Staying Compliant While Co-Managing Care

Tracy Kenniff, MBA, OCS, Administrator
Eye & Lasik Center
Donna McCune, CCS-P, COE, CPMA, Vice President
Corcoran Consulting Group

Objectives

- Discuss the Medicare rules for compliant co-management
- Create a successful / compliant approach to co-management

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

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

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

Financial Disclosure

Donna McCune is a consultant for Corcoran Consulting Group and acknowledges a financial interest in the subject matter of this presentation.

Tracy Kenniff is a Practice Administrator for the Eye & LASIK Center and has no financial interest in the subject matter of this presentation.
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.

Definitions

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.

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

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

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).
**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).

**Change in Postop Course**

- Development of a complication
- Development of intercurrent disease

**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.

**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.

**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.

**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.
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.

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.

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.

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.

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

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)
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)

Co-management 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

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)

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

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
Financial Separation

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

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

Co-management for the Eye & LASIK Center

- We are a high volume cataract practice that performs around 2,500 procedures each year with 60% being referred by external co-managers.

- Our current Co-Management Network is composed of over 100 Optometrists within a 30 mile radius of our six offices

How We Got Started

- We first identified all Optometrists within 5 miles of our main office and then we ventured out to our satellite offices.

- We then created a sophisticated spreadsheet that included all vital information in regards to the doctor as well as key staff members (front desk personnel or those who would be making subsequent appointments for specialists).

Time to Go Meet our Newest Associates!

- A schedule was then created for which our Community Outreach Coordinator would go and meet the potential referring doctors and staff.

- These meetings were outlined on an executive calendar surrounding each office

- Dependent on the location, several visits were scheduled for each day for first thing in the morning and closer to the noon hour with hopes to meet with the Optometrist

- The visit included bringing a packet along with our surgeons bios and a handful of appointment cards
The Next Step
• The idea behind the initial meeting was to introduce the Co-Management program and set up a meeting time for the Optometrist and the Surgeons
  • These meetings were scheduled during the lunch hour or dinner meetings, whichever was preferred by the OD.
  • The intent of this meeting was to hand deliver the Co-Management workbook and to outline the relationship and responsibilities of each party.

Making It Happen
• The Optometric practice now has a new crisp Bio included in the packet that the patient will receive at the time of the appointment.
• All those responsible for billing in the OD practice have reviewed the appropriate modifiers to attach to their claim form.
• We have now taken business and appointment cards back to our office to ensure the patient will return to the OD upon checking out from their one day post-op.

Training the Teams – Keeping Everyone Informed
• There needs to be a seamless transition for the patients when they call the practice, the staff cannot miss a beat when a Co-Managed patient calls.
  • We need to make sure that all staff members know we are working with Dr. X in order to give superior customer service from the Front Desk, Techs and Surgical Scheduling Team – even the Optical Shop
  • Appropriate labeling of the appointment needed: NP CAT CNSLT – DR OD

Surgery is Performed – Then What?
• Post-Op day 1 – Surgeon sees the patient
  • Report of Surgery and findings of day 1 are sent to the referring OD
• 1 week – the patient is seen by the Co-Managing Optometrist
• All subsequent post op appointments are with the OD

Follow Up
• Ensuring proper paper work has been completed, signed and a copy sent along to the Co-Managing Optometrist
  • Co-Management Agreement
  • Transfer of Care Contract
  • Copies of Examinations
• Upon the end of the 3 month global period, a checklist is reviewed and the final post operative exam and summary is uploaded into the patients chart.

Forms
Microsoft Word Document
Adobe Acrobat Document
Thank you
tracyk@eyeandlasik.com

Additional Assistance
(800) 399-6565
Website: www.CorcoranCCG.com
Mobile App: Corcoran 24/7
Email: dmccune@CorcoranCCG.com