American Optometric Association
243 N. Lindbergh Blvd. • St. Louis, MO 63141 • (314) 991-4100
FAX: (314) 991-4101

OPTOMETRIC POSTOPERATIVE CARE

This paper discusses the proper role and responsibilities of providers in co-managing patients, consistent with federal regulations and ethical standards. For purposes of the paper, co-management is defined as two or more independently licensed health care professionals sharing responsibility for the diagnosis, treatment and management of a patient's medical or surgical condition.

Background

Doctors of optometry have been successfully co-managing patients with ophthalmic surgeons for many years. The federal government has long recognized the role of optometrists in providing this care. In 1980, Congress amended the Medicare statute to allow payment to doctors of optometry for cataract post-operative care. The report from the then Department of Health, Education and Welfare (HEW) upon which this legislation was based concluded, "The services appear to be effective in patient management, including the management of aphakic and cataract patients. They are reasonable, non-experimental, safe and generally acceptable to the vision/eye care community and the public."

Recently, the American Academy of Ophthalmology (AAO) and the American Society of Cataract and Refractive Surgery (ASCRS) have issued a joint position paper on this issue. The paper purports to offer guidelines on when co-management is ethical and proper and concludes that such situations should be an exceptional occurrence. This conclusion is not grounded in law, regulation, or the American Academy of Ophthalmology's own Code of Ethics. At the same time, government regulation of referral relationships does require providers to carefully assess such relationships to assure both compliance with federal requirements as well as good patient care. This paper seeks to offer guidance in this area.

Government Activity

Medicare Carriers
Two Medicare carriers have issued local medical review policies on the issue of co-management, Connecticut in 1998 and New York in 1999.

The Connecticut policy clearly states that co-management can occur whenever the patient chooses to return to the referring provider for necessary care. It is our understanding that the New York carrier intends to provide for such patient choice and is currently redrafting its policy to reflect this.

No other carriers have acted in this area. At least two other carriers have withdrawn more restrictive proposed policies following consultation with officials of the Health Care Financing Administration (HCFA).

Office of Inspector General (OIG)
On November 19,1999 the Department of Health and Human Services Office of Inspector General issued a final rule revising safe harbor protection under the Medicare Anti-Kickback statute. The rule outlined safe harbors for referral arrangements for specialty services. Noting a potential for abuse when the referring physician and the specialty physician receiving the referral split a global payment from a Federal health program, the IG rule specifically excluded such situations from the safe harbor. The rule made clear, however, that the IG did not intend for this action to be construed as meaning all such

relationships violate the anti-kickback statute. Instead the rule stated that whether a particular referral situation violated the statute would depend on a case-by-case analysis of the facts and circumstances, including whether the specialty services are medically necessary, whether the timing of the referral back to the originating referral source is clinically appropriate and whether the services performed are commensurate with the portion of the global fee received.

AAO-ASCRS Paper

The AAO-ASCRS joint paper states that co-management should be an exceptional occurrence. As previously noted, no federal requirements support this claim. Nor does the American Academy of Ophthalmology's Code of Ethics. The AAO's advisory opinion on the code states

> "Ethical Rules 7 and 8 (Delegation of Service and Postoperative Care) would not preclude an Academy member from referring patients to a non-ophthalmological physician or allied health care personnel for those aspects of postoperative care that are not within the unique competence of the ophthalmologist (which include those aspects of postoperative care permitted by law to be performed by auxiliaries, and, for non-ophthalmological physicians, may also include additional functions), provided that the person is legally entitled and professionally trained, experienced, and qualified to provide the particular services."

There is no mention as to the frequency with which such care should occur. The Federal Trade Commission (FTC), which conditionally approved the AAO Code of Ethics at AAO's request, stated specifically "the rule would not prevent ophthalmologists from arranging for optometrists to provide post-operative eye care services consistent with state law." The Commission further concluded "Serious antitrust concerns would, of course, be raised by an ethical rule that unreasonably interfered with legitimate competition by ophthalmologists working in conjunction with non-physician health care professionals, or prevented optometrists or others from providing services they are legally and professionally qualified to provide."

Suggested Guidelines

Co-managed care should always adhere to the basic tenets of good patient care, the ethical responsibilities of providers, and governmental rules. The following suggested guidelines are offered to help providers meet these objectives.

- The selection of an operating surgeon for patient referral should be based on providing the best potential outcomes for that patient. Financial relationships between providers should not be a factor.

- The patient's right to choose the method of postoperative care should be recognized consistent with the best medical interest of the patient. Co-management of post-operative care should be determined on a case-by-case basis and not prearranged. For example, agreements to refer all patients back on a date certain should be avoided[1]. The patient should be advised prior to surgery of potential postoperative management options.

- The transfer of post-operative care must be clinically appropriate and depend on the particular facts and circumstances of the surgical event.

- Following surgery, transfer of care from the operating surgeon to an optometrist should occur when clinically appropriate at a mutually agreed

[1] Federal Register, November 19, 1999, page 63548

upon time or circumstance; and such time should be clearly documented via correspondence and be included in the patient's medical record. For example, Section 4822 of the Medicare Carriers' Manual states that "Both the surgeon and the physician providing the postoperative care must keep a written transfer agreement in the beneficiary's record". This may be accomplished by including the appropriate information in the referral letter from the ophthalmic surgeon to the optometrist at the time of transfer of care.

- The operating surgeon and the co-managing optometrist should communicate during the post-operative period to assure the best possible outcome for the patient.

- Compensation for care should be commensurate with the services provided. Cases involving care for Medicare beneficiaries should reflect proper use of modifiers and other Medicare billing instructions.

Conclusion

The American Optometric Association believes that referrals for specialty services should be based on achieving the best possible outcome for the patient and not on financial relationships between providers. All health care professionals have an ethical obligation to patients for whom they are responsible to insure that medical and surgical conditions are appropriately evaluated and treated. Decisions to co-manage should be made on an individual basis and should always include proper and complete documentation and communication between providers. Co-management should occur only when these basic principles are followed.

This paper is provided for informational purposes. It suggests voluntary guidelines, which are not enforceable by AOA, for consideration by an individual practitioner in determining what co-management relationships are in his or her patients' best interests and are appropriate. Practitioners should exercise their professional judgment in applying these guidelines to the particular circumstances of their practice and to the specific needs of individual patients. This paper is not intended to, and does not, provide legal advice or a legal opinion with respect to Federal or state laws regulating co-management, or any specific co-management circumstances. Practitioners should consult with their own attorneys regarding any questions with respect to such legal matters.

Approved AOA Board of Trustees, April 27, 2000