Co-management Essentials and New Concepts

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History of Co-management

• 1980s
  • OIG Investigation
  • US Senate Hearings
  • States – CA AG, NC AG, FL ALJ, Iowa Board of Medicine
• 1990s
  • Physician payment reform – 54/55 modifier rules
  • Issues surrounding co-management of refractive surgery
    • Anti-kickback law
    • Fee-split prohibition
    • Corporate practice of medicine prohibition
    • Unethical conduct

History of Co-management (cont.)

• Other legal issues
  • Malpractice
    • Negligent referral
    • Patient abandonment
    • Inadequate informed consent
  • Medicare Carrier’s limits on co-management
    • Dec. 1998 Blue Shield of Kansas Policy Manual provision entitled “Perioperative Management”
    • 1999 – 3 New York carriers publish restrictive policies
    • 2000 – TrailBlazer publishes restrictive policies
    • HCFA overruled the carriers

History of Co-management (cont.)

• 1999
  • OIG declined to grant safe harbor protection
  • Co-management to be evaluated on a case-by-case basis
• 2000s
  • Missouri – various restrictive legislative proposals fail
  • Florida – proposed legislation for disciplinary action failed
  • Nevada – optometric “collaboration” permitted
  • OIG subpoenas

History of Co-management (cont.)

• Feb 2000 – AAO/ASCRS joint position paper
• April 2000 – SEE policy statement
• Oct 2000 – ISRS position paper

• Stress surgeon responsibility
• Patient’s condition is a primary consideration
• Clearly inform patient; responsive to patient’s wishes
• Not universal – case-by-case
• Financial disclosure, transparency, fairness

Financial Disclosure

• Kevin L. Waltz, OD, MD - No financial interests or relationships to disclose
• Kevin J. Corcoran is President of Corcoran Consulting Group and founder of Corcoran Compliance Connection and acknowledges a financial interest in the subject matter of this presentation.
• Damon S. Dierker, OD – No financial interests or relationships to disclose
History of Co-management (cont.)

• Mar 2000 – AOA bulletin

• American Academy of Optometry
  “...finds nothing in these new guidelines, nor in the report from the Office of Inspector General’s ruling on safe harbor for co-management arrangements, that precludes such arrangements as long as they are handled at appropriate referral times and without regard to economic considerations.”

History of Co-management (cont.)

• 2005 CMS presbyopia-correcting IOL rule
• 2007 CMS astigmatism-correcting IOL rule
• 2011 AAO/ASCRS guidance on femtosecond laser
• 2011 OIG Advisory Opinion 11-14
  • OIG publishes opinion on co-management involving non-covered services associated with premium IOls
  • Tightly worded favorable opinion
• 2012 CMS guidance on femtosecond laser

Changes to Practice Patterns

Modifiers – Ophthalmology (18)

• Modifier 54
• 23% of cataract surgeries co-managed in 2012

Source: CMS data, 2012 18 – Ophthalmology

Co-management for Non-Medicare

• State laws
• Coverage and payment policy of third party payer
• Credentialing of optometrists by third party payer
• Coding and billing issues
• Chart documentation supporting patient choice

Co-management

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

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
• When no agreement exists, use E/M codes
• Group members are ineligible

Source: MCPM Chapter 12, §40.2.A.3
Group Practice

When different physicians in a group practice participate in the care of the patient, the group bills for the entire global package if the physicians reassign benefits to the group. The physician who performs the surgery is shown as the performing physician.

Source: MCPM, Ch. 12, 40.2 B

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

- Patient’s consent to co-manage
- Rationale
- Clinically appropriate
- Competency
- Provision for complications
- Authorization to share information
- Financial statements clearly disclosed
- Signatures (patient, both doctors)

Cataract Co-management

M.D. CARE O.D. FOLLOW-UP
0 10 90
MAY 1 MAY 12 JULY 30

SURGEON’S CLAIM 5/1 66984-54
5/2 - 5/11 66984-55
5/12 - 7/30 66984-55

OPTOMETRIST’S CLAIM
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

Correspondence

May 11
Dear Optometrist:
On May 1, our patient, Mrs. Ida Cancie, underwent successful cataract surgery with implantation of an IOL on her right eye. I saw her on May 2 and today, and her best corrected vision was 20/20 OD, 20/40 OS. Her recovery from surgery has proceeded smoothly and is expected to continue that way.

At this time, I am discharging her to your care and have asked her to make an appointment to see you in about two weeks. Please keep me informed of her progress and contact me if any problems arise. Mrs. Cancie will be needing glasses before too long and I trust you can assist her. Best regards.

Sincerely,
Surgeon
Correspondence

June 1
Dear Optometrist:

On May 1, our patient, Mrs. Ida Cancie, underwent successful cataract surgery with implantation of an IOL on her right eye. I saw her on May 2, May 10 and June 1 following surgery and her best corrected vision was 20/20 OD, 20/40 OS. Her recovery from surgery has proceeded smoothly and is expected to continue that way.

I have asked her to make an appointment to see you in about two weeks at which time I will transfer her future postoperative care to you. In the meantime, I have asked Mrs. Cancie to call me if she has any problems, questions, or concerns. Please let me know when you see her and how she is progressing. I will be happy to see her again if any complications develop. Mrs. Cancie will be needing glasses before too long and I trust you can assist her. Best regards.

Sincerely,
Surgeon

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Correspondence

June 1
Dear Surgeon:

I first saw our patient, Mrs. Ida Cancie on June 1 following her 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 x 165
  VA 20/20
- OS: -1.00 - 0.50 x 180
  VA 20/50
- ADD +2.50 OU

The remainder of her eye exam was unremarkable. I will let you know if her condition changes. Best regards.

Sincerely,
Optometrist

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Correspondence

June 17
Dear Surgeon:

Thank you for your letter of June 1 concerning our patient, Mrs. Ida Cancie. I first saw her on June 16 following her 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 x 165
  VA 20/20
- OS: -1.00 - 0.50 x 180
  VA 20/50
- ADD +2.50 OU

The remainder of her eye exam was unremarkable. I will let you know if her condition changes. Best regards.

Sincerely,
Optometrist

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Correspondence

Key Points

- Patient name
- Operated eye
- Nature of the operation
- Date of surgery
- Clinical findings
- Discharge instructions
- Transfer date

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Claims Submission

Key Points

- Date of surgery
- Type of surgery (CPT codes)
- Which eye
- Surgeon’s name & NPI
- Place of surgery & ID number
- Dates of care during post-op
- Number of days (units)
- Proper use of modifiers
- Rendering doctor
- Useful comments
- Support documentation
Claim Format

“Both the bill for the surgical care only and the bill for the postoperative care only, will contain the same date of service and the same surgical procedure code, with the services distinguished by the use of the appropriate modifier.”

Source: MCPM, Ch. 12, 40.2.A.3

Claim Format

“. . . The date on which care was relinquished or assumed, as applicable, must be shown on the claim. This should be indicated in the remarks field / free text segment on the claim form / format.”

Source: MCPM, Ch. 12, 40.2.A.3

Claim Example – Surgeon

Claim Example – Surgeon

Claim Example – Optometrist

Co-management

Advanced Technology IOLs

• Advanced Technology IOLs
• Presbyopia-correcting IOLs
• Astigmatism-correcting (toric) IOLs
### Co-management Advanced Technology IOLs

**Do**
- Assign roles and responsibilities
- Reduce surgeon’s refractive fee
- Collect separate payment for noncovered refractive services performed
- Obtain two financial waivers for noncovered services (MD, ASC)

**Do not**
- Extrapolate Medicare’s 80/20 rule to determine value of noncovered services
- Comingle funds
- Factor in the cost of IOL
- Fail to provide patient with clear description of co-management arrangement

### Financial Separation

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

### Co-management Best Practices

- Proper motivation consistent with professionalism
- Surgeon decides suitability for surgery and plan
- Surgeon and patient discuss postop care options
- Co-management depends on what is best for patient
- Document patient’s choice
- Adhere to Medicare instructions
- Follow other third party payers’ policies
- Ensure fair market value for services performed
- Transparent billing so patient knows amount paid to each provider

### Co-management Case #1

The surgeon performs cataract surgery on a patient who is not a Medicare beneficiary. Shortly thereafter, the surgeon receives a request to co-manage the postop care from the patient’s optometrist.

How should the surgeon respond?

### Co-management Case #2

The surgeon’s administrator recommends a new general policy for the surgeons practice that co-managing optometrists bill all 90 days of the postop care and that the surgeon bill only for the intraoperative service.

Is this a good idea?
- For the optometrist?
- For the surgeon?
Co-management Case #3
One of the surgeon’s primary referral sources asks the surgeon how the surgeon plans to co-manage advanced technology IOLs, with and without femtosecond laser. The optometrist asks if the surgeon will pay 20% of the fees for noncovered service to the referring optometrist.

How would the surgeon describe their policy?  
What parameters are acceptable to CMS?

Co-management Case #4
The surgeon’s administrator asks the surgeon how to file co-managed postop care for the optometrists within the surgeon’s medical group.

How should the surgeon answer?

Co-management Case #5
An optometrist refers a patient with cataract and astigmatism and instructed the surgeon that the patient has elected a toric IOL.

How should the optometrist say this?  
How should the surgeon respond to the optometrist?  
How should the surgeon respond to the patient?

Co-management Case #6
The surgeon implants a toric IOL with the guidance of intraoperative wavefront aberrometry and assistance of a femtosecond laser. The patient paid the surgeon extra for the intraoperative wavefront aberrometry and the femtosecond laser.

What would be an appropriate percentage of the extra charges for the surgeon to pay a co-managing optometrist?

Questions Or Concerns?
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More help…
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