**Co-management Guidelines**

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**Executive Summary**

- History of co-management
- New AAO/ASCRS guidance
- AOA guidance
- OIG’s guidance
- CMS’ guidance
- Claims instructions
- Other related issues

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**History**

- Physician Payment Reform (1992)
- Global surgery package
  - Preoperative care
  - Intraoperative services
  - 90-days of postop care
  - In-office care of postop complications
- Postop care valued at 20% of the global surgery package

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**Anti-kickback Statute**

The AKS makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration directly or indirectly to induce or reward referrals of items or services reimbursable by a Federal health care program.

If certain types of arrangements satisfy regulatory safe harbors, the AKS will not treat these arrangements as offenses.

Source: Medicare Learning Network  ICN 006827 Aug 2014
Source: 42 U.S.C. §1320a – 7b

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**Financial Disclosure**

Stephen S. Lane, MD
- No financial interests or relationships to disclose.

Kevin J. Corcoran is President of Corcoran Consulting Group and acknowledges a financial interest in the subject matter of this presentation.

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**Qui Tam Lawsuit**

The False Claims Act (31 U.S.C. §§ 3729–3733, also called the "Lincoln Law") is an American federal law which allows people who are not affiliated with the government to file actions against federal contractors claiming fraud against the government. The act of filing such actions is informally called "whistleblowing." Persons filing under the Act stand to receive a portion (usually about 15-25%) of any recovered damages.

Source: Wikipedia: Qui Tam, False Claims Act
Frequency of Co-management

- CY 2014 – 20.5% of cataract surgeries co-managed within Part B Medicare
- Growth rate – 3-4% per year since mid-1990s

Highlights of AAO-ASCRS Guidelines

- Updates key definitions
- Sharing management can serve patient’s legitimate interest
- Emphasizes mutually agreed standards
- Adds 3 circumstances that justify co-management
- Identifies 9 criteria for acceptable arrangements
- Requirement for written consent and allows verbal consent with documentation

Source: ASCRS/AAO Guidance, Sept 2015

New Professional Guidance

- The qualified operating ophthalmologist has the ultimate responsibility for the preoperative and postoperative care of the patient, beginning with the determination of the need for surgery and ending with completion of the postoperative care contingent on medical stability of the patient.
- Economic considerations, such as inducement for surgical referrals or coercion by the referring practitioner, should never influence the decision to co-manage, or the timing of the transfer of a patient’s care following surgery. This is unethical and, in many jurisdictions, illegal.

Source: ASCRS/AAO Guidance, Sept 2015

Definitions

Co-management is a relationship between an operating ophthalmologist and a non-operating practitioner for shared responsibility in the postoperative care when the patient consents to multiple providers, the services being performed are within the providers’ respective scope of practice and there is agreement between the providers to share patient care.

Source: ASCRS/AAO Guidance, Sept 2015

Transfer of care occurs when there is complete transfer of responsibility for a patient’s care from one qualified healthcare provider operating within his/her scope of practice to another who also operates within his/her scope of practice.

Source: ASCRS/AAO Guidance, Sept 2015

Reasons for Transfer of Care

- Patient inability to return to operating ophthalmologist’s office for follow up care
- Operating ophthalmologist’s unavailability
- Patient prerogative
- Change in postoperative course

Source: ASCRS/AAO Guidance, Sept 2015
### Patient’s Limitations
- Patient inability to return to operating ophthalmologist’s office for follow up care
- Patient is unable to travel due to distance or development of another illness
- Lack of availability of the person(s) or organization previously responsible for bringing the patient to the operating ophthalmologist’s office

Source: ASCRS/AAO Guidance, Sept 2015

### Surgeon’s Limitations
- The operating ophthalmologist will be unavailable to provide care (e.g., travel, leave, itinerant surgery in a rural area, surgery performed in an ophthalmologist shortage area, retirement, or illness).

Source: ASCRS/AAO Guidance, Sept 2015

### Patient’s Choice
- The patient requests and/or consents to co-management or transfer of care to minimize cost of travel, loss of time spent travelling, or the patient’s inconvenience
- The patient requests and/or consents to transfer of care for any other reasonably compelling personal consideration (e.g., comfort with the non-operating practitioner doctor-patient relationship), provided that the operating ophthalmologist is familiar with the non-operating practitioner and their qualifications (compliance with scope of practice and state licensure)

Source: ASCRS/AAO Guidance, Sept 2015

### Change in Postop Course
- Development of a complication
- Development of intercurrent disease

Source: ASCRS/AAO Guidance, Sept 2015

### Required Criteria
- The patient requests, or is given the option and makes an informed decision to be seen by the non-operating practitioner for postoperative care.
- The operating ophthalmologist determines that the operative eye is sufficiently stable for transfer of care or co-management to be clinically appropriate.
- The non-operating practitioner is willing to accept the care of the patient.

Source: ASCRS/AAO Guidance, Sept 2015

### Required Criteria
- State law permits the non-operating practitioner to provide postoperative care and the non-operating practitioner is otherwise qualified to do so.
- There is no agreement between the operating ophthalmologist and a referring non-operating practitioner to automatically send patients back to non-operating practitioner.
- The arrangement complies with all applicable federal and state laws and regulations, including the federal anti-kickback and Stark laws and state fee splitting laws.

Source: ASCRS/AAO Guidance, Sept 2015
**Required Criteria**

- The operating ophthalmologist or an appropriately trained ophthalmologist is available upon request from either the patient or non-operating practitioner to provide medically necessary care related to the surgical procedure directly or indirectly to the patient.

Source: ASCRS/AAO Guidance, Sept 2015

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**Required Criteria**

- Transfer of care or co-management is documented in the medical record as required by carrier policy.
- All relevant clinical information is exchanged between the operating ophthalmologist and the non-operating practitioner.

Source: ASCRS/AAO Guidance, Sept 2015

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**Financial Compensation**

- The non-operating practitioner’s co-management fees should be commensurate with the service(s) actually provided.
- For Medicare/Medicaid patients, the co-management arrangement should be consistent with all Medicare/Medicaid billing and coding rules and should not result in higher charges to Medicare/Medicaid than would occur without co-management.

Source: ASCRS/AAO Guidance, Sept 2015

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**Financial Compensation**

- The patient should be informed of any additional fees that the non-operating practitioner may charge beyond those covered by Medicare/Medicaid or other third party payors.
- For services that are not covered by Medicare or Medicaid, other fee structures may be appropriate, though they should also be commensurate with the services provided and otherwise comply with all applicable federal and state laws and regulations.

Source: ASCRS/AAO Guidance, Sept 2015

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**Other Instruction**

- The operating ophthalmologist should consult with qualified legal counsel and other consultants to ensure that his/her co-management practices are consistent with federal and state law and best legal practices.
- Above all, patients’ interests must never be compromised as a result of co-management.

Source: ASCRS/AAO Guidance, Sept 2015

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**Caveat**

This position paper is provided by ASCRS and the AAO for informational purposes only and is intended to offer practitioners voluntary, non-enforceable co-management guidelines. Practitioners should use their personal and professional judgment in interpreting these guidelines and applying them to the particular circumstances of their individual practice arrangements. This paper is not intended to provide legal advice and should not be relied upon as such. Practitioners are encouraged to consult an experienced health care attorney if they have questions about the propriety of their co-management arrangements under applicable laws and regulations.
AOA’s Response

Christopher J. Quinn, OD, AOA Vice President:
“This is a very positive acknowledgement of what has become standard practice. It’s a reflection of the many years of successful patient care and good work that our members provide.”

AOA Guidelines: Co-Management

• Co-managed care should always adhere to the basic tenets of good patient care, the ethical responsibilities of providers, and governmental rules.
• 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.

Source: AOA Optometric Postoperative Care, April 27, 2000

AOA Guidelines: Co-Management

• 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 avoided. The patient should be advised prior to surgery of potential postoperative management options.

Source: AOA Optometric Postoperative Care

AOA Guidelines: Co-Management

• 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… should be clearly documented via correspondence and be included in the patient’s medical record.

Source: AOA Optometric Postoperative Care

AOA Guidelines: Co-Management

• 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”.
• The operating surgeon and the co-managing optometrist should communicate during the postoperative 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.

Source: AOA Optometric Postoperative Care

AOA: Co-Management Refractive Surgery

• Follow-up schedule:
  • 1 day  Hx, VA, SLE
  • 1 week  Hx, VA, SLE, IOP
  • 1 month  Hx, BCVA, SLE, IOP
  • 3 months  Hx, CT, BCVA, SLE, IOP, DFE
  • PRN, 9-12 months  Varies

Source: AOA Co-management of Refractive Surgery Patients
**OIG Advisory Opinion: Co-Management**

- OIG publishes opinion on co-management involving non-covered services associated with premium IOLs
- Tightly worded favorable opinion

Source: OIG Advisory Opinion No. 11-14  (2011)

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**OIG Co-Management Caveats**

- No written or unwritten agreements to co-manage with optometrist
- Surgeon informs patient that optometrist may charge for noncovered services associated with advanced IOL
- No impact on charges for covered services
- Added charges are for noncovered services
- Patient is returned to optometrist at the patient’s request

Source: OIG Advisory Opinion No. 11-14  (2011)

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**CMS Instructions**

- Requires transfer agreement
- Written documentation
- Proper use of modifiers (54, 55)
- Segregation of postop care based on responsible parties
- Receiving doctor must see the patient
- Group members are ineligible
- When no transfer agreement exists, use office visit codes

Source: MCPM Chapter 12, §40.2.A.3

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**Postoperative Care Request Form**

- Rationale for co-managed care
- Clinically appropriate care
- Competency of the providers
- Logistics explained
- Provision for complications
- Full disclosure of financial arrangements
- Authorization to share information between doctors
- Patient consents to co-managed postop care
- Signatures (patient, both doctors)

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**Co-management: Consent**

I (pt) voluntarily, knowingly and willingly desire to have (co-manager), perform follow-up care after my surgery. I wish to be followed by my (co-manager) because: (reason here)

I understand that I will not see (co-manager) until you believe it is clinically appropriate. I have discussed my choice with (co-manager) and … he/she is competent to perform this care … … there is no additional cost to Medicare

The logistics of this arrangement have been explained and I desire to proceed.

SIGNED: PATIENT
SIGNED: Co-Manager
SIGNED: Surgeon

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**Co-management: Transfer Letter**

- Dear (Co-manager):
  - Date: May 11, 20xx
- On May 1 our patient, Mrs. Ida Cancie, underwent successful cataract surgery with an IOL on her right eye. I saw her on May 2 and today, and her best-corrected vision was 20/20 OD and 20/40 OS.
- Enclosed please find … operative report and post-operative instruction sheet. Her recovery from surgery has proceeded smoothly …
- At this time, I am discharging her to your care and have asked her to see you in about two weeks … keep me informed of her progress and contact me if any problems …
- SIGNED: Surgeon
Co-management: Transfer Response

• Dear Surgeon:  Date: June 1, 20xx
  • I first saw our patient, Mrs. Ida Cancie, on June 1 following successful cataract surgery on her right eye. She is doing well with best corrected visual acuity of 20/20 in that eye. Her refraction is:
    • OD  -0.75 -0.50  x165  VA 20/20
    • OS  -1.00 -0.50  x180  VA 20/50
    • ADD +2.50 OU
  • The remainder of her eye exam of the right eye was unremarkable. I will let you know if her condition changes.
  • SIGNED Co-Manager

Cataract Co-management

<table>
<thead>
<tr>
<th>M.D. CARE</th>
<th>O.D. FOLLOW-UP</th>
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<tbody>
<tr>
<td>MAY 1</td>
<td>MAY 12</td>
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<tr>
<td></td>
<td></td>
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<tr>
<td>SURGEON’S CLAIM</td>
<td>OPTOMETRIST’S CLAIM</td>
</tr>
<tr>
<td>5/1</td>
<td>66984-54</td>
</tr>
<tr>
<td>5/2 - 5/11</td>
<td>66984-55</td>
</tr>
<tr>
<td>5/12 - 7/30</td>
<td>66984-55</td>
</tr>
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</table>

Reimbursement

• Postop care is 20% of global package
• Value of postop care is apportioned:
  • 10/90ths to Surgeon
  • 80/90ths to Optometrist

Claim Example – Surgeon

Claim Example – Optometrist

Medicare Payment

• Medicare allowable for 66984  $650
• 80% for surgery  $520
• 20% for post-op care (90 days)  $130
• Value per day ($130 / 90)  $ 1.44

Source: MPFS 2016
Financial Separation

- Separate charges
- Separate checks
- Separate credit card charge slip
- Separate money orders
- Separate promissory notes

Co-Management

Example – Financial Separation

<table>
<thead>
<tr>
<th></th>
<th>SURGEON</th>
<th>OPTOMETRIST</th>
<th>ASC</th>
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<tbody>
<tr>
<td>Covered</td>
<td>$650</td>
<td>$130</td>
<td>$975</td>
</tr>
<tr>
<td>Noncovered</td>
<td>$1000</td>
<td>$200</td>
<td></td>
</tr>
<tr>
<td>Deluxe IOL</td>
<td>$1,000</td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>TOTAL</th>
<th>TOTAL</th>
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<tbody>
<tr>
<td></td>
<td>$1,650</td>
<td>$330</td>
<td>$1,975</td>
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</table>

For illustration purposes only

Co-Management Premium IOLs

- Premium IOLs
  - Presbyopia-correcting IOLs
  - Astigmatism-correcting IOLs

Co-Management Premium IOLs

<table>
<thead>
<tr>
<th>Do</th>
<th>Do not</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assign roles and responsibilities</td>
<td>Extrapolate Medicare’s 80/20 rule to determine value of noncovered services</td>
</tr>
<tr>
<td>Set discrete fees for additional services rendered that are not part of standard cataract surgery</td>
<td>Comingle funds</td>
</tr>
<tr>
<td>Collect separate payment for non-covered refractive services performed</td>
<td>Factor in the cost of IOL</td>
</tr>
<tr>
<td>Obtain two financial waivers for non-covered services</td>
<td>Fail to provide patient with clear description of co-management arrangement</td>
</tr>
</tbody>
</table>

Other Co-management Issues

- Decision for surgery
- Related diagnostic testing (e.g., biometry)
- Femtosecond laser in cataract surgery
- Advanced technology IOLs
- Co-management by an employee doctor
- Third party payers who do not accept modifiers 54/55

Other Co-management Issues

- Decision for surgery – surgeon’s sole responsibility
Other Co-management Issues

• Related diagnostic testing (e.g., biometry) – surgeon’s obligation as part of surgery

• Femtosecond laser in cataract surgery – surgeon’s election

• Advanced technology IOLs – facility is solely responsible

• Co-management by an employee doctor – ineligible for 54/55; administered within the practice payroll system

• Third party payers who do not accept modifiers 54/55 – ineligible for co-management; use office visit

Best Practices

• Follow professional ethical practice guidelines
• Stay in legal corridor for co-management
• Comply with regulatory instructions
Questions…

Please contact Dr. Lane at:

(651) 275-3000
or
SSLane@AssociatedEyeCare.com

Additional Assistance

(800) 399-6565
Website: www.CorcoranCCG.com
Mobile application: Corcoran 24/7