Comanagement of Cataract Surgery

A brief history and how to comply with current guidelines.

BY ALAN E. REIDER, JD, MPH, AND ALLISON W. SHUREN, JD

The comanagement of cataract surgery by ophthalmologists and optometrists is a topic that has generated controversy since the Medicare statute was amended in the mid-1980s, expanding the right of optometrists to bill for routine eye examinations. Many believed this amendment confirmed the legitimacy of comanagement arrangements. Others disagreed, believing that comanagement was improper from a clinical perspective and nothing more than a thinly veiled kickback scheme in which optometrists would offer their cataract referrals to ophthalmic surgeons in exchange for a promise that the patient would be referred back for postoperative care. (Editor's note: For a detailed discussion of the Anti-Kickback Statute [AKS], see, "There Is No Such Thing as the *Stark Anti-Kickback Statute*," pg 48.)

There are generally accepted guidelines that, if followed, support comanagement as an appropriate mechanism for coordinated care between an ophthalmologist and optometrist; however, failure to follow these guidelines can raise compliance risks, including allegations of violating the AKS. This article focuses on the comanagement of patients receiving services covered by Medicare, Medicaid, or another federal program. The comanagement of patients covered by private insurance is subject to the terms of the provider agreement with the insurer as well as state law. Although not absolute, it is generally helpful to follow the rules applicable to the comanagement of Medicare-covered services in connection with the comanagement of patients covered by other third-party payers.

THE EARLY YEARS

Proponents of comanagement in the early years noted that it is a widely recognized practice in other specialties. They often cited how cardiovascular surgeons transfer care of their patients to cardiologists within a day of surgery. They also noted that Current Procedural Terminology codes specifically provide for a billing regimen in which a patient is comanaged. Finally, proponents pointed out that comanagement is consistent with the change in the Medicare statute that allows optometrists to bill for services that constitute postoperative care.

Those opposed to comanagement took the position that postoperative care is part of the surgical procedure, which optometrists were not licensed to perform. They also argued that ophthalmologists who failed to provide postoperative care were abandoning their patients. More fundamentally, however, the opposition alleged that

comanagement arrangements were agreements to refer, which is prohibited under the AKS. This position was bolstered by a 1989 statement from the Office of the Inspector General (OIG), which stated that an agreement to refer constituted *something of value*, meaning that an agreement to refer back by an ophthalmologist in exchange for an agreement to refer for a surgical procedure could violate the AKS. Importantly, however, the OIG's statement made it clear that determining whether a comanagement arrangement is not compliant requires a determination of the intent of the parties—a critical element of a violation of the AKS.

The dispute continued for many years in many different forums. There were attempts by Medicare contractors to deny payment for comanagement services except in the most restrictive circumstances. The Medicare program intervened and prohibited contractors from implementing those policies. Attempts were made to prohibit comanagement under state law, but those efforts failed as well. (Nevada and Florida passed legislation relating to comanagement, but both specifically permitted it as long as certain guidelines were followed.)

In 2000, several professional ophthalmology societies published guidelines related to comanagement. The critical difference among them was the frequency of comanagement. Some guidelines prohibited routine comanagement and stated that it was appropriate only in limited circumstances. Others rejected the limitations and focused instead on the need to inform patients fully about the availability of comanagement and to ensure that it was their decision whether to return to the referring optometrist for postoperative care.

Despite all the controversy and allegations of improper conduct, there was virtually no enforcement activity relating to comanagement during this period. This is not surprising because the rules for comanagement relating to a Medicare-covered service are clear and leave little opportunity for abuse. Medicare dictates the billing protocol, which specifically allows comanagement. It requires each provider to bill for the services that the provider performs, and Medicare sets the amount that it will pay for those services. The only potential for a violation is if there is an agreement between the surgeon and the comanager to refer back—just as the OIG noted in its 1989 statement. Proving such an agreement, however, requires a fact-driven investigation, and barring a smoking gun such as an ill-considered email or letter soliciting referrals with the promise to comanage, those cases are difficult to prove.

More recently, the evolution of premium IOLs and the provision of noncovered services in combination with covered cataract surgery rekindled the comanagement controversy and triggered some potentially significant enforcement activity.

RECENT RULINGS

In 2005, CMS issued Ruling 05-03 to establish a new policy in connection with the implantation of a presbyopia-correcting IOL. This policy, which has become known as the *two-aspect rule*, resulted in new challenges to compliant comanagement arrangements. (For an explanation of the two-aspect rule, see the sidebar to the right.)

Patients make significant out-of-pocket payments in connection with premium IOL implantation, often in the range of $3,000 per eye or $2,000 more than the additional cost of the

WHAT IS THE TWO-ASPECT RULE?

- When a Medicare patient in need of cataract surgery elects to receive a presbyopia-correcting IOL, Medicare will recognize and reimburse for the procedure as if a conventional IOL is implanted.
- The ruling also permits the physician and the facility to collect additional payment from the patient in connection with the cost of the IOL as well as additional services performed.
- In 2007, CMS issued Ruling 1536R, which provides the identical policy in connection with the implantation of an astigmatism-correcting IOL.

IOL. The question was whether a comanaging optometrist is entitled to a portion of this additional payment, and, if so, how much payment is appropriate.

ESTABLISHING PROPER FEE STRUCTURES

Some argued that, consistent with the Medicare comanagement formula, a comanager should receive an additional payment of 20% of the patient's out-of-pocket payment. There are, however, a number of problems with this position. Specifically, the Medicare formula is based solely on the payment to the surgeon for the surgical procedure plus postoperative care. By contrast, the patient's out-of-pocket payment relating to the implant of a premium IOL covers the following:

- The additional cost of a premium IOL;
- Additional facility costs beyond the IOL;
- Additional diagnostic services performed by the surgeon;
- Additional intraoperative services required; and
- Additional postoperative care provided to premium IOL patients that is not otherwise provided to a conventional IOL patient.

> "Presuming it has been established that the comanager is responsible for additional services, the question to be addressed is this: What payment is appropriate?"

A more supportable analysis is to determine what payment is appropriate for the additional postoperative care provided by the comanager beyond the care provided to a conventional IOL patient. This article does not take a position on what additional postoperative care is required by premium IOL patients compared with that required by conventional IOL patients—that is a clinical question that must be addressed by ophthalmologists and optometrists. If the answer is that premium IOL patients require the same amount of postoperative care as conventional IOL patients, then the comanager is entitled to no additional payment beyond the amount paid by Medicare.

Because implanting a premium IOL reflects both a covered procedure and a noncovered refractive procedure, many practices have followed the protocol developed for other refractive procedures such as radial keratotomy, PRK, and LASIK and have extended the postoperative period from 90 to 180 days or even 1 year. If a comanager is responsible for the care during this extended period, then the comanager is entitled to additional payment. Furthermore, if it can be shown that premium IOL patients require more visits and/or more extensive services during their visits than a conventional IOL patient during the 90-day global postoperative period, this would also support additional payment for the comanager.

Presuming it has been established that the comanager is responsible for additional services, the question to be addressed is this: What payment is appropriate?

Here, the response is clear, and the comanager is entitled to the fair market value of the additional services for which the comanager is responsible. This amount is not calculated based on the Medicare reasonable charge but on whatever charge formula is used for the provision of noncovered services. If the comanager receives an amount in excess of the fair market value of the services to be provided, the concern is that the additional payment was made in exchange for the initial referral. Because that referral was for a Medicare-covered service as well as a noncovered service, it could trigger an allegation of a violation of the federal AKS.

The identical analysis applies when the ophthalmologist's noncovered fee is increased in connection with the use of a femtosecond laser. If the comanager performs no additional services when a femtosecond laser is used, the comanager is entitled to no additional fee relating to that service. We are not aware of a case in which the work of the comanager increases as a result of the use of a femtosecond laser.

OTHER CONSIDERATIONS

Following the guidelines set forth earlier to establish a proper fee structure with a comanager should address the most significant risk related to the comanagement of a premium IOL patient. There are, however, other compliance issues that should be addressed in this context.

▸ **No. 1: Although Medicare requires that each provider of care bill for the services performed by each provider, this rule does not apply to noncovered services.** Nevertheless, the optics of an ophthalmologist's making a payment to a referring optometrist can raise compliance concerns following the Medicare rule requiring that the surgeon and comanager each bill and collect for the services they perform. If this arrangement is not practical, however, one of two other options may be implemented.

- The first and preferable option is to collect two separate payments from the patient, one for the surgeon and one for the comanager.
- The second option is to collect a single payment but to provide the patient with an itemized invoice or other documentation that reflects the amount paid to the surgeon and the amount paid to the comanager.

Regardless of which payment mechanism is followed, it is crucial that the patient know and agree to the amounts to be paid to the surgeon and the comanager.

▸ **No. 2: The comanager must understand that the additional payment is for additional services, and the comanager must perform those services.** There are ongoing investigations into and challenges to current comanagement arrangements. In one ongoing investigation, a comanager allegedly told investigators that he did not know why he received an additional payment from the ophthalmologist. It is crucial that both the surgeon and the comanager understand what additional postoperative services are to be provided to premium IOL patients for which additional payment is being made.

▸ **No. 3: The additional services must be provided by the surgeon (or the surgeon's practice) when the patient elects to stay with the surgeon for postoperative care.** If additional postoperative services are not provided by the surgeon/practice when the patient elects not to be comanaged, it suggests that the ophthalmologist believes that these additional services are not necessary when a premium IOL is implanted and that the additional payment is, in fact, to secure the referral.

▸ **No. 4: A premium IOL patient must be provided with information to make an educated decision about the additional services required and must be given an opportunity to choose from whom to obtain these services.** For the protection of the surgeon and the comanager, the patient's choice must be made in writing and retained in the patient's record so that it can be produced if a question is raised.

CONCLUSION

Familiarizing yourself with the comanagement guidelines discussed in this article can help you to reduce the risk of triggering compliance issues, including allegations of violating the AKS. If followed correctly, these guidelines can facilitate proper comanagement between an ophthalmologist and optometrist and extend the benefits of coordinated care. ■

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