THE STATUS OF CO-MANAGEMENT IN THE UNITED STATES

Co-management of patients became popular among ophthalmologists and optometrists caring for cataract surgery patients. With the introduction of the excimer laser into the ophthalmologist's arsenal, co-management has again become a popular method to care for patients.

Acceptance of the co-management arrangement has not been uniform in all fifty of the states in the U.S. In some states, ophthalmologists have campaigned actively (and successfully) to prevent optometrists from taking a larger role in the management of surgical patients. In others, the medical boards have indicated their approval of the co-management arrangement. In many, however, there has been no pronouncement or guidance for the practitioner. This article will describe generally the status of co-management in most of the fifty states, based on information the author received from the medical and optometric boards and societies of the states which responded to the author's questionnaire.

The questions posed were:

1. Whether management of post-ophthalmic surgery care by an optometrist is considered the unauthorized practice of medicine, or is it considered to be within the bounds of optometric care.

2. If an optometrist is permitted to manage a patient's post-operative care, must the optometrist be supervised by an ophthalmologist and, if so, what degree of supervision is required.

3. Can a global bill for surgery, pre and post-operative care be sent by the ophthalmologist, then divided with the optometrist in a co-management relationship?

In response to these questions, the following information was gained. **PLEASE NOTE THAT THIS IS NOT A THOROUGH EXAMINATION OF THE LAWS IN THE VARIOUS STATES, BUT RATHER AN INFORMAL SURVEY OF STATE BOARDS.** Some additional information has been gained from extra research done in some states, but it may not be up-to-date. Consequently, **THE INFORMATION CONTAINED IN THIS ARTICLE SHOULD NOT BE CONSIDERED LEGAL ADVICE.** It is informational only. If you wish to pursue a co-management arrangement in your state, you should contact an attorney who is familiar with local laws regarding such practices.

STATES ACCEPTING CO-MANAGEMENT

Maryland The Chief of Compliance responded in July, 1995, saying that the BPQA had not then rendered an opinion in regard to the co-management questions set forth. In

December of 1998, the Administrator for the Maryland Department of Health and Mental Hygiene, Board of Examiners in Optometry, responded and indicated that the Board had considered the questions posed and answered the questions as follows: Regarding whether an optometrist can manage post-ophthalmic surgery care, that is considered within the bounds of optometric care as long as the procedures performed are within the scope of optometric practice. Regarding whether the optometrist must be supervised by an ophthalmologist, the answer was no, subject to the above response. As to global billing arrangements, the Board does not have jurisdiction over the billing issues and therefore declined to respond.

Mississippi The Executive Officer of the Mississippi State Board of Medical Licensure responded in 1997 that, because optometrists are permitted to medicate and care for the external eye, post-operative care would be authorized care. (Presumably this would also mean pre-operative examination would be authorized as well.) They added, however, that the ophthalmologist (the surgeon?) is still legally responsible for the medical care provided, whether by a nurse, optometrist or other provider. Finally, the Board apparently considers global billing by one practitioner for the services of another to be an illegal fee-splitting arrangement, referring to the Mississippi State Board of Medical Licensure Corporate Practice of Medicine Policy, item 4.

Oklahoma The Chief Administrative Officer of the Board of Examiners in Optometry responded on September 14, 1995 that in the State of Oklahoma optometrists can perform pre and post-operative surgical care on an independent basis. He also advised that modifiers were used on pre and post-operative procedures for reimbursement. On April 7, 1997, the Deputy Director for the Board of Medical Licensure and Supervision advised that in January, 1996, the Board had issued a declaratory ruling that it was illegal for a surgeon to bill for a surgical procedure and then pay an optometrist to provide post-operative care (fee-splitting).

Oregon In the past few years, the Oregon Board of Medical Examiners has changed its position on co-management. The board had previously not permitted ophthalmologists to delegate post-operative care to optometrists. In a March 27, 1997 letter, the Medical Director of the Oregon Board of Medical Examiners advised that, because Medicare allowed postoperative care and billing by optometrists, then it should be allowed by the state as well. The letter went on to indicate that the optometrist did not necessarily have to be supervised by the ophthalmologist in the post-operative setting. (The wording of the letter suggests to the author that this is a case-by-case issue, and the best interests of the patient should always be kept at the forefront.)

STATES LIMITING OR REJECTING CO-MANAGEMENT

California A co-management relationship in which the ophthalmologist guarantees a referring optometrist that the patient will return to the optometrist for post-operative care has been viewed with disfavor by the Medical Board of California. A March 16, 1994 opinion letter to the Board from legal counsel for the California Department of Consumer affairs said the arrangement clearly served as an inducement to refer patients to the ophthalmologist, in violation of Section 650 of the Business and Professions Code. Counsel went on to state "[t]he purpose off Section 650 is to ensure that health care provider referrals are made on the basis of the

patient's needs and not on the basis of whether they generate income for the referring provider." Since, in the situation described above, the referring optometrist derived income directly from the referral he or she made to the physician, and the fees served as an inducement, there was a clear violation of Section 650 in staff counsel's opinion.

A February 22 letter from the California Department of Consumer Affairs to physicians in California also stated clearly that the performance of post-operative care was outside the scope of an optometrist's license.

But in a March 15, 1995 letter from staff counsel for the Department of Consumer Affairs, the issue of co-management was not commented on, unfavorably or otherwise, when addressing a related question. Although counsel described when a co-management relationship might or might not violate the anti-kickback laws, they did not comment on the co-management relationship itself. Consequently, the question of co-management in California appears to be very case-specific.

Florida On June 26, 1995, the Executive Director of the Agency for Health advised that the co-management arrangement set forth in the letter "would be in violation of 59R-9.007 Florida Administrative Code and 458.331 (1) (i) Florida Statutes." The Board rule related to the standards of practice as interpreted by the Board; the Statute set forth the law in Florida on fee-splitting. In March, 1997, the Board reaffirmed their position.

The responses refer to the state's "Surgical Care Rule" (formerly 21M - 10.015) which states that post-operative care is the responsibility of the operating physician, and can be delegated ("discretionary postoperative activities" – including activities requiring exercise of professional judgment by the physician) only to equivalently trained licensed doctors of medicine or osteopathy, residents or other health care practitioners who are supervised by the operating surgeon, equivalently trained physicians or residents.

The Rule was challenged before a Hearing Officer in the case of Florida Board of Optometry v. Florida Board of Medicine. The Hearing Officer, upheld Rule 21M - 10.015, finding that "once a patient is operated on, the optometrist's training, experience and licensure are not sufficient to allow the performance of post-operative activities without supervision." The ruling was upheld by the Florida Court of Appeals in *Florida Board of Optometry v. Florida Board of Medicine*, 616 So.2d 581 (Fla. App. 1993).

Thus, it appears that in Florida, under 59R-9.007 (formerly 21M-10.015), co-management of the postoperative care may be done only with an equivalently trained physician, a resident or an optometrist who is under the supervision of an equivalently trained physician or resident. The degree of "supervision" required is not defined by the Surgical Care Rule or by the case upholding it.

Iowa On November 12, 1992, the Iowa Board of Medical Examiners issued, under the signature of the Chairman and the Executive Director, an opinion in response to a request for a declaratory ruling on eight ophthalmologic hypothetical scenarios, including co-management in cataract surgery situations. The Board's declaratory ruling included a thoughtful analysis of

prior legal and administrative precedent and the state's statutes. The Board opined that "[I]n our view an ophthalmologist must be responsible for the preoperative care of a cataract surgery patient." They also said, with respect to postoperative care "the surgical ophthalmologist is responsible for providing all postoperative care during the usual and customary postoperative period, unless that care is delegated to an equivalently-trained physician. . . . Management of postoperative ophthalmic care constitutes the practice of medicine and cannot be managed by other health care practitioners, except under the direct supervision of the surgical ophthalmologist." They went on to note that physician licensing agencies in "at least thirteen other jurisdictions" had taken the position that postoperative care of cataract patients must be provided by physicians, not optometrists. (Author's note - My total in this area did not reach thirteen. The difference may be accounted for by the non-responses or by the slightly different question posed. It may also reflect the less-than-rigorous nature of the inquiry process used to gather information.)

This being said, the Board then observed that, because their jurisdiction extends only to physicians, it could not bind optometrists. It did address the various scenarios presented, however, and consistently found that, in situations where pre- or post-operative care was delegated to an optometrist, the ophthalmologist had violated rule 12.4(27) of the Iowa Administrative Code Section 653. In some of the hypotheticals posed, they concluded that the physician may also be participating in the unauthorized practice of medicine. In conclusion, unsupervised co-management in Iowa with someone other than an equivalently trained physician should be avoided or entered into only after careful consultation with a local attorney conversant in these issues.

Maine On June 27, 1995, the Executive Director of the Maine Board of Registration in Medicine said that, at that time, an optometrist could do neither pre or post-operative care. He added, however, that the legislature was investigating the expansion of duties for optometrists and the issue would be revisited in January, 1996. In response to the 1997 letter, however, the Executive Director indicated there had been no change.

Optometrists who wish to gain financially from the growing interest in refractive surgery should be aware that Maine also has a statute that prohibits referrals to an outside facility in which the doctor has a financial interest. There are exceptions to the prohibition, however that should be examined.

Nebraska The Nebraska Board of Medical Examiners responded to the March, 1997 inquiry by enclosing a position statement adopted by the Board of Examoners on December 11, 1988, and most recently revised on February 3, 1991. The position statement indicated that "the Board of Examiners in Medicine and Surgery have determined that the management of post-ophthalmic surgical care constitutes the practice of medicine and cannot be managed by other health care practitioners." It went on to say, however, that "so long as the operating ophthalmologist has provided post-surgical care in accordance with accepted professional standards, the ophthalmologist may suggest or recommend that a recovered post-surgical patient consult with an optometrist for a refraction or any service which is within the optometrist's lawful scope of practice. The provision of such services is not to be confused with or

represented to the patietn or any third party payor as the management of post-ophthalmologic surgical care."

The issue would then seem to be: at what point is a post-surgical patient "recovered?" And in any event, the practitioner must not represent to the patient that the optometrist is providing post-surgical care.

New Jersey On April 4, 1997 the Executive Director of the New Jersey Board of Medicine provided a 1989 pronouncement of the New Jersey State Board of Medical Examiners, indicating that no further pronouncements had been issued since that time on the issue of co-management. At the July 12, 1989 meeting, the Board restricted the post-operative management of ophthalmic surgery patients as follows: Management of post-operative care is the practice of medicine and the responsibility of the operating ophthalmologist. "Management of post-ophthalmic surgical care" was defined as "personal, first-hand observation by the operating ophthalmologist of the patient on a regular basis following the surgical procedure." The operating surgeon should remain responsible for the care until the patient has fully recovered. In the unusual event that the operating ophthalmologist is unable to personally render post-operative care, the surgeon may, with the patient's consent, delegate the care to an equivalently trained ophthalmologist. Post-operative care may not be delegated to a non-physician.

The Board went on to state, however, that the operating surgeon may suggest or recommend to a "recovered or recovering" patient that they consult with an optometrist for refractions or other services within the optometrist's scope. This may not, however, be represented to the patient as the management of post-surgical care.

The pronouncement suggests that the operating ophthalmologist may, upon personally determining that the patient is "recovered or recovering", refer the patient to an optometrist for further follow-up care, as long as it is not confused with or represented to the patient as management of post-ophthalmic surgical care. Although actual post-ophthalmic surgical care may be delegated to another ophthalmologist, this is restricted to those who are equivalently trained an skilled, and the delegation cannot be a routine situation. Thus, although there can be limited co-management of patients, the operating surgeon must personally care for the patient after surgery.

North Carolina On August 6, 1986, the North Carolina Attorney General's Office issued an opinion in response to a request of the Board of Medical Examiners. Discussing the co-management arrangement arising in the context of cataract surgery, the Office stated that management of patients by optometrists after uncomplicated surgery would not constitute the unauthorized practice of medicine as long as the services performed are within those permitted of optometrists by state statute (G.S. 90-114). In doing so, the Office rejected the Medical Board's argument that because surgery is not included in the definition of optometry (G.S. 90-114), and post-operative care cannot be separated from surgery, then post-operative care is therefore excluded from the practice of optometry.

In September, 1991, however, the North Carolina Board of Medical Examiners restated its position with respect to the scope of care by optometrists after cataract surgery. They said the surgeon cannot delegate responsibility for the preoperative diagnosis and evaluation of the

patient or discussion of risks and benefits. The surgeon, or an ophthalmologist selected by the surgeon (in the case of an emergency), must perform a 24 hour post-operative examination. After that exam, the ophthalmologist must continue to provide post-operative care until healing is complete. The ophthalmologist may involve optometrists in the post-operative care, as long as the surgeon retains responsibility for the care and examines the patient to assess the healing process and long-term results.

Ohio In May of 1989, the State Medical Board of Ohio issued a Policy statement on post-operative management which stated that the care of the patient remains the responsibility of the operating surgeon, who must provide post-operative care until the patient is stabilized and released. Furthermore, the care must be provided by the operating surgeon or an equivalently trained and licensed doctor of medicine, osteopathy or podiatry. This policy statement appears to have been superceded in October of 1995, however.

On October 31, 1995 Rule 4731-18-01 of the Ohio Administrative Code was revised. It currently states that management of post-operative care is the responsibility of the surgeon of record, and that responsibility can be fulfilled several ways. First, the surgeon may render the postoperative care. Second, the care may be delegated to equivalently trained physician or physicians. Third, defined aspects of the care may be delegated to appropriately trained and supervised allied health care personnel, provided that the surgeon retains responsibility for the quality of care rendered by the personnel under his or her supervision and control. The patient must also give their fully informed consent to this delegation. Fourth, defined aspects of the care may be delegated to licensees of other health regulatory boards who are licensed to independently provide the scope of practice and level of care required. Again, the surgeon of record must remain primarily responsible for the patient's overall care, and must examine the patient during the postoperative period. Consequently, it appears that an optometrist acting within the scope of his or her license may render postoperative care as long as the surgeon retains primary responsibility and has examined the patient personally in the postoperative period.

STATES WITH NO OPINION AS TO CO-MANAGEMENT

Alabama In a May 6, 1997 letter, General Counsel for the Alabama State Board of Medical Examiners advised that the State Board had not issued any opinions or made any administrative or adjudicative determinations on the issues. As to issue number three in the questionnaire, Alabama has a statute which prohibits fee-splitting by optometrists (Section 34-22-23) and ophthalmologists (Section 34-24-360) for patient referrals.

Alaska On June 5, 1997, the Executive Administrator of the Alaska State Medical Board responded that, since there had been no complaints in this area, the Board had no opinion as to whether the practice of co-management was appropriate or not.

Colorado On March 10, 1997, the Program Administrator for the Colorado Board of Medical Examiners responded that the Board had not taken a position on any of the questions posed.

Delaware The Executive Director of the Delaware Board of Medical Practice did respond in June1995, however, saying that no opinion or official position had been taken on the subject of co-management of surgical patients by ophthalmologists and optometrists. In 1997, the Executive Director responded by telephone, indicating that the statutes did not address whether post-operative care by an optometrist is considered the unauthorized practice of medicine, and the Delaware Board of Medical Practice had not rendered an opinion on that subject either.

Georgia On March 12, 1997, "SW", presumably of the Georgia Composite Board of Medical Examiners (he or she did not identify him/herself by title, address or otherwise) stated "We have no opinions in these matters and don't give advice. We let the laws and rules speak for themselves." Hopefully this means simply that they have not yet offered any opinions on these matters, as the Georgia Board presumably does have opinions, and does give advice when asked (which we specifically did not ask them to do).

The Georgia Attorney General did issue an opinion in response to a question on Medical Assistance reimbursement to optometrists for diagnostic services which were also with the scope of ophthalmology. The Attorney General opined that as long as the services were within the scope of the practice of optometry in Georgia, then they were reimbursable. While not completely relevant to the issue of co-management, this may suggest that it may be permitted as long as the services were within the scope of the practice of optometry. (But see the opinions from the California AG's office, above.)

Hawaii On March 3, 1997, the Hawaii Board of Medical Examiners responded that they had not taken any position on the questions posed. The same response had been received in 1995.

Idaho On March 17, 1997, the Executive Director for the Idaho State Board of Medical Examiners responded that they had not taken any position on the questions posed. The same response had been received in 1995.

Michigan The Michigan Board on Medicine responded to the March, 1997 inquiry by telephone, and the Licensing Manger indicated on Novernber 16, 1998 that a physician can delegate care of a patient to an optometrist (within the scope of the optometric practice act) but the physician remains ultimately liable for the care. Consequently, it would appear that the co-management may not be a referral, but rather a delegation to an agent, with the concomitant liabilities. The Licensing Manger added that the Michigan statute defining optometry does not include the performance of invasive procedures. In response to question two, she responded that no on-site supervision of an optometrist is needed for the optometrist to provide post-operative care.

New Hampshire On March 10, 1997, the Administrator of the New Hampshire Board of Medicine responded that they had not taken any position on the questions posed. The same response had been received in 1995.

New Mexico On March 17, 1997 the President of the New Mexico Board of Medical Examiners reported that the Board had not taken any position on the delegation of post-operative care to optometrists. The President went on to state, however, that informal discussions with medical colleagues led him to believe that the majority of New Mexico physicians had great concerns about optometrists performing this function, from the standpoints of ethics and qualifications. He further added that global billing by the ophthalmologist and subsequent division of the fee with an optometrist would be, in his opinion (although this was not an official Board opinion) fee splitting and a violation of the New Mexico Medical Practice Act (Section 61-6-15. D. (16) NMSA 1978).

South Carolina On July 5, 1995, the Board Administrator for the South Carolina Board of Medical Examiners responded that the Board had rendered no opinions and stated no specific positions concerning the questions outlined in the 1995 inquiry. On March 20, 1997 the Board Administrator advised that he was unaware of any additional information or documents issued by the State Board of Medical Examiners in the areas of inquiry. Review of the South Carolina statutes revealed that the state has laws restricting or prohibiting self-referrals (Code of Laws of South Carolina, Section 44-113-30). Non-surgeons referring patients to surgical facilities in which they have an interest may run afoul of this law.

Texas On September 22, 1995, the General Counsel for the Texas State Board of Medical Examiners responded that the Board had, to his knowledge, issued no opinions and stated no formal positions concerning the questions outlined in the 1995 inquiry. In response to the request for updated information, on May 1, 1997 the Director of Hearings Division provided minutes of a hearing on an unrelated issue involving the scope of practice of optometrists. Presumably, since the Director had reviewed the Board's records for relevant statements, and found nothing relating directly to the co-management issues presented, the Board had still not taken any position of the issue of co-management.

Vermont The Vermont Board of Medical Practice's General Counsel responded to the March, 1997 inquiry, indicating that, to his knowledge, that Board had not adjudicated a case, issued an opinion, or promulgated any rules regarding the questions posed. The Board Counsel had similarly responded in September, 1995 by saying that the Board had not rendered an opinion in regard to the co-management questions set forth.

West Virginia On June 29, 1995, Counsel for the West Virginia Board of Medicine responded that the Board had rendered no opinions concerning the questions outlined in the 1995 inquiry. On March 11, 1997 Counsel advised that she was unaware of any additional information or documents issued by the State Board of Medicine in the areas of inquiry.

STATES WHOSE STATUS IS NOT COMPLETELY CLEAR

Arkansas In Opinion No. 89-342, in response to an inquiry by Erwin Lax, O.D., the state Attorney General indicated that an optometrist can provide post-operative eye care during the healing period "[i]f the eye care falls within the 'practice of optometry' as defined under A.C.A. Section 17-89-101(a) (Supp. 1989) . . .." The opinion further stated that, although the practice of optometry did not include surgery, this did not preclude optometrists from performing functions within the defined practice of optometry in the post-operative setting.

A later Opinion No. 94-262, in response to an inquiry from Marc Parnell, O.D., the Attorney General reiterated that there was nothing prohibiting an optometrist from performing functions within the defined scope of the practice of optometry, while co-managing a patient in the pre-operative or post-operative setting.

It should be noted, however, that in response to this author's inquiry in 1995, the Executive Secretary for the Arkansas State Medical Board said that although there was no written policy, "the standard the Board has followed is that the person performing the surgery needs to care for the patient.

It sorting out this possible difference of opinion, it should be noted that, in most states, the Attorney General would be responsible for prosecuting an action for violation of the state's codes. Consequently, the Attorney General's opinions may be of greater weight. But since the Attorney General may rely on advice from the medical board in prosecuting physician-related actions, the issue is not completely clear.

Connecticut The Health Board Liaison responded in 1995, saying that there had been no formal opinion or position taken on the subjects set forth in the letter. She did point out that Connecticut does prohibit fee-splitting between practitioners, which would touch on the issue of "global billing." In response to the 1997 inquiry, the Board helpfully provided the State's statutes defining the practice of medicine (Chapter 370, Section 20-8 through 20-14k) and the practice of optometry (Chapter 380, Section 20-127 through 20-128-8). The statutes appear to allow optometrists to examine, diagnose and, in some cases, treat diseases of the eye. The statute describing and permitting the practice of medicine and surgery does not specifically address whether post-operative care would be considered the practice of medicine or surgery, so this will likely be a matter of interpretation by the Board, and the Board had not yet weighed in on the issue.

Indiana The Indiana Medical Licensing Board responded to the March, 1997 inquiry by enclosing the state statutes addressing the practices of medicine and optometry. The statute defining optometry is restrictive in comparison to some states. The practice of medicine and definition of surgery does not appear to specifically encompass the post-operative care, so the medical Board would probably define the issue if the opportunity arose.

Kentucky On October 28, 1996, the Kentucky Board of Medical Licensure responded to an inquiry from a Kentucky law firm as to whether a professional corporation of physicians which employed optometrists could offer shareholder status to the partners. The Board stated in the response that "as a general matter, the Board does not believe that licensees would violate the provisions of the Kentucky Medical Practice Act, KRS 311.530 - 311.620, by

simply entering into a business relationship with another." This suggests that a co-management relationship should be acceptable. The Board added two very important caveats, however. First, the relationship must not involve fee-splitting. (See KRS 311.595(19), 311.595(9) and 311.595(4).) Second, "if a licensee were to choose a particular course of action based primarily upon the potential value to the business relationship, rather than the patient's specific [needs], that could be considered a violation." Put another way, the patient's needs come before the co-management relationship. The patient must also be informed if there is any potential conflict of interest between the patient's interests and the licensee's business interests an any referral. Concluding, the Board stated that it is not the business relationship itself, but rather the conduct within the relationship, which determines the propriety of the relationship.

Kentucky Revised Statute 311.595(19) states that "nothing contained in this subsection shall abrogate the right of two or more persons holding valid and current licenses under KRS 311.530 to 311.620 [medical or osteopathic licenses] to receive adequate compensation for concurrently rendering professional care to a single patient and divide a fee, if the patient has full knowledge of the division and the division is made in proportion to the services performed and responsibility assumed by each.

Please note that the Board's opinion did not specifically address the question posed regarding a co-management relationship. But the broad language of the opinion in the 1996 letter, as well as several other similar opinions in prior Board correspondence and the language of KRS 311.595(19) suggests to this author that a co-management relationship would be acceptable as long as the patient's care was always the foremost consideration, and any potential conflicts of interest between the patient's interests and the physician's business interest were disclosed. Retention of local counsel for the purpose of obtaining an advisory opinion from the Board would be the safest course of conduct.

Louisiana In response to the 1995 inquiry, the Louisiana State Board of Medical Examiners provided a Statement of Position and several opinion letters regarding the scope of practice of optometrists. While none of the documents specifically addressed the question of co-management, they did indicate that the State Board strictly construes the laws defining the scope of practice for optometrists, and does not permit them to engage in any activities which could be considered the practice of medicine. This raises the question of whether post-surgical management would be considered the practice of medicine. Consultation with local counsel and perhaps a letter requesting an advisory opinion from the Board would be the best course to take before beginning a co-management relationship.

Minnesota In response to the 1995 inquiry, the Minnesota Board of Medical Practice indicated that it had not taken any position on the co-management issue. In response to the 1997 inquiry, the Board indicated that it did not issue opinions on any issue unless there had been a complaint registered, in which case it would investigate on a case-by-case basis. This suggests that the if a practitioner does not register a complaint with the Board, there is no way to know of the Board's position.

Montana Although the Board of Medical Examiners did not respond to the 1997 inquiry, they did refer in 1995 to a relevant pronouncement of the Board from October 26, 1989.

The opinion was adopted in January, 1989 and was addressed to all ophthalmologists practicing in the state of Montana and stated "it was moved, seconded and carried to adopt a Statement of Opinion that the management of postoperative care constitutes the practice of medicine." This indicates that optometrists would not be permitted to conduct pre or post-operative care, but an ophthalmologist could. It also raises the question of whether delegation of discrete tasks, and the supervision thereof, to a non-physician is acceptable in this or other circumstances.

The Board of Optometry responded on November 19, 1998 through it's Board Administrator, who stated that co-management "is allowed in the state of Montana." In response to question two, she responded that supervision by an ophthalmologist was not necessary for post-operative management. In response to question three, she responded that a global bill cannot be sent by the ophthalmologist, then be divided with the optometrist.

Pennsylvania In response to the 1997 inquiry, on March 7, 1997 the Administrator Chief of the Physician /Podiatrist unit of the State Board of Medicine advised that the Board had taken no position on the issue. In response to the 1995 inquiry, however, the Board had provided a January 8, 1988 letter from a past Board Chairman which indicated that the Board believed that post-surgical care was inseparable from the surgical process, that post-surgical care constituted the practice of medicine and thus could not be managed by other health care practitioners. The letter also stated that referral of the patient to anyone other than the surgeon for postoperative care should occur only after due consideration was given to the patient's best interests. Consultation with local counsel and perhaps a letter requesting an advisory opinion from the Board would be the best course to take before beginning a co-management relationship.

Washington In response to the 1995 inquiry, the Program Manager, Health Professions Section Four, Board of Optometry, provided a copy of Attorney General Opinion 1988 No. 28. The opinion was a response to an inquiry regarding a co-management arrangement between an ophthalmologic surgeon and an optometrist. The Attorney General noted that, while the Medical Board could not regulate optometrists, It could regulate the conduct of ophthalmologists referring patients to optometrists. Looking to the statute defining unprofessional conduct, the Attorney General noted there were at least eight acts or conditions which had the potential for providing authority to prohibit the delegation of postoperative care to an optometrist. (R.C.W. 18.130.180(1), (3), (4), (7), (10), (13), (14), (16).) The question posed, however, lacked specific facts about the circumstances of the delegation of care, and thus the Attorney General could not provide an opinion as to whether any of those sections of the Washington Code had been violated. Consequently, the prospective co-manager should review the applicable sections and perhaps seek the opinion of counsel as to obtaining an advisory opinion from the Board.

In response to the March, 1997 inquiry, the Program Manger advised that there had been no major regulation or policy change on the issue of co-management of surgical patients by ophthalmologists and optometrists in Washington.

Wisconsin On September 15, 1995, the Attorney, Office of Board Legal Services responded that neither the Medical Examining Board nor the Optometry Examining board had considered the question. On June 29, 1995, the Administrator for the Division of Health Professions and Services Licensing said the Board had taken no position concerning the

questions outlined in the 1995 inquiry. On November 12, 1998, the Chairperson of the Optometry Board of Examiners in Wisconsin responded by stating that post-surgical care by an optometrist is permitted as long as the optometrist in question is TPA certified. In response to the second question, he indicated that optometrists require no direct or indirect supervision by an ophthalmologist when performing post-ophthalmic surgical care. As to the third question, actual surgical fees cannot be split, but the optometrist may bill separately for the pre-operative and post-operative care.

NO RESPONSE

Arizona No response from the Arizona State Board of Medical Examiners. The state does have a statute which prohibits charging a fee for services not rendered or dividing a professional fee for patient referrals among health care providers or health care institutions . (Section 32-1401 (24)(u))

Washington, D.C. No response from the District of Columbia Board of Medicine to the March, 1997 inquiry. The Acting Executive Director did respond in September 1995, however, saying that he was unaware of any existing policy, position paper, administrative or judicial determination on the subjects set forth in the letter. He did refer to the statute which defined the practice of optometry for the District: D.C. Law 6-99, Section 2-3301.2(10)(A).

Illinois No response from the Illinois Medical Licensing Board to the March, 1997 inquiry. The state does have a statute which prohibits referrals by a health care worker to an outside entity in which the health care worker is an investor, unless the health care worker provides services within that entity and will be personally involved in the care of the referred patient. (225 ILCS 47/20.)

Kansas No response from the Kansas Board of the healing Arts to the March, 1997 inquiry. In response to the 1995 inquiry, General Counsel for the Board searched for prior opinions on the issue and found none relating to co-management of surgical patients by optometrists and ophthalmologists.

Massachusetts No response from the Massachusetts Board of Registration in Optometry to the March, 1997 inquiry. The Chairman did respond on August 16, 1995 that, as long as the optometrist fulfilled the requirements of the statutes of the state, then they were practicing within the scope. This suggests that, as long as the co-managers do not engage in fee-splitting, the Board sees no obstacle to a co-management arrangement.

Missouri No response from the Missouri State Board of Registration to the March, 1997 inquiry. The Executive Director of the Missouri State Board of Optometry did respond on Decmber 3, 1998, enclosing the State's Optometry Practice Act, Rules and Regulations, and indicated that the Board did not provide prospective legal opinions.

Nevada No response from the Nevada Board of Medical Examiners to the March, 1997 inquiry.

New York No response from the New York Board of Medical Examiners to the March, 1997 inquiry.

North Dakota No response from the North Dakota State Board of Medical Examiners to the March, 1997 inquiry. They did, however, respond to the 1995 inquiry on September 15, 1995, stating that they had adopted the position that an ophthalmologist who permits an optometrist to manage or provide care to the ophthalmologist's patient will remain responsible to the Board for the quality of care provided to the patient until the completion of therapy. The statement was made in response to an inquiry from an ophthalmologist asking what the Board would say about a co-management situation in which on optometrist takes over the post-surgical care the day after surgery.

Rhode Island No response from the Rhode Island Board to the March, 1997 inquiry. In response to the 1995 inquiry, the Chief Administrative Officer for the Rhode Island Board of Medicine indicated that the Board had not taken any position on the co-management issue. He further indicated that the Board did not issue advisory opinions on any issue unless there had been a complaint registered, in which case it would investigate on a case-by-case basis. He added, however, that there had been no real problems to his knowledge with respect to co-management between ophthalmologists and optometrists, including the provision of pre and post-operative care. The practitioner seeking to pursue co-management in Rhode Island may want to consult with local counsel experienced in Board matters before making a significant investment.

South Dakota No response from the South Dakota State Board of Medical Examiners to the March, 1997 inquiry. They did, however, respond to the 1995 inquiry on September 14, 1995, stating that they had not issued any position paper, opinion letter or prior administrative determination on the questions posed. The Legal Counsel for the Board did add, in his response, that in a co-management arrangement, the Board would look to the ophthalmologist for total responsibility for patient care, despite any agreement between the co-managers.

Tennessee No response from the Nevada Board of Medical Examiners to the March, 1997 inquiry.

Utah No response from the Utah Physicians Licensing Board to the March, 1997 inquiry. Information from a prior survey done by the American Academy of Ophthalmology indicates that the Board, on December 5, 1988, had taken the position that management of post-operative care constituted the practice of medicine, was part of the surgical procedure, and was the responsibility of the operating surgeon or another ophthalmologist. Further, independent postoperative eye care could not be performed by an optometrist. In special circumstances, the optometrist may participate in post-operative care if they are in immediate consultation with the operating surgeon or another ophthalmologist. The patient must consent to such an arrangement pre-operatively.

Virginia No response from the Virginia State Board of Medicine to the March, 1997 inquiry. Personal communication by the author with an attorney from Washington, D.C. indicated that the Virginia Department of Health Regulatory Boards had, in a November 10, 1987 letter, suggested that independent post-operative management by an optometrist was forbidden. But, in a December 22, 1993 letter, the Virginia State Board of Medicine indicated that the issue had been submitted to an internal committee for recommendation and, as of August, 1995, no final decision had been made. (Personal communication, August 1995, with Alan E. Reider, J.D. of Arent, Fox, Plotkin & Khan, Washington, D.C. office)

Wyoming No response from the Wyoming Board of Medicine to the March, 1997 inquiry. They did, however, respond to the 1995 inquiry on September 14, 1995, stating that they had not issued any official opinion on the questions posed. The Executive Secretary for the Board did add, in her response, that in a co-management arrangement, the Board would consider the postoperative care as an integral part of the practice of medicine which is the responsibility of the surgeon. Although it is the surgeon's decision as to whether postoperative care should be delegated to an appropriately trained and licensed individual, the surgeon remains ultimately responsible for the care.