OPHTHALMIC POSTOPERATIVE CARE

A Joint Position Paper of the American Academy of Ophthalmology and the American Society of Cataract and Refractive Surgery

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This position paper, co-authored by The American Society of Cataract and Refractive Surgery (ASCRS) and the American Academy of Ophthalmology (AAO), offers guidelines on co-management and transfer of care, and when these arrangements are appropriate.

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.

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.

Federal Medicare policy concerning co-management has been adapted and interpreted by states and carriers with variations in details and restrictions. 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.

The management of a patient with the participation of a non-operating practitioner rather than solely by the operating ophthalmologist, whether as part of a co-management arrangement or as a transfer of care, may be appropriate when the conditions set forth in this position paper are met. Examples of circumstances in which co-management and transfer of care are appropriate (assuming compliance with conditions in this position paper) include the following:

Patient inability to return to the operating ophthalmologist**'s office for follow-up care**

- Patient is unable to travel due to distance or the 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.

Operating Ophthalmologist's Unavailability

- 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 Prerogative

- 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 Postoperative Course

- Development of a complication.
- Development of intercurrent disease.

When the operating ophthalmologist enters into a co-management arrangement or transfers care, each of the following criteria must be met:

- 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.
- 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.[1]
- 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.
- Financial compensation to the non-operating practitioner is consistent with the following principles:
    - 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.
    - 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

[1] Ophthalmologists are encouraged to review the HHS Office of Inspector General's Advisory Opinion on a proposed co-management arrangement between an ophthalmology group and optometrists external to that group. See AO 11-14 (2011) at http://oig.hhs.gov/fraud/docs/advisoryopinions/2011/AdvOpn11-14.pdf.

with the services provided and otherwise comply with all applicable federal and state laws and regulations.

- 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.

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.[2]

The American Society of Cataract and Refractive Surgery and the American Academy of Ophthalmology agree with the above positions. Above all, patients' interests must never be compromised as a result of co-management.

**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.*

Approved June 2015 by the American Academy of Ophthalmology and the American Society of Cataract and Refractive Surgery.

[2] The laws on co-management vary from state to state. For instance, some states may require that patient consent to co-management arrangements be obtained in writing. Also, certain co-management arrangements can raise legal risk under federal and state fraud and abuse and fee-splitting laws.