surgery. On the day of surgery, the ophthalmologist might conduct a cursory third exam before proceeding to perform surgery. Each time the patient hits one of these "pinball bumpers" the price of care goes up. Co-playing optometrists and ophthalmologists willingly operate the "flippers" to "keep the ball in play," thus ringing up a score of costs, all of which might have been averted in the absence of the scheme.

By encouraging redundant optometric exams, by offering optometrists mini-fellowships, and by using them to manage their clinics, these ophthalmologists communicate their willingness to split fees and to support legislation to expand the optometric scope of practice. By tossing these "carrots" to optometrists, scheme-dependent eye surgeons sustain the loyalty of their referring optometrists.

Government licensure is supposed to protect the public from professionals who practice beyond their level of competence, but in fact it can serve to reassure the public, falsely, that anyone who is allowed to perform certain functions is adequately trained for them—and that all licensees are interchangeable. If licensure were abolished and replaced by a free-market certifying mechanism, optometrists could no longer so readily use the political clout of scheme-dependent ophthalmologists to expand their scope of practice by fiat rather than by merit. The need to obtain a politically dependent privilege—a license—is certainly no remedy for a scheme that rewards inappropriate referrals and removes any incentive for the consumer to evaluate the worth of a service for himself.

Even if optometrists and ophthalmologists refused to respond to the scheme's crass incentives to create or magnify the significance of disease, optometrists would still stand to gain from it because it bestows a halo effect on them. The scheme raises optometrists to a higher professional status and perceived competence than they would otherwise enjoy, because the government has granted optometrists the near equivalent of physician status, in collusion with some ophthalmologists. The latter help perpetuate the lie in exchange for the ample bounty of government revenues that some optometrists channel to their sponsors.

Participating ophthalmologists also benefit from a higher status: they use the high surgical volumes made possible by the scheme to market themselves as "superior" surgeons. This has hindered talented, ethical ophthalmologists who refuse to participate in the scheme from reaching their full potential because optometrists steer patients to those ophthalmologists willing to pay kickbacks. Without access to sufficient patients, innately gifted surgeons may be denied the opportunity to perfect their skills, and their medical practices may be destroyed because of their high ethical standards. No one has been able to refer me to a single high-volume ophthalmology practice in the entire U.S. that does not participate in this scheme.

The ramifications of this corrupt and unethical scheme are far-reaching. Medicare soon became aware of the relatively high incomes enjoyed by a few eye surgeons who compromised their ethics to obtain the government money. Needless to say, Medicare did not attribute these high incomes to the very government-sanctioned kickback scheme it had created. Instead, Medicare used the existence of these "high incomes" to justify draconian fee cuts. High-volume, scheme-dependent surgeons could absorb the cuts, but those who avoided the scheme watched in disbelief as their practices were placed on financial life support because their fees were also slashed. In effect, the government's scheme selected for the survival of unethical physicians and assured the extinction of those surgeons who sought to practice honest medicine by contracting with their patients directly.

The scheme, especially in conjunction with managed care, allows some optometrists and ophthalmologists to control the flow of large patient populations. The patients are unwitting pawns in a system that enables surgeons to delegate all aspects of eye care to assistants, except surgery. Freed of the responsibility of examining patients, diagnosing eye disease, and discussing treatment options, scheme-dependent surgeons can devote most of their time to performing highly remunerative surgery.

Ophthalmologists who have been thrown into this sea of corruption may be faced with two stark choices: abandon ophthalmology, or swallow their pride, abandon their ethics, and become employees of mega-clinics owned by a handful of scheme-dependent ophthalmologists.

All the "players" in the scheme, from the "top" surgeons to the lowly janitor at the mega-clinic, see the scheme as beneficial. Patients like the apparent Mayo Clinic-like thoroughness of all the testing. The outcome of surgery is generally good. Those who bear the costs are unseen. Our grandchildren have no choice about paying for what is, in many cases, a high-cost substitute for glasses. Patients cannot choose to pay extra for the attention of a nonparticipating ophthalmologist who does his own examinations, does not operate on an assembly line, and does not encourage premature surgery. Nor can they benefit from forgoing unnecessary tests. Ultimately, patients will have no choice about the severe rationing that will come when the system is bankrupt.

Conclusion

The solution to the unethical government kickback scheme is simple. We must return to a free-market system that permits competition on the basis of both cost and quality.

The right of contract, better known as the patient-doctor relationship, in concert with real insurance, must be restored. The knowledge transmitted by free-market prices must replace government price controls, which are inevitably arbitrary and poorly informed. Without the government destruction of the marketplace, the economic chaos and ethical lapses suborned by the incentives and pressures of managed care and the optometric-ophthalmic kickback scheme would have never seen the light of day.

Robert P. Gervais, M.D., an ophthalmologist residing in Mesa, AZ, is incoming president of AAPS. Contact: rgervais1@cox.net.