Nuances of Co-management

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Executive Summary

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


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 (AKS)

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

Society Guidance

- AAO/ASCRS Joint Position Paper (Sept 2015)

- AAO Comprehensive Guidelines (Sept 2016)
  https://www.aao.org/ethics-detail/guidelines-comanagement-postoperative-care
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

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.

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

Documentation

Required
- Written transfer
- Obvious transfer date
- Available to Medicare upon request

Optional
- Patient’s written request, signed
- Operative report with f/u instructions

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

Cataract Co-management

M.D. CARE O.D. FOLLOW-UP
MAY 1 MAY 12 JULY 30

SURGEON’S CLAIM OPTOMETRIST’S CLAIM
5/1 66984-54
5/2 - 5/11 66984-55 5/12 - 7/30 66984-55
Refer to surgery DOS

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

Co-management

• Value of postop care is 20% of global package
• Surgeon uses 54 modifier
• Surgeon does part or no postop care
• One or both doctors use 55 modifier
• Value of postop care is apportioned by DOS
• Subject to applicable state laws

Co-management Deluxe IOLs

• Deluxe IOLs
  - Presbyopia-correcting IOLs
  - Astigmatism-correcting IOLs
• Potential Risks
  - Balance billing in violation of assignment
  - Violations of state anti-kickback laws
  - Fee splitting

Co-management Deluxe IOLs

<table>
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<tr>
<th>Do</th>
<th>Do not</th>
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<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>
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<tr>
<td>• Obtain two financial waivers for non-covered services</td>
<td>• Fail to provide patient with clear description of co-management arrangement</td>
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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

More help…

For additional assistance or confidential consultation, please contact us at:

(800) 399-6565

or

www.CorcoranCCG.com