

Special Report: Operating Room Access



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The Centralization of Emergent Retina Surgery: Causes and Consequences

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Emergent vitreoretinal surgery—especially for rhegmatogenous retinal detachments (RRDs)—is increasingly being funneled to a limited number of tertiary centers and large referral practices.



An illustrative example comes from Miami's Bascom Palmer Eye Institute (BPEI), where the volume of RRD surgery has increased by 138%—from 490 cases in 2018 to 1167 cases by 2025—even though the local Miami-Dade County population grew only about 5% and BPEI's surgical retina faculty increased by approximately 25% in that time ([Figure 1](#)).

Demand for emergent RRD surgery has skyrocketed without commensurate local population

growth or new surgeons, suggesting that more patients from outside BPEI's primary service area are being referred for urgent surgery.

This phenomenon appears to reflect a broader trend. A recent study at an academic eye center in Oregon found that between 2011 and 2019, surgical RRD repair cases increased by about 119%, whereas macular surgery volumes (eg, membrane peels) rose only 23%.^[1]

In contrast, national Medicare data showed only a modest 26% increase in RRD surgery during a similar period.^[1] Emergent RRD cases are becoming concentrated in certain centers at rates far exceeding overall national growth in these procedures. Despite there being more practicing retina specialists than ever, many urgent surgical cases are being managed by a shrinking subset of providers and facilities.

Reduced financial viability of surgery centers

Several reports have investigated why emergent retina care is being centralized. A major contributing factor is the changing economic landscape of retina practice. Over the past 2 decades, Medicare reimbursements for common retina surgeries have plummeted—one analysis found an average 32% decline in inflation-adjusted fees from 2000 to 2021.^[2]

At the same time, retina practice patterns have shifted dramatically with the rise of anti-VEGF therapy—intravitreal injection volumes exploded by more than 1000-fold in that period.^[2] The net effect: today, retina practices derive a large share of their income from high-volume, in-office injection therapy, while the relative profitability of operative cases has diminished drastically.

Multiple cost analyses have found that from the practice standpoint, surgical RRD repair often barely breaks even—or even loses money—under current reimbursements. One time-driven activity-based costing study found that a standard RRD vitrectomy cost about \$5,132 per case to perform, yet Medicare reimbursed only around \$4,505—meaning the hospital lost money on roughly half of routine RRD cases.^[3]

For more-complex RRD repairs, adding an estimated \$1,185 in extra costs, the institution lost money on about 90% of cases at Medicare rates. Other reports have identified average losses of \$2,500 and \$975 per RRD surgery when factoring in the true costs of OR time, supplies, and staffing. Although the final numbers differ due to assumptions built into each model's cost calculations, all models consistently show Medicare payments falling short of the actual cost of RRD surgery.

It becomes even harder to make the math work in an ambulatory surgery center (ASC) setting.

Medicare’s facility reimbursement for ASCs is substantially lower than for hospital outpatient departments —only about 57% of the hospital OR reimbursement for the same surgery. This steep discount means the ASC facility fee often barely covers the surgical pack, consumables, and amortized equipment costs. Even with substantially lower overhead than a hospital, many ASCs cannot financially justify offering complex retina surgery—especially emergent cases that are unpredictable and time-consuming.

In contrast, cataract surgery is the ideal ASC procedure: quick, highly predictable, and profitable, especially with elective premium lens upgrades. The revenue per OR minute for cataract far exceeds that of a vitrectomy.

It’s little wonder that for-profit ASCs tend to favor the reliable, high-margin cataract cases over the lengthy, minimally

Indexed Growth of Rhegmatogenous Retinal Detachment Surgery at Bascom Palmer, 2018-2025

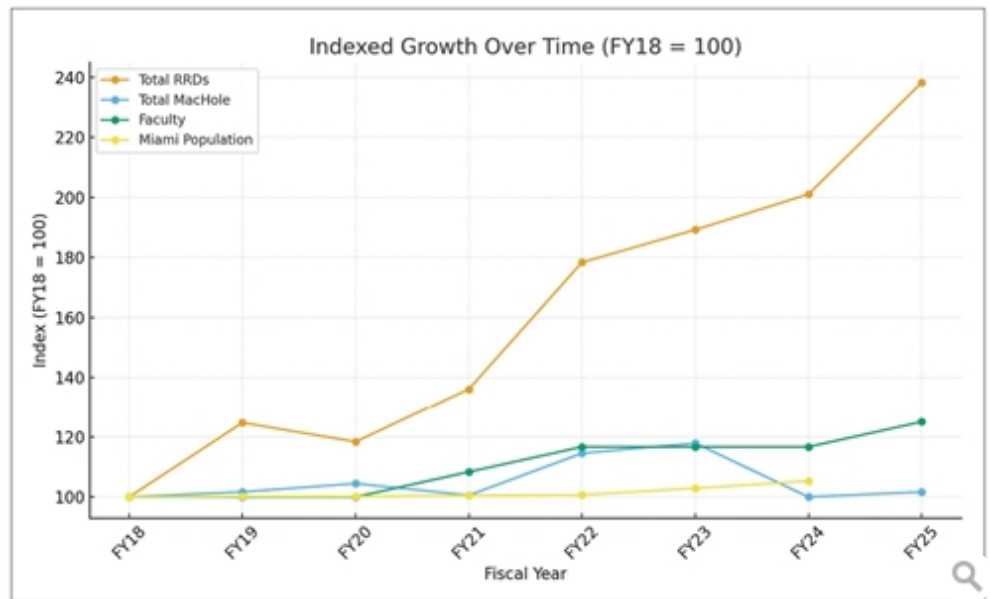


Figure 1. Indexed growth rate of rhegmatogenous retinal detachment (RD) surgery (CPT code 67108) performed at Bascom Palmer Eye Institute vs macular hole surgery (CPT code 67042), Miami-Dade County population, and surgical retina faculty staff from fiscal year 2018 to 2025. *Image courtesy Bascom Palmer Eye Institute.*

Access to Anesthesiology—Another Complicating Factor

As the recent ASRS OR Access Survey shows, one of the most significant issues affecting access to surgery is a significant shortage of US anesthesia providers.

Nearly 60% of US survey respondents said that facility anesthesia limitations are affecting their OR access.

The shortage of anesthesiology providers preferentially affects non-academic practices, which don’t have their own anesthesia providers.

In the survey, the other top reasons US ASRS members cited for limited OR access were: scheduling conflicts/limited block availability (61.2%); facility staffing limitations (51.5%); and lower reimbursement for vitreoretinal surgery than other procedures (45.3%).

The survey also asked US members what changes they have seen in their referrals for urgent/emergent cases due to regional limited OR access. (See Figure 2.)

Source: Access to OR Survey of US-based ASRS members. American Society of Retina Specialists; conducted October 15 to November 18, 2025.

profitable retina cases. In practice, many ASCs simply steer away from retina cases, leaving hospitals and academic centers as the main sites for these complex surgeries.

The opportunity cost of leaving clinic

From the physician's perspective, declining surgical fees have created significant opportunity costs for performing surgery vs staying in clinic. A recent analysis by the ASRS Health Economics Committee compared the work Relative Value Units (wRVUs) of surgery to what a retina specialist could earn seeing patients in the office during the same global period.

The findings were startling: performing any of the 10 most common retina surgeries resulted in a substantial net loss of potential revenue—on average, about a 49% loss compared to equivalent clinic time.^[4] For an average retina specialist who sees 40 patients in an 8-hour clinic day, the break-even surgery time would be only 5 minutes per case.

Adding an unscheduled emergency case to an already-full clinic day further highlights these inefficiencies. If a surgeon has to leave clinic to handle a same-day RRD surgery, it often means canceling or rescheduling a half-day of patients—an opportunity cost that current surgical fees don't come close to offsetting.

And if the case is added after hours or on a non-OR day, there are often workflow inefficiencies such as slower staff turnover, waiting for an open room, and staff unfamiliar with retina instruments, which can add 20% to 50% more time to the overall process.^[5]

All of this work essentially goes uncompensated relative to clinic time, and smaller practices still have to cover their clinic overhead. These financial and logistical hurdles make it very difficult for many community retina specialists to accommodate emergent surgeries promptly.

What changes have you seen in your referrals for urgent/emergent cases due to limited OR access in the region? (Please check all that apply.)

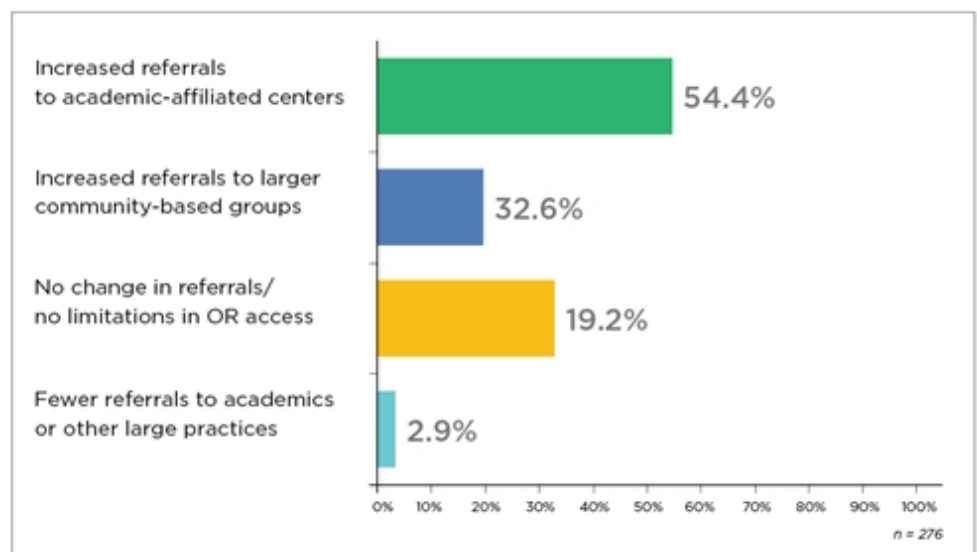


Figure 2. ASRS US members note changes in referrals for urgent/emergent cases due to limited regional OR access. Source: ASRS Access to OR Survey of US-based ASRS members, conducted October 15 to November 18, 2025.

Private equity and surgical case deferrals

Another modern trend impacting where surgery is done is the rise of private equity (PE) ownership of ophthalmology and retina practices. PE firms have acquired many ophthalmology groups in the past decade, including retina-only practices. While each PE-owned practice generally remains an independent entity, there may be additional pressure to increase profitability and efficiency.

A recent study examining 535 retina specialists who joined PE-owned practices found that after acquisition, those physicians performed about 19.6% fewer RRD repairs per surgeon than matched controls, even as their clinic volumes remained robust.^[6]

A 2025 study confirmed this pattern, showing that areas with more PE-owned retina practices had a corresponding increase in RRD vitrectomy cases at nearby academic centers.^[7] In other words, when community providers opt—or are financially forced—not to operate on RRDs, those cases end up concentrating at the remaining surgery-capable centers.

Impact on patients

Patients with an urgent RRD or other surgical emergency may experience the real-life consequences of these systemic shifts; instead of immediate surgical scheduling, patients may be “bounced” between providers before finally reaching the operating table.

For example, a patient might first see a comprehensive ophthalmologist or optometrist who diagnoses the RRD. The patient then is referred to a retina specialist who doesn’t have surgical privileges or capacity, requiring the patient to be referred yet again—this time to a tertiary center—for the actual repair.

Each referral introduces delay. This is especially dangerous for acute macula-on RRDs, where the goal is to operate within 24 hours to preserve vision. At BPEI, we increasingly encounter patients whose surgery is delayed beyond ideal timing due to lack of community OR availability.

Patients with emergent cases are now traveling farther to get care—and patients from rural or outlying areas often must journey many miles (sometimes across regions or states) to reach a tertiary surgical center willing to take emergency cases. We have treated RRD patients who had to travel 2 to 3 hours by car (or even fly) to Miami for surgery.

Postoperatively, these displaced patients face challenges in follow-up—some have had to secure local lodging because traveling back and forth the same day was impractical. For well-resourced patients, this is an inconvenience; for others with limited funds or no family support, it can be

prohibitive.

The risk is that patients of lower socioeconomic means or limited health literacy may simply fall through the cracks—they might delay seeking a tertiary evaluation, skip the trip entirely, or miss critical postoperative visits—resulting in worse visual outcomes. In short, the siloing of emergent retina surgery into far-off centers could exacerbate health disparities, as those least able to navigate or afford travel are most likely to suffer vision loss.

The influx of outside emergency cases is straining capacity at major retina centers. Academic institutions like BPEI are now handling far more RRD emergencies than in the past. This can tax OR availability and surgeon bandwidth. We at BPEI have expanded OR hours and added staff to accommodate the volume, but it often leads to overbooked schedules and a rise in after-hours or weekend surgeries.

There is concern that an overextended system could lead to suboptimal outcomes. Ironically, funneling most RRD surgeries to a few high-volume surgeons at tertiary sites may be clinically efficient as those surgeons get very experienced—but it's logistically inefficient and frustrating from the patient perspective. Most patients would prefer to receive timely care close to home, rather than being shuttled around the state for what is often a vision-threatening emergency.

The rise of in-office surgery—a limited solution

In response to these challenges, some retina providers have experimented with offering office-based surgery (OBS) for urgent cases. The idea is appealing on paper, and early adopters have reported success with in-office vitrectomy for select cases—for example, same-day RRD repairs in a dedicated office surgical suite, under local anesthesia.^[8] This approach can improve access and convenience for patients who would otherwise wait or travel, but there are compliance and reimbursement challenges that still must be overcome to make this truly a viable alternative.

Financial barriers are the first hurdle: professional fees from Medicare and most insurers do not include additional payment for a facility fee for OBS because the office is not an accredited ASC or hospital in their eyes.

Yet, the service is considered covered, raising compliance concerns as to whether the patient may be charged any additional fees beyond the standard co-payment for the office-based procedure. The practice, therefore, may have to carry the additional overhead and simply absorb the cost for urgent uninsured patients and bill only the professional fee. This scenario is not sustainable or equitable on a large scale. Until payors recognize OBS facilities, this model is not going to be adopted widely.

The clinical scope of office-based retina surgery is another limiting factor. Not every case or patient is suited for an office setting. Typically, only medically stable patients who can tolerate local anesthesia are candidates. Office-based vitrectomy is usually done under topical or sub-Tenon's anesthetic with no intravenous sedation or general anesthesia. This works for straightforward cases, but more complex or lengthy procedures can push the limits of patient comfort and safety.

For instance, adding a scleral buckle or managing proliferative vitreoretinopathy might require longer operative times or akINETIC anesthesia—difficult to achieve without an anesthesiologist. Patients with high anxiety, severe back pain, or significant systemic illness are also poor candidates for OBS and are better treated in a hospital or ASC environment.

While a growing number of retina surgeons are exploring OBS, it is not a panacea for broader systemic issues. OBS remains a niche solution that can help in select situations, but it cannot substitute for having a viable network of surgery-capable centers distributed in the community.

Keeping emergency surgical care in our patients' reach

The ongoing siloing of emergency retina surgery is a complex problem at the intersection of medicine, economics, and health policy. On one hand, the trends we're seeing are a rational response to perverse incentives—declining surgical reimbursements, high opportunity costs, and business pressures naturally push providers toward clinic-based services and away from time-consuming surgeries that barely pay for themselves.

On the other hand, the result is a looming public health issue: life-altering, vision-saving care is becoming more consolidated and potentially less accessible to those who need it most. As retina specialists, we entered this field to save vision; we must not allow financial logistics to stand between our patients and the care they need.

Reversing these trends will require advocacy and policy changes. It is critical that we push for reimbursement reforms that better align payments with the true resource costs—and the critical value—of emergent RRD repair. Ultimately, our goal should be to keep sight-saving surgical care within reach for all patients—not just those who live near a tertiary center or have the means to navigate a fragmented system.

The concentration of RRD surgery in a few centers need not become “the new normal”. By addressing the financial disincentives and coordinating care more effectively, we can preserve a more distributed, patient-centric emergency retina care network. We, the retina specialist community, we must strive to preserve our ability to deliver vision-saving surgery when and

where patients need it most.

ASRS members share their perspectives



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These surgical limitations signify an important patient access issue. I have personally been involved on multiple sides of this—as academic faculty on the receiving end of convenience referrals; as a retina surgeon in a practice

that sold to PE and then a corporate entity; as past chair of the ASRS Health Economics Committee that performed research on surgery access; and now as the recent founder of my own practice struggling to explain the value of retina surgery to hospitals as I establish new surgical privileges.

At its core, this problem arises from absence of physician control, built up from years of complacency and compounded by recent shifts in the landscape of practice ownership.

Although our reimbursement structure is predicated on payor-over-physician control, truly limited physician engagement in advocacy efforts has resulted in loss of the physician voice and a dwindling of physician reimbursements to embarrassing lows while insurance profits soar.

As practice owners have recently sold ownership for personal financial gain, the resulting divergence of priorities of a financially driven company vs patient-centric care has ramifications beyond individual practice dynamics—surgical access represents just one example of negative broader community effects.

These surgical access issues are important but represent the tip of a devastating and approaching iceberg. This is a wake-up call for me—and I hope, for all of us—to stop placing our individual priorities over progress as a medical community. Otherwise, I shudder to imagine what the focus of the next Special Report might be.

As retina providers, we take on many roles. This article highlights the utmost importance of the often-neglected role of advocacy. Sometimes it can seem there are precious few waking hours between the last patient of today and the first patient of tomorrow. It can be difficult to find the time to fill the role of advocate.



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However, each of our voices adds to the strength of the collective chorus. Given the recently released significant cuts impacting retina surgical codes in the 2026 Centers for Medicare & Medicaid Services (CMS) Medicare Physician Fee Schedule, the need for a resounding choir is urgent.

I appreciate the efforts taken by the ASRS to push back on the impending cuts. Each of us can assist in these efforts in a variety of ways. We can get to know our local representatives and senators by attending town hall meetings or subscribing to their newsletters, allowing us to see how our message might align with their key priorities.

Whether or not our political views align with those of our lawmakers, we can reach out via email or schedule a meeting to discuss how cuts impact the practice of retina—and thus their constituents with vision-threatening and life-altering emergencies such as RRDs.

We may even be able to invite lawmakers to join us at our practices to see our work firsthand. What we cannot do is pass on this role. To quote (and addend) YouTube personality Philip DeFranco, “You may not mess with politics, but politics will mess with [your patients]”.



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As a retina specialist in a large PE-owned practice, I have seen smaller practices begin to refer more urgent cases to our group due to limited OR access or a desire not to disrupt busy clinic schedules.

Our practice has several physicians in the OR each weekday, in addition to weekend block time, so it is less disruptive for us to schedule a surgical case than for a small-group practitioner. The pressures on our specialty to keep up with demand may play a significant role in this practice pattern.

It is difficult to see a full clinic and head to the OR afterward. If a solo provider has the option to refer to a group with a constant OR presence, they may choose this route in the absence of financial influence.

Our practice has a retina-specific ASC that continues to be profitable due to the economies of scale involved with performing 2000+ annual retina cases. In fact, we are adding another retina-dedicated ASC to keep up with demand. Our PE backers are both facilitating and encouraging this addition.

There is no interference by our financial partners in the practice of medicine. The idea that a PE group would invest in surgical practices and then pressure those doctors to stop performing surgery is nonsensical. Our PE backers assist with contract negotiations, purchasing agreements, and revenue cycle management to keep the business healthy; they do not influence our care decisions.

Yes, nonsurgical retina care is more profitable than RRD surgery, but delivering urgent surgical care is a vital part of a thriving retina practice—and arguably the most fulfilling part of many surgical retina specialists' careers.

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FINANCIAL DISCLOSURES

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