

HB

142

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Alaska Academy of Ophthalmology

Carl Rosen, M.D.
President
542 W. 2nd Ave
Anchorage, Ak 99501
907-563-8526

MAR 7 - 2003

3/7/03

Alaska House of Representatives
Pouch V
Juneau, Ak 99801

Dear Representative,

Representative Wilson

The Alaska and American Academy of Ophthalmology endorses HB 142 (introduced by State Representative Cheryl Heinze), an act relating to provider responsibility for ocular postoperative care in Alaska, to regulate potential abuses of comanagement arrangements.

This legislation closes a patient protection loophole. Ocular care is one of the rare areas where non-physicians inappropriately perform post-operative care.

This legislation would prevent itinerant ophthalmologists from allowing non-medical personnel to provide inappropriate post-operative care after eye surgery.

It is imperative that trained physicians see patients after surgery to check for infections, other diseases, complications that might occur following surgery to prevent potential loss of vision.

It is irresponsible to permit delegation of post-operative care to an optometrist who can neither accurately diagnose nor treat complications and emergencies.

This legislation would have no fiscal impact to consumers or to health care costs. In fact, patients would receive better and safer treatment at no additional costs.

Below, please find our analysis of HB 142. We ask for your support and co-sponsorship of this important legislation.

BRIEFING: HB 142

HB 142, an act relating to provider responsibility for ocular postoperative care in Alaska, has been introduced to regulate potential abuses of comanagement arrangements.

- HB 142 recognizes the unique challenges of practicing in Alaska. HB 142 does not prohibit legitimate comanagement. HB 142 would have no effect on responsible surgical practice in Alaska. HB 142 is consistent with the principles of the Joint Position Paper of the American Academy of Ophthalmology and the American Society of Cataract and Refractive surgery on Ophthalmic Postoperative Care.
- HB 142 provides that unless a surgeon enters into a written comanagement agreement with the patient, the bill requires a surgeon to be physically available to a patient for postoperative care in the community in which the operation was performed for 120 hours after the surgery.
- HB 142 PERMITS COMANAGEMENT if:
 - the distance the patient would have to travel to the regular office of the operating surgeon would result in an unreasonable hardship for the patient, as determined by the patient;
 - the surgeon will not be available for postoperative care as a result of the surgeon's personal travel, illness, travel to an area of the state for occasional practice of medicine, or travel to an area of a state designated as a physician shortage area; or
 - other justifiable circumstances exist, as determined by the State Medical Board.
- HB 142 PROTECTS OPHTHALMOLOGISTS AND PATIENTS by prohibiting comanagement arrangements:
 - in which a fee is paid to the person to whom the care is delegated that does not reflect the fair market value of the services performed by that person;
 - that are entered into as a matter of routine and not on a case-by-case basis;

- o that are not clinically appropriate for the patient;
 - o that is made with the intent to induce surgical referrals; or
 - o that is based on economic considerations affecting the surgeon.
- HB 142 CONTAINS EXTRA FLEXIBILITY for the surgeon by allowing the surgeon to delegate postoperative care of a patient without a written comanagement agreement because of unanticipated circumstances that were reasonably foreseeable before the surgery was performed.

Please feel free to call me at anytime @ 907-563-8526 and I would be glad to answer any question you may have or provide you with more information.

Sincerely,


Carl Rosen, M.D.
Alaska Academy of Ophthalmology
President

Testimony Against Alaska Co-Management Bill (HB142)

April 22, 2003

Optometrists have been co-managing for over 30 years to the benefit of patients in Alaska as well as the rest of the country. This has been recognized Federally. In 1980, Congress amended the Medicare statues to include payment to Optometrists for co-management of cataract post-operative care. Federal Law is already regulating co-management of surgical patients by Optometrists and is already quite extensive in providing protections for patients.

In Alaska, co-management is important due to the distances that have to be traveled by patients to receive surgical care. There 98 Optometrists in at least 17 locations throughout Alaska and there are only 26 Ophthalmologists in 6 locations in Alaska. Surgical co-management is part of our education, training and licensure, and is part of our standard of care.

This co-management bill brings up several of the following issues:

By stating that co-management may only occur in situations when a surgeon is on vacation, illness or out of town:

Limits a patient's rights to choose a physician to manage their care.

In the state of Alaska, a patient will often have to travel long distances with great expenses for post surgical care. (Including airfare, car rental, hotel and food.) Follow-up surgical care at least includes a one day, one week, one month and three month follow-ups if everything goes normal.

Additionally, it indicates that we are capable of co-managing if the surgeon is on vacation, illness or called on an emergency, but unless it is one of these situations, we are not capable of co-management under this bill.

By stating that a surgeon may only go into a co-management agreement after five Days (if he is on vacation, sick, called on an emergency). This means that a surgeon is going to have to design his surgical schedule so that he is in his office five days after he does the surgery. This will create problems if a surgeon wants to go on vacation or for surgeons who travel to remote towns in Alaska which do not have a patient base to support a surgeon for five days. In the last case, these services will not be offered anymore. Additionally, this limits outside competition from coming to this state as well as special surgical procedures.

By stating if the surgeon needs to go into a co-management situation that the surgeon gets to decide if the Optometrist is qualified to treat the patient.

The qualification of an Optometrist is determined by the National Boards, Alaska State Optometry Board and the Alaska department of occupational licensure. Not by an Ophthalmologist.

This bill limits competition and risks price fixing. Competition is important to the growth of all profession. It continually tests and increases the standards of care, it keep prices competitive, and with a patients freedom to choose which provider is best for their needs, it keep the industry honest and progressive.

Co-management is in no way new to Optometry and has been successfully done for over 20 year in this state. This bill would be a set back in the healthcare provided to Alaskans.

- regulation of all surgeons would be necessary.
- no public health reason.

Dr. Sheryl Lentfer - Wasilla
O.D.

Alaska Academy of Ophthalmology

Carl Rosen, M.D.

President

542 W. 2nd Ave

Anchorage, Ak 99501

907-563-8526

4/11/03

Alaska House of Representatives

Pouch V

Juneau, Ak 99801

Dear Representative,

FINANCE COMMITTEE MEMBERS

The Alaska and American Academy of Ophthalmology endorses HB 142 (introduced by State Representative Cheryl Heinze), an act relating to provider responsibility for ocular postoperative care in Alaska, to regulate potential abuses of comanagement arrangements.

This legislation closes a patient protection loophole. Ocular care is one of the rare areas where non-physicians inappropriately perform post-operative care.

This legislation would prevent itinerant ophthalmologists from allowing non-medical personnel to provide inappropriate post-operative care after eye surgery.

It is imperative that trained physicians see patients after surgery to check for infections, other diseases, complications that might occur following surgery to prevent potential loss of vision.

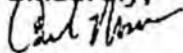
It is irresponsible to permit delegation of post-operative care to an optometrist who can neither accurately diagnose nor treat complications and emergencies.

This legislation would have no fiscal impact to consumers or to health care costs. In fact, patients would receive better and safer treatment at no additional costs.

- that are not clinically appropriate for the patient;
 - that is made with the intent to induce surgical referrals; or
 - that is based on economic considerations affecting the surgeon.
- HB 142 CONTAINS EXTRA FLEXIBILITY for the surgeon by allowing the surgeon to delegate postoperative care of a patient without a written comanagement agreement because of unanticipated circumstances that were reasonably foreseeable before the surgery was performed.

Please feel free to call me at anytime @ 907-563-8526 and I would be glad to answer any question you may have or provide you with more information.

Sincerely,



Carl Rosen, M.D.
Alaska Academy of Ophthalmology
President

ALASKA STATE HOUSE OF REPRESENTATIVES

Session

(907)-465-4930
FAX# 465-3834
State Capitol
Room 416



Representative Cheryl Heinze

ECONOMIC DEVELOPMENT, TRADE AND TOURISM

**CHAIR
HB 142**

SPONSOR STATEMENT

The majority of eye surgery performed in the United States today is technologically advanced and is safer and more effective than ever before. The most common major eye surgery performed in the United States is cataract surgery; with more than 1.5 million cases a year. Cataract surgery has evolved to such an advanced state that many cases take less than 15 minutes to perform. The speed with which modern cataract surgery can be performed has tended to trivialize the seriousness of this surgery in the public's mind, causing patients to infer that it is risk free. No surgery is risk free, including short cases such as uncomplicated cataract surgery. However, complications do occur and can be serious. Permanent loss of vision and patient death are some of the more serious potential complications. It is important for postoperative care to be managed by an ophthalmologist familiar with the surgery and the potential complications.

Unfortunately, reduction of surgical time for cataract surgery has led to the appearance of so-called "cataract mills" where patients are referred in large numbers by an optometrist and, in return for a "co-management fee", the referring optometrist is then allowed to manage the patient postoperatively. The operating surgeon, in this setting, often meets the patient just minutes prior to surgery and takes no responsibility after surgery. In some cases this surgeon may travel from cataract mill

to cataract mill and is unavailable for any postoperative consultation or advice. The patient's follow-up care is therefore abandoned, by pre-arrangement, to the referring

Optometrist who is not qualified by training or experience to handle any serious complications resulting from the cataract surgery.

Another serious situation may arise as a result of the "cataract mill". Should the patient require hospitalization, the surgeon is unlikely to have local hospital privileges. The patient is then dumped on another ophthalmologist unfamiliar with the patient but now responsible for rendering critical care.

Co-management of eye surgery as currently practiced in Alaska is a recipe for sub-optimal patient care. House Bill 142 addresses the issue of postoperative care for eye surgery in Alaska, taking into account the unusual and sometimes-difficult medical and surgical challenges our state often poses in terms of isolation, limited medical resources and transportation difficulties.

Alaska State Legislature
HOUSE OF REPRESENTATIVES
House Finance Committee

AGENDA

April 23, 2003 - Wednesday

*HB 203 – AIDEA DIVIDEND

No Public Testimony. Heard and Held from previous meeting.

Rep. Hawker / David Brewster
Teleconference for Questions :
Sarah Fisher-Goad, AIDEA
Valerie Walker - Deputy Director Finance (teleconference)

HB 61 – OIL / GAS TAX CREDIT

Testifiers:

Rep. Chenault
JOHN A. BARNES, P.E., Unit Manager, Marathon Oil
Chuck Logsdon, Chief Petroleum Economist, Revenue
Mark Meyers, Director, Division of Oil and Gas, DNR

*HB 165 – COMMUNITY SCHOOLS

No Public Testimony except by invitation.

Testifiers:

Eddy Jeans, Manger, School Finance, DEED

FISCAL NOTE

STATE OF ALASKA
2003 LEGISLATIVE SESSION

Fiscal Note Number: 1
 Bill Version: HB 142
 (H) Publish Date: 4/2/03

Revision Date/Time (Note if correction):
 Title An Act relating to provider responsibility for
ocular postoperative care;
 Sponsor Representative Heinze
 Requester House HESS

Dept. Affected: DCED
 BRU Occupational Licensing (117)
 Component Occupational Licensing
 Component No. 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()	0.0	0.0	0.0	0.0	0.0	0.0
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other 1156 - Receipt Supported Services						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2003) cost: 0.0

Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

HB 142 creates new responsibilities for physicians when providing ocular postoperative care. New funds are not required to implement this bill.

Prepared by: Jennifer Strickler, Administrative Manager
 Division: Occupational Licensing
 Approved by: Edgar Blatchford, Commissioner
 Agency: Department of Community & Economic Development

Phone (907) 465-2144
 Date/Time 4/1/03 1:55 PM
 Date 4/1/2003



James N. Matson, O.D., P.C.
Jill L. Geering, O.D.
Doctors of Optometry

April 22, 2003

Representative Bill Williams
Chair, House Finance Committee
Fax 465-3793

Re: HB142

Dear Representative Williams:

I understand that there will be a hearing on HB 142 tomorrow, April 23, 2003. I am planning on attending and wish to testify against this bill. So that it may be entered into the official record, I am giving you a copy of my testimony. It is my hope that you vote no on HB 142.

Sincerely,

A handwritten signature in cursive script that reads "Jill Geering, O.D.".

Jill Geering, OD

April 22, 2003

Arguments Against Alaska Co-Management Bill

1. Co-management of surgical patients by optometrists is already adequately regulated under Federal law. In 1980, Congress amended the Medicare statute to allow payment to doctors of optometry for cataract post-operative care. The report from the then Department of Health, Education, and Welfare upon which this legislation was based concluded, "The services appear to be effective in patient management, including the management of aphakic and cataract patients. They are reasonable, non-experimental, safe and generally acceptable to the vision/eye care community and the public." The Federal law is quite extensive in providing patient protections and should not be tampered with. States are avoiding doing this, and the Alaska bill would be an unwise first.
2. Federal law is premised on protecting patients from financial exploitation in co-management arrangements. Neither Federal law nor any state law has ever questioned the clinical competence of optometrists to co-manage patients, and optometrists have been doing so successfully for over twenty years. There is no public health justification for the Alaska co-management bill.
3. The Alaska co-management bill effectively eliminates optometrists from the co-management of patients by preventing them from being involved in patient care for 5 days following surgery. This is harmful to patients.
4. The Alaska bill forces patients to seek out less available and more expensive ophthalmological care for no legitimate health care reason. Again, the co-management regulation adopted by the Federal laws was not premised on patients being in any health care danger, but was premised on protecting patients from being taken advantage of financially. Both an optometrist's and an ophthalmologist's ordinary obligations not to commit medical malpractice would work to prevent any harmful clinical co-management decisions within the first five days of surgery. This bill adds nothing to those protections, and is a step backwards from Federal law in that it limits patient access to care and makes it more likely that patients will unnecessarily pay more for care (from ophthalmologists) – exactly what the Federal law was aimed at preventing.
5. Even if I believed that co-management should be limited, I would argue against this bill. It is full of technical flaws and ambiguities.
 - a) While this doesn't specifically prohibit optometrists from performing post op care after the 5 day period, it is a barrier. It eliminates patient's freedom of choice, and creates fear. According to the bill (section C, number 5, and letter g), the patient is to be made aware of special risks that may happen to them if they enter into a co-management agreement. Since there are no special risks (as

- determined by Congress over 20 years ago), I would like to see what such a description would say, because optometrists and other ophthalmologists, are licensed and qualified to perform such care.
- b) There seems to be a double standard in regards to many of the exceptions. The Alaska bill shifts the determination of patient travel hardship onto the shoulders of the patient, which is an unworkable legal standard. The exemption for the surgeon's travel that says, "if the surgeon will not be available for postoperative care...as a result of the surgeon's personal travel, illness, etc....." is obviously self serving on the surgeons part. If the true intent of this bill is to protect the public, why is it unsafe and not good medicine for other well trained eye care professionals to co-manage in normal circumstances, but if a surgeon is going on vacation, then it is ok for others to co-manage safely?
 - c) The agreement can only be entered into if the surgeon confirms that the co-manager is qualified to treat the patient. This is not the surgeon's job, this is the licensing department's job. Does this mean that the surgeon must contact occupational licensing before entering into a co-management agreement?
 - d) The co-managing doctor cannot further delegate care to another. What if the co-managing doctor is sick, ill, or called out of town on an emergency and the surgeon is off on vacation? Any referral to a third doctor would violate this law, but the co-managing doctor is ethically bound to arrange care for that patient.
 - e) An exception is made to US Public Health Service doctors or US Armed Forces doctors who are volunteering without pay or other remuneration. This implies that patients are safe for co-managing if follow up care is free, but not safe if it isn't free? Or does this just mean that the ophthalmologists shouldn't have to provide free follow up care...but they are the only one who should provide follow up care if it is paid for?
 - f) Midwives are exempt. This bill would pass into law a provision that allows midwives to perform follow up care for someone who had cataract surgery.

As some of you may know, there is an unfortunate divide between ophthalmologists and optometrists in this state. Most of which is professional jealousy. Optometrists seek to move forward by way of improving on and learning new techniques to better serve the citizens of Alaska, including adding oral medications to our licensure. Ophthalmologists have opposed that. This bill is another attempt at limiting our scope of care and superseding the Alaska Board of Optometry. This bill would not only limit us, but it would move our profession back to the 1960's. I encourage you to vote no.

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

04/22/2003

House Finance Committee Members
Alaska State Legislature
State Capitol
Juneau, Alaska 99801

Re: HB 142— Ocular Postoperative Care

Dear Finance Committee Members,

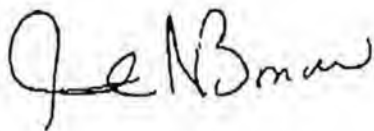
The Alaska State Medical Association (ASMA) represents Alaska's patients and the physicians who care for them.

ASMA is writing to support HB 142. Appropriate postoperative care following ocular surgery by an "EYE MD", an Ophthalmologist, is imperative for good patient care.

Today's technology makes many surgical procedures, including ocular surgeries, appear to be routine. Most often, such surgeries have a high rate of success. So high, the public loses sight of the seriousness of the surgery and of the complications that might occur.

HB 142 provides for appropriate ocular postoperative care by the appropriate professional, the ophthalmologist (the "Eye MD").

Sincerely,



Jeanne Bonar, MD
President

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA


(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mall Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

March 19, 2003

SUBJECT: Sectional Analysis (HB 142)
TO: Representative Cheryll Heinze
FROM: Terri Lauterbach
Legislative Counsel



You have requested a sectional summary of the above-described bill.

As a preliminary matter, please note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. Since you have not expressed questions about any particular aspect of the bill, this summary is brief. Let me know if you have specific questions.

Section 1. Places limits on how and when a surgeon who performs eye surgery in this state may delegate responsibility to someone else for post-operative care of the patient.

Secs. 2 - 3. Require compliance with sec. 1 of the bill by certain people who are exempt from licensing as physicians.

Sec. 4. Adds definition of "knowingly," which is a term used in secs. 1 and 3 of the bill.

Secs. 5 and 7. Allow the State Medical Board to begin the regulations process before the rest of the bill takes effect.

Sec. 6. Applies the amendments made by the bill to eye surgery occurring on or after the effective date of secs. 1 - 4 of the bill.

TML:med
03-323.med



Rick D. Swearingen, O.D.
Erik D. Christianson, O.D.

TESTIMONY REGARDING HB 142

April 23, 2003

Members of Alaska House Finance Committee,

My name is Erik D. Christianson, OD and I am an optometrist in private practice in Ketchikan. I have practiced in Ketchikan since January 1990. Prior to that time I was the eye coordinator and staff optometrist in Barrow, Alaska from 1987-90. While I was in Barrow I was employed by the North Slope Borough Health Department.

HB 142 is a good example of poorly thought out legislation.

I am opposed to the spirit of this bill. By that I mean that entire premise on which it is founded is wrong. The premise is that post-operative care after eye surgery or co-management needs to be regulated. Co-management of surgical patients by optometrists is already regulated under federal law. No other state has this type of law. If you are regulating co-management between ophthalmologists and optometrists then why not other types of surgical specialties and the local doctors who will follow their patients. This is not the job of the legislature!!!

It questions the clinical competence of optometrists to co-manage patients. Optometrists have been performing this to a high level for more than 20 years. I have been a member of the Board of Optometry for 5+ years and we have never had a case brought us where an optometrist caused a patient harm.

It is an attempt to legislate clinical decision making on the part of ophthalmic surgeons. If a surgeon is performing "bad surgery" federal law, malpractice, referring providers, and the PATIENTS themselves will cause this surgeon to stop.

It is bad for rural Alaska in that it limits the potential choices available to these patients. Currently certain eye surgical procedures are performed at Ketchikan General Hospital (KGH) and the ophthalmologists who perform them would have a hard time managing the 5 day time limit. I do not co-

351 Carlanna Lake Road
Ketchikan, Alaska 99901
907-225-2020
Fax: 907-247-2015

manage with these doctors except when their patients develop problems after they leave. In the 13 years I have been in Ketchikan I have had to only help out a handful of times. HB 142 would not allow me as an optometrist to help out within the critical first 5 days. Even though only 35 surgeries per year are done at KGH it offers a choice for those persons who have difficulty traveling or are covered by Medicaid or Medicare and cannot afford travel.

Optometrists live where the patient lives. We are the eye care expert in rural Alaska limiting our ability to care for our patients is bad for these patients and the communities we serve.

HB 142 is an attempt to limit patient access to care it is obviously special interest legislation, and is both anti-consumer and anti-patient.

Do not allow HB 142 to move forward.

Erik D. Christianson, O.D.
Secretary Alaska State Board of Examiners in Optometry
351 Carlanna Lake Rd
Ketchikan, AK 99901
907-225-2020

OLIVER M. KORSHIN, M. D.
DISEASES AND SURGERY OF THE EYE

ALASKA MEDICAL PLAZA
1200 AIRPORT HEIGHTS DRIVE, SUITE 310
ANCHORAGE, ALASKA 99508
(907) 276-8838
FAX (907) 258-0735

March 10, 2003

Representative Pete Kott
State Capitol
Juneau, Alaska 99801-1182

Dear Representative Kott:

I am writing to ask your support of HB 142, a bill to regulate ocular postoperative care in Alaska. The bill is also known as the "co-management bill."

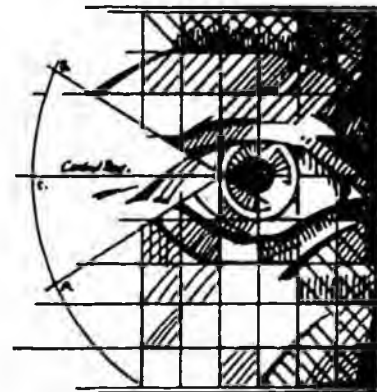
Co-management means that a practitioner other than the operating surgeon provides postoperative care. Because co-management frequently involves splitting of the surgical fee between the surgeon and the provider of postoperative care, co-management arrangements have drawn the attention of the U. S. DHHS Office of the Inspector General in an ongoing national effort to assure that such arrangements do not violate federal anti kick-back statutes.

But co-management not only poses the potential for illegal kickbacks — perhaps more important, it can harm patients. Let me explain.

Eye surgery performed in the United States today has become so technologically advanced that it is safer and more effective than ever before. This applies particularly to cataract surgery, the most common major surgery performed in our country — more than 1.5 million cases a year. Cataract surgery has become so advanced that many cases take less than fifteen minutes, using tiny incisions and foldable intraocular lens implants. Patients go home almost immediately and not infrequently are able to see 20/20 that same day.

The speed with which modern cataract surgery can be performed, as well as its astounding success rate, have unfortunately trivialized the seriousness of this surgery in the public's mind, causing patients to infer that it is risk-free. This is rather like inferring that handling a high-performance jet fighter plane is risk-free. With high-performance jet planes — as with 21st century eye surgery — increased speed and increased performance sometimes mean that things can go very wrong very quickly. And they do.

In other words, modern cataract surgery is still subject to complications, some of them serious. Although serious complications occur infrequently, they do occur with statistical regularity. When they occur, often in the first 72 hours following surgery, they must be managed by a qualified ophthalmologist who is familiar with the surgery, its potential complications and how these complications must be managed.



The reduction in the time it takes to perform cataract surgery has led to the appearance of so-called cataract mills, to which patients are referred in large numbers by optometrists, who receive a co-management fee for following the patient after surgery, including the diagnosis and treatment of short- and long-term surgical complications.

Often the surgeon in a cataract mill does not see the patient until a few minutes before surgery. After surgery, the patient may never see the surgeon again. In fact, the surgeon may leave town a shortly after surgery, traveling to another cataract mill location (which may be out-of-state). He may not return for weeks or longer, and then it is not to see his post-operative patients, but to operate on the next wave of referrals. A patient's follow-up care is therefore delegated, by pre-arrangement, to the referring optometrist, who is not qualified by training or experience to manage the major complications of cataract surgery, some of which require additional and sometimes complex surgery to treat.

When the co-managing optometrist is presented with a serious complication of cataract surgery that may require admission to a hospital, he must "dump" the patient into the hands of a local ophthalmologist, as the mill surgeon has left town or, if in town, may not have local hospital privileges. The new ophthalmologist is suddenly responsible for rendering critical care a very ill patient fearful of going blind, whom he has never seen before and about whom he knows nothing.

Hence, co-management of eye surgery can be a recipe for sub-optimal postoperative care. House Bill 142 addresses this important patient safety issue while taking into account the unusual and sometimes difficult medical-surgical challenges our state poses in terms of isolation, vast distances and transportation difficulties.

How do I handle cataract surgery in my own practice? I stopped all cataract surgery last year, so I refer my patients who need cataract surgery to other local ophthalmologists. I refuse to co-manage: postoperative care is the surgeon's responsibility. I refer only to ophthalmologists who will provide all my patients' postoperative care — not just for 120 hours as stipulated in this bill, but for the entire 90-day "global" postoperative period. I believe this represents sound and ethical medical practice. One hundred and twenty hours is the bare minimum.

I urge you to support HB 142.

Sincerely,



Oliver Korshin, M. D.



March 21, 2003

Alaska State Senators and Representatives

Dear Legislators

Representative Wilson,

I am writing to ask for your support of HB 142 and companion bill SB 129, legislation to ensure that Alaska citizens have the necessary information regarding postoperative surgical eye care. The enactment of HB 142 and SB 129 is a positive step forward to enhance patient understanding of postoperative surgical eye care treatment.

This legislation sets forward clear rules as to the procedures that an ophthalmologist and optometrists must follow when a comanagement agreement is agreed upon. Just as importantly, this legislation informs the patient as to the type of care he or she will be receiving from each health care provider – the ophthalmologist and the optometrist. Patient protection is this legislation's objective. With enactment of HB 142 and SB 129, the ethical relationship between the ophthalmologist, the optometrist, and patient is once again paramount.

As a working pediatric ophthalmologist in Anchorage who attended the University of Alaska-Fairbanks, I have a perspective of the Alaska health care system both as a citizen and as a physician.

The delivery of quality health care is a challenge due to our state's size and rural nature. For example, I travel to our practice's satellite clinics in Wasila, Codova, Kodiak, and Homer. It is my goal to deliver quality and affordable pediatric ophthalmic care to urban and rural residents of our Great State. I have coordinated several research efforts including the 6 plus years, cooperative, charitable project to vision screen every preschool Alaskan called the "Alaska Blind Child Discovery." We have provided pre-school vision screening to over 14,000 Alaska children free of charge. I have also served as the Eye section Chief at Providence hospital for the last 11 years coordinating emergency eye call for much of the state.

>From my residency training at the Mayo Clinic and my practice in Anchorage with Ophthalmic Associates, I have learned the value of careful, open-referral and consultative medicine. Ophthalmic Associates is a subspecialty eye practice of optometrists (ODs) and ophthalmologists.

I mention referral and consultative medicine because as a legislator you must often feel that ophthalmologists and optometrists do not work well together. This is not the case. For example, Ophthalmic Associates is a subspecialty eye practice of ophthalmologists (MDs) and optometrists (ODs). We can and do work together to deliver quality patient eye care services.

However, there is what I would term a growing pressure for ophthalmologists and optometrists to enter into what is called "co-management" practice pattern in regards to postoperative surgical eye care that is not in the best interest of the patients.

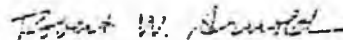
From my professional observation of the increased pressure for these types of agreements, I believe HB 142 and SB 129 are needed and are in the patient's best health care interest.

I am not against all collaborative care arrangements between Alaska's optometrists and ophthalmologists. I have and will continue to collaborate with other optometrists; family physicians and ophthalmologists in the medical and long-term postoperative care of Alaskan citizens, to and referred patients from the Russian Far-East (charitable surgical care).

However, you must be made aware that the current practicing environment works to destroy ethical arrangements between optometrists and ophthalmologists and fosters comanagement relationships between optometrists and ophthalmologists that are not in the best long-term interests of patients. That is why I support HB 142 and SB 129.

The enactment of HB 142/SB 129 will ensure that if a physician chooses to comanage a patient, its will be for health care considerations, not for future referrals or some other economic consideration. This legislation is a positive step forward to improve patient understanding of postoperative surgical eye care treatment.

Sincerely Yours,



Robert W. Arnold, M.D.



Rick D. Swearingen, O.D.
Erik D. Christianson, O.D.

April 8, 2003
Representative Bill Williams
State Capitol
Juneau, AK 99801-1182

RE: HOUSE BILL 142; "An Act relating to provider responsibility for ocular postoperative care; and providing for an effective date."

Representative Williams,

I am writing to ask you to VOTE NO on House Bill 142. This bill is a camouflaged attempt by big city health care professionals (this time ophthalmologists) to protect their "turf" under the guise of delineating care. I filled Randy Ruaro in on the specifics. I appreciated his listening ear. In addition to this letter I am also enclosing a paper written by the American Optometric Association for their optometry members outlining "Optometric Postoperative Care".

Arguments Against Alaska Co-Management Bill

1. Co-management of surgical patients by optometrists is already adequately regulated under Federal law. The Federal law is quite extensive in providing patient protections and should not be tampered with. States are avoiding doing this, and the Alaska bill would be an unwise first.
2. Federal law is premised on protecting patients from financial exploitation in co-management arrangements. Neither Federal law nor any state law has ever questioned the clinical competence of optometrists to co-manage patients, and optometrists have been doing so successfully for over twenty years. There is no public health justification for the Alaska co-management bill.
3. The Alaska co-management bill effectively eliminates optometrists from the co-management of patients by preventing them from being involved in patient care for 5 days following surgery. This is harmful to patients especially in communities that do not have an ophthalmologist or have only itinerant surgeons.
4. The Alaska bill forces patients to seek out less available and more expensive ophthalmological care for no legitimate health care reason. Again, the co-management regulation adopted by the Federal laws was not premised on patients being in any health care danger, but was premised on protecting patients from being taken advantage of financially.
5. Technical flaws -- the Alaska bill shifts the determination of patient travel hardship onto the shoulders of the patient, which is an unworkable legal standard, and creates exceptions for the surgeon providing post-operative care that fly in the face of the bill's purported concern for patient welfare (for example, a personal travel exception for the surgeon -- in case he wants to take a vacation after surgery?).

351 Carlanna Lake Road
Ketchikan, Alaska 99901
907-225-2020
Fax: 907-247-2015

6. Both an optometrist's and an ophthalmologist's ordinary obligations not to commit medical malpractice would work to prevent any harmful clinical co-management decisions within the first five days of surgery. This bill adds nothing to those protections, and is a step backwards from Federal law in that it limits patient access to care and makes it more likely that patients will unnecessarily pay more for care (from ophthalmologists) – exactly what the Federal law was aimed at preventing.

Feel free to contact me if you need someone to testify or need more information.

Regards,



Erik D. Christianson, O.D.

Cc: file

erik @ karnet. net

OPTOMETRIC POSTOPERATIVE CARE

This paper discusses the proper role and responsibilities of providers in co-managing patients, consistent with federal regulations and ethical standards. For purposes of the paper, co-management is defined as two or more independently licensed health care professionals sharing responsibility for the diagnosis, treatment and management of a patient's medical or surgical condition.

Background

Doctors of optometry have been successfully co-managing patients with ophthalmic surgeons for many years. The federal government has long recognized the role of optometrists in providing this care. In 1980, Congress amended the Medicare statute to allow payment to doctors of optometry for cataract post-operative care. The report from the then Department of Health, Education and Welfare (HEW) upon which this legislation was based concluded, "The services appear to be effective in patient management, including the management of aphakic and cataract patients. They are reasonable, non-experimental, safe and generally acceptable to the vision/eye care community and the public."

Recently, the American Academy of Ophthalmology (AAO) and the American Society of Cataract and Refractive Surgery (ASCRS) have issued a joint position paper on this issue. The paper purports to offer guidelines on when co-management is ethical and proper and concludes that such situations should be an exceptional occurrence. This conclusion is not grounded in law, regulation, or the American Academy of Ophthalmology's own Code of Ethics. At the same time, government regulation of referral relationships does require providers to carefully assess such relationships to assure both compliance with federal requirements as well as good patient care. This paper seeks to offer guidance in this area.

Government Activity

Medicare Carriers

Two Medicare carriers have issued local medical review policies on the issue of co-management, Connecticut in 1998 and New York in 1999.

The Connecticut policy clearly states that co-management can occur whenever the patient chooses to return to the referring provider for necessary care. It is our understanding that the New York carrier intends to provide for such patient choice and is currently redrafting its policy to reflect this.

No other carriers have acted in this area. At least two other carriers have withdrawn more restrictive proposed policies following consultation with officials of the Health Care Financing Administration (HCFA).

Page 2 of 3

Office of Inspector General (OIG)

On November 19, 1999 the Department of Health and Human Services Office of Inspector General issued a final rule revising safe harbor protection under the Medicare Anti-Kickback statute. The rule outlined safe harbors for referral arrangements for specialty services. Noting a potential for abuse when the referring physician and the specialty physician receiving the referral split a global payment from a Federal health program, the IG rule specifically excluded such situations from the safe harbor. The rule made clear, however, that the IG did not intend for this action to be construed as meaning all such relationships violate the anti-kickback statute. Instead the rule stated that whether a particular referral situation violated the statute would depend on a case-by-case analysis of the facts and circumstances, including whether the specialty services are medically necessary, whether the timing of the referral back to the originating referral source is clinically appropriate and whether the services performed are commensurate with the portion of the global fee received.

AAO-ASCRS Paper

The AAO-ASCRS joint paper states that co-management should be an exceptional occurrence. As previously noted, no federal requirements support this claim. Nor does the American Academy of Ophthalmology's Code of Ethics. The AAO's advisory opinion on the code states

"Ethical Rules 7 and 8 (Delegation of Service and Postoperative Care) would not preclude an Academy member from referring patients to a non-ophthalmological physician or allied health care personnel for those aspects of postoperative care that are not within the unique competence of the ophthalmologist (which include those aspects of postoperative care permitted by law to be performed by auxiliaries, and, for non-ophthalmological physicians, may also include additional functions), provided that the person is legally entitled and professionally trained, experienced, and qualified to provide the particular services."

There is no mention as to the frequency with which such care should occur. The Federal Trade Commission (FTC), which conditionally approved the AAO Code of Ethics at AAO's request, stated specifically "the rule would not prevent ophthalmologists from arranging for optometrists to provide post-operative eye care services consistent with state law." The Commission further concluded "Serious antitrust concerns would, of course, be raised by an ethical rule that unreasonably interfered with legitimate competition by ophthalmologists working in conjunction with non-physician health care professionals, or prevented optometrists or others from providing services they are legally and professionally qualified to provide."

Suggested Guidelines

Co-managed care should always adhere to the basic tenets of good patient care, the ethical responsibilities of providers, and governmental rules. The following suggested guidelines are offered to help providers meet these objectives.

- The selection of an operating surgeon for patient referral should be based on providing the best potential outcomes for that patient. Financial relationships between providers should not be a factor.

Page 3 of 3

- The patient's right to choose the method of postoperative care should be recognized consistent with the best medical interest of the patient. Co-management of post-operative care should be determined on a case-by-case basis and not prearranged. For example, agreements to refer all patients back on a date certain should be avoided¹. The patient should be advised prior to surgery of potential postoperative management options.
- The transfer of post-operative care must be clinically appropriate and depend on the particular facts and circumstances of the surgical event.
- Following surgery, transfer of care from the operating surgeon to an optometrist should occur when clinically appropriate at a mutually agreed upon time or circumstance; and such time should be clearly documented via correspondence and be included in the patient's medical record. For example, Section 4822 of the Medicare Carriers' Manual states that "Both the surgeon and the physician providing the postoperative care must keep a written transfer agreement in the beneficiary's record". This may be accomplished by including the appropriate information in the referral letter from the ophthalmic surgeon to the optometrist at the time of transfer of care.
- The operating surgeon and the co-managing optometrist should communicate during the post-operative period to assure the best possible outcome for the patient.
- Compensation for care should be commensurate with the services provided. Cases involving care for Medicare beneficiaries should reflect proper use of modifiers and other Medicare billing instructions.

Conclusion

The American Optometric Association believes that referrals for specialty services should be based on achieving the best possible outcome for the patient and not on financial relationships between providers. All health care professionals have an ethical obligation to patients for whom they are responsible to insure that medical and surgical conditions are appropriately evaluated and treated. Decisions to co-manage should be made on an individual basis and should always include proper and complete documentation and communication between providers. Co-management should occur only when these basic principles are followed.

This paper is provided for informational purposes. It suggests voluntary guidelines, which are not enforceable by AOA, for consideration by an individual practitioner in determining what co-management relationships are in his or her patients' best interests and are appropriate. Practitioners should exercise their professional judgment in applying these guidelines to the particular circumstances of their practice and to the specific needs of individual patients. This paper is not intended to, and does not, provide legal advice or a legal opinion with respect to Federal or state laws regulating co-management, or any specific co-management circumstances. Practitioners should consult with their own attorneys regarding any questions with respect to such legal matters.

Approved AOA Board of Trustees, April 27, 2000

¹ Federal Register, November 19, 1999, page 63548

KETCHIKAN EYE CARE CENTER
351 CARLANNA LAKE ROAD
KETCHIKAN, ALASKA 99901

FAX TRANSMITTAL SHEET

RETURN FAX NUMBER (907) 247-2015

TO: RANDY RUDOLPH

FROM: DR. CHESTERSON

DATE: APRIL 8, 2003 NUMBER OF PAGES, INCLUDING COVER PAGE: 6

IF THERE ARE ANY PROBLEMS WITH THIS TRANSMITTAL PLEASE CALL (907) 225-2020.

NOTE: _____

HB 142

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Thank you

Issue 1

February 2003

Alaska Optometry News

Alaska Optometric Association
1689 C Street, Suite 222
Anchorage, AK 99501

E-mail: akoa@alaska.com
Web: www.ako2.org



The State of Alaska has 98 practicing **Optometrists** in:

- 45 Anchorage
- 3 Bethel
- 1 Barrow
- 1 Dillingham
- 7 Eagle River
- 15 Fairbanks
- 1 Homer
- 6 Juneau
- 2 Kenai
- 2 Ketchikan
- 2 Kodiak
- 1 Kotzebue
- 2 Nome
- 1 North Pole
- 2 Sitka
- 2 Soldotna
- 5 Wasilla

And 27 practicing **Ophthalmologists** in:

- 20 Anchorage
- 2 Fairbanks
- 1 Homer
- 2 Juneau
- 1 Soldotna
- 1 Wasilla



Eye Opener: The external muscles that move the eyes are the strongest muscles in the human body for the job that they have to do. They are 100 times more powerful than they need to be.

PRIMARY EYE CARE: OPTOMETRY

Optometrists (O.D.) are independent primary health care providers that specialize in treatment of the eye and visual system by prescribing drugs, vision therapy, glasses, contact lenses, and other procedures according to various state laws. Optometry training is 8-9 years of college and graduate school for a doctor's degree, plus yearly continuing education required by state law. The training is the same medical model as dentists and physicians.

Primary Care providers, such as optometrists, podiatrists, dentists, advanced nurse practitioners, and family care MD's offer care for the majority of conditions, but refer to specialists for more complex Secondary Care or sub-specialists for most complex Tertiary Care. The entire medical community teams with specialists such as ophthalmologists, cardiologists, neurosurgeons, etc. Primary care is cost-effective, while specialty care is more expensive.

Optometrists provide 70-100% of the primary eye care services in Alaska, because they are more widely distributed geographically around the state. Many small communities had limited eye care in the past, but now have better access to optometric care.

Doctors of optometry, (O.D.) are primary health care professionals who examine, diagnose, treat and manage diseases and disorders of the visual system, the eye and associated structures, as well as diagnose related systemic conditions. They prescribe glasses, contact lenses, low vision rehabilitation, vision therapy and medications, as well as perform certain surgical procedures as regulated by state law.

An ophthalmologist (M.D.) practices eye care, specializing in consultation, treatment and surgery of the human eye and related structures.

PRIMARY EYE CARE	SECONDARY EYE CARE	TERTIARY EYE CARE
Conjunctivitis	Eyelid surgery	Reconstructive oculoplastic surgery
Eyelid infection (stye)	Eyelid tumor	Intraocular tumor
Anterior uveitis	Posterior uveitis	Vitreoretinal surgery
Corneal abrasion	Corneal laceration	Corneal transplant
Therapeutic treatment of glaucoma	Laser surgery for glaucoma	Filtering surgery for glaucoma
Foreign body removal-Anterior eye surface	Foreign body removal- Interior of eye	Foreign body removal with complications
Cataract care, pre-op & post-op	Cataract surgery	Severe complications of cataract surgery
Refractive surgery care, pre-op & post-op	Refractive surgery	Severe complications of refractive surgery



**AMERICAN ACADEMY
OF OPHTHALMOLOGY**
The Eye M.D. Association

March 31, 2003

Dear House Health, Education and Social Services Committee Member,

As President of the American Academy of Ophthalmology (AAO) with a membership of approximately 27,000 ophthalmologists, I want to bring to your attention an important patient care issue relating to eye surgery.

Many of your constituents are at an age where their eyesight is deteriorating and are in need of medical care. Much of this medical care includes surgical procedures and other treatments that are best provided by a medical doctor or a doctor of osteopathy. Surgical post-operative care clearly falls within this category.

HB 142 would eliminate abuses in the collaboration of surgical post-operative care in Alaska between providers. Specifically, this bill would eliminate incentives for entering into a collaborative post-operative care arrangement that is driven primarily by economic incentives such as an inducement for surgical referrals. I believe the only legitimate reason for entering into collaborative post-operative care arrangement are patient needs.

In February 2000, the American Academy of Ophthalmology published a paper on "Ophthalmic Postoperative Care." The provisions of HB 142 are consistent with the principles of this policy. Furthermore, I believe that the provisions of this bill are also flexible enough to allow physicians to provide the best possible care given the special geographic and climatic conditions unique to Alaska.

If you have any further question, please do not hesitate to contact me at 202-737-6662.

Michael R. Redmond

Michael Redmond, MD
President

cc: *Alaska State Legislature*

P.O. Box 7466
San Francisco, CA 94120-7466

622 Beach Street
San Francisco, CA 94106-1338

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Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

04/10/2003

Honorable Cheryll Heinze
Honorable Robin Taylor
Alaska State Legislature
State Capitol
Juneau, Alaska 99801

Re: HB 142/SB 129 – Ocular Postoperative Care

Dear Representative Heinze and Senator Taylor,

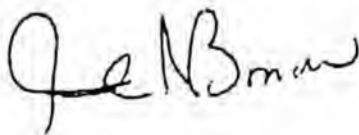
The Alaska State Medical Association (ASMA) represents Alaska's patients and the physicians who care for them.

ASMA is writing to support HB 142 and SB 129. Appropriate postoperative care following ocular surgery by an "EYE MD", an Ophthalmologist, is imperative for good patient care.

Today's technology makes many surgical procedures, including ocular surgeries, appear to be routine. Most often, such surgeries have a high rate of success. So high, the public loses sight of the seriousness of the surgery and of the complications that might occur.

HB 142 and SB 129 provides for appropriate ocular postoperative care by the appropriate professional, the ophthalmologist (the "Eye MD").

Sincerely,



Jeanne Bonar, MD
President

Cc: Other members of the Alaska State Legislature

April 21, 2003

Alaska State House Finance Committee Members:

Dear Finance Committee *Chair Williams,*

I am writing to ask for your support of HB 142, legislation to ensure that Alaska citizens have the necessary information regarding postoperative surgical eye care. The enactment of HB 142 is a positive step forward to enhance patient understanding of postoperative surgical eye care treatment.

This legislation sets forward clear rules as to the procedures that an ophthalmologist and optometrists must follow when a comanagement agreement is agreed upon. Just as importantly, this legislation informs the patient as to the type of care he or she will be receiving from each health care provider - the ophthalmologist and the optometrist. Patient protection is this legislation's objective. With enactment of HB 142, the ethical relationship between the ophthalmologist, the optometrist, and patient is once again paramount.

As a working pediatric ophthalmologist in Anchorage who attended the University of Alaska-Fairbanks, I have a perspective of the Alaska health care system both as a citizen and as a physician.

The delivery of quality health care is a challenge due to our state's size and rural nature. For example, I travel to our practice's satellite clinics in Wasilla, Codova, Kodiak, and Homer. It is my goal to deliver quality and affordable pediatric ophthalmic care to urban and rural residents of our Great State. I have coordinated several research efforts including the 6 plus years, cooperative, charitable project to vision screen every preschool Alaskan called the "Alaska Blind Child Discovery." We have provided pre-school vision screening to over 14,000 Alaska children free of charge. I have also served as the Eye section Chief at Providence hospital for the last 11 years coordinating emergency eye call for much of the state.

From my residency training at the Mayo Clinic and my practice in Anchorage with Ophthalmic Associates, I have learned the value of careful, open-referral and consultative medicine. Ophthalmic Associates is a subspecialty eye practice of optometrists (ODs) and ophthalmologists.

I mention referral and consultative medicine because as a legislator you must often feel that ophthalmologists and optometrists do not work well together. This is not the case. For example, Ophthalmic Associates is a subspecialty eye practice of ophthalmologists (MDs) and optometrists (ODs). We can and do work together to deliver quality patient eye care services.

However, there is what I would term a growing pressure for ophthalmologists and optometrists to enter into what is called "co-management" practice pattern in regards to postoperative surgical eye care that is not in the best interest of the patients.

From my professional observation of the increased pressure for these types of agreements, I believe HB 142 is needed and is in the patient's best health care interest.

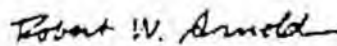
I am not against all collaborative care arrangements between Alaska's optometrists and ophthalmologists. I have and will continue to collaborate with other optometrists; family physicians and ophthalmologists in the medical and long-term postoperative care of Alaskan citizens, tourists and referred patients from the Russian Far-East (charitable surgical care).

However, you must be made aware that the current practicing environment works to destroy ethical arrangements between optometrists and ophthalmologists and fosters comanagement relationships between optometrists and ophthalmologists that are not the best long-term interests of patients. That is why I support HB 142.

The enactment of HB 142 will ensure that if a physician chooses to comanage a patient, its will be for health care considerations, not for future referrals or some other economic consideration. This legislation is a positive step forward to improve patient understanding of postoperative surgical eye care treatment.

Sincerely Yours,

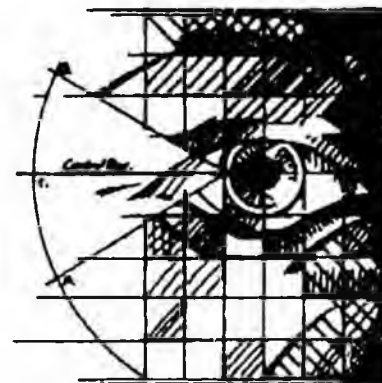
Robert W. Arnold, M.D.



Pediatric Ophthalmology and Strabismus, Ophthalmic Associates, a P.C. 542 West Second Avenue, Anchorage, Alaska 99501-2242 • 907-276-1617, Fax, 278-1705

OLIVER M. KORSHIN, M. D.
DISEASES AND SURGERY OF THE EYE

ALASKA MEDICAL PLAZA
1200 AIRPORT HEIGHTS DRIVE, SUITE 310
ANCHORAGE, ALASKA 99508
(907) 276-8838
FAX (907) 258-0735



April 21, 2003

Representative Bill Williams
Co-Chair, House Finance Committee
State Capitol
Juneau, Alaska 99801-1182

Dear Representative Williams:

I am writing to ask your support of HB 142, a bill to regulate ocular postoperative care in Alaska. The bill is also known as the "co-management bill."

Co-management means that a practitioner other than the operating surgeon provides postoperative care. Because co-management frequently involves splitting of the surgical fee between the surgeon and the provider of postoperative care, co-management arrangements have drawn the attention of the U. S. DHHS Office of the Inspector General in an ongoing national effort to assure that such arrangements do not violate federal anti kick-back statutes.

But co-management not only poses the potential for illegal kickbacks — perhaps more important, it can harm patients. Let me explain.

Eye surgery performed in the United States today has become so technologically advanced that it is safer and more effective than ever before. This applies particularly to cataract surgery, the most common major surgery performed in our country — more than 1.5 million cases a year. Cataract surgery has become so advanced that many cases take less than fifteen minutes, using tiny incisions and foldable intraocular lens implants. Patients go home almost immediately and not infrequently are able to see 20/20 that same day.

The speed with which modern cataract surgery can be performed, as well as its astounding success rate, have unfortunately trivialized the seriousness of this surgery in the public's mind, causing patients to infer that it is risk-free. This is rather like inferring that handling a high-performance jet fighter plane is risk-free. With high-performance jet planes — as with 21st century eye surgery — increased speed and increased performance sometimes mean that things can go very wrong very quickly. And they do.

In other words, modern cataract surgery is still subject to complications, some of them serious. Although serious complications occur infrequently, they do occur with statistical regularity. When they occur, often in the first 72 hours following surgery, they must

be managed by a qualified ophthalmologist who is familiar with the surgery, its potential complications and how these complications must be managed.

The reduction in the time it takes to perform cataract surgery has led to the appearance of so-called cataract mills, to which patients are referred in large numbers by optometrists, who receive a co-management fee for following the patient after surgery, including the diagnosis and treatment of short- and long-term surgical complications.

Often the surgeon in a cataract mill does not see the patient until a few minutes before surgery. After surgery, the patient may never see the surgeon again. In fact, the surgeon may leave town a shortly after surgery, traveling to another cataract mill location (which may be out-of-state). He may not return for weeks or longer, and then it is not to see his post-operative patients, but to operate on the next wave of referrals. A patient's follow-up care is therefore delegated, *by pre-arrangement*, to the referring optometrist, who is not qualified by training or experience to manage the major complications of cataract surgery, some of which require additional and sometimes complex surgery to treat.

When the co-managing optometrist is presented with a serious complication of cataract surgery that may require admission to a hospital, he must "dump" the patient into the hands of a local ophthalmologist, as the mill surgeon has left town or, if in town, may not have local hospital privileges. The new ophthalmologist is suddenly responsible for rendering critical care to a very ill patient fearful of going blind, whom he has never seen before and about whom he knows nothing.

Hence, co-management of eye surgery can be a recipe for sub-optimal postoperative care. HB 142 addresses this important patient safety issue while taking into account the unusual and sometimes difficult medical-surgical challenges our state poses in terms of isolation, vast distances and transportation difficulties.

How do I handle cataract surgery in my own practice? I stopped all cataract surgery last year, so I refer my patients who need cataract surgery to other local ophthalmologists. I refuse to co-manage: postoperative care is the *surgeon's* responsibility. I refer only to ophthalmologists who will provide *all* my patients' postoperative care — not just for 120 hours as stipulated in this bill, but for the entire 90-day "global" postoperative period. I believe this represents sound and ethical medical practice. One hundred and twenty hours is the bare minimum.

I urge you to support HB 142.

Sincerely,

A handwritten signature in black ink, appearing to read "Oliver Korshin". The signature is written in a cursive, somewhat stylized script.

Oliver Korshin, M. D.