EYE CONSULTANTS
OF TEXAS

CO-MANAGEMENT BILLING

As per guidelines published by Medicare in 1992, specific components of major surgery were defined as the "global surgery package." The components they identified included pre-operative care, intraoperative services, post-operative care (90 days), and in-office care for any postoperative complications. In addition, the value of post-operative care for surgical procedures was standardized and post-operative care for ophthalmic surgery was valued at 20% of the global surgery package.

Medicare also published instructions to Medicare carriers on split billing of post-operative care, also known as post-operative co-management, within eye care. These instructions incorporated the following points, which are further defined in this section of our co-management manual:

1. Co-management requires a written transfer agreement between the surgeon and the co-managing optometrist.
2. Specific modifiers must be used on claims (54 – surgical care only; 55 – post op management only).
3. The co-managing optometrist cannot bill for any part of the service included in the global period until he/she has provided at least one service.

WRITTEN TRANSFER AGREEMENT

The split of post-operative care cannot be done or pre-arranged in advance of the surgery. Instead, a unique transfer agreement should be constructed for each patient. The essential elements of the Transfer of Care Form **from the surgeon to the co-managing optometrist** should include the following:

Patient Name
Operative Eye
Nature of Operation
Date of Surgery
Clinical Findings
Discharge Instructions
Transfer Date

According to current Medicare policy, the transfer date is "determined by the date of the surgeon's transfer order." The co-managing optometrist should assume care of the patient on the day following the transfer date, who may then submit a claim for services once he/she has seen the patient. Because the surgeon cannot be certain the patient will actually keep the appointment with the optometrist, communication from the co-managing optometrist is necessary and is evidence that the optometrist actually saw the patient. This complies with Medicare's requirement that the optometrist "...has provided at least one service."

Essential elements of the transfer agreement **from the co-managing optometrist to the surgeon** should include the following:

Patient Name
Operative Eye
Nature of Operation
Transfer Date
Results of First Postoperative Visit

Both doctors should retain copies of this documentation as part of the patient's permanent record. They may also serve as a useful attachment on claims, if necessary.

If you have any questions, please call our Direct Physician Phone Line at **(817) 416-7907** to speak with a billing specialist. You may also email us at **comgmt@eyecontx.com**

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MODIFIERS FOR CLAIMS SUBMISSION

Immediately following surgery, the surgeon will submit a claim for the surgical component of care using the appropriate CPT Code (e.g. 66984) and Modifier 54. This modifier is used to indicate the surgical event in a co-managed case. Medicare assigns 80% of the global fee to the intraoperative service.

At a later date, the surgeon will submit a claim for his/her portion of post-operative care. In order for this claim to be accurate, the surgeon needs to know the date the co-managing optometrist assumed responsibility for the remaining post-operative care (the transfer date noted above). This claim will be filed using the appropriate CPT Code (e.g. 66984) and Modifier 55, which indicates postoperative management only.

After the optometrist has seen the patient for post-operative care, he/she will submit a claim for the post-operative care provided, using the appropriate CPT Code (e.g. 66984) and Modifier 55. Again, in order for the claim to be accurate the co-managing optometrist must know the date he/she assumed responsibility for post-operative care (the transfer date).

Medicare uses chronology and number of days to calculate payment for care rendered by each doctor during the 90-day postoperative period. The fees submitted by the surgeon and optometrist will be different, depending on the number of days of post-operative care each one provided.

Date of Surgery: 5/1 FIRST EYE				
Claim	**Surgeon**		**Optometrist**	
Surgical	5/1	66984-54	N/A	N/A
Post-op	5/2	66984-55	5/3-7/30	66984-55
Ophthalmic Physician's post op care is 20% of global package value of postop care apportioned in accordance with expected usual and customary office visit charges In this example: 2/90th of 20% to the surgeon 88/90th of 20% to the optometrist				

When submitting claims, many Medicare carriers instruct providers to write a comment in the body of the claim form, as follows:

Surgeon: *"Assumed post-operative care on January 2, relinquished care on January 10"*
Co-managing optometrist: *"Assumed post-operative care on January 11, relinquished care on April 1."*

OVERLAPPING POST-OPERATIVE CO-MANAGEMENT

Many patients will have cataract surgery performed on the second eye shortly after their first surgery, in which case post-operative care may overlap temporarily. When these patients are co-managed, claims for each surgery are handled separately. The surgeon will file both the second surgical and post-operative care claim similar to the manner in which the first claims were submitted, but will append Modifier 79 to indicate the second surgery is unrelated to the first. The co-managing optometrist will also file a claim similarly to the first, but will also append Modifier 79.

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Date of Surgery: 5/22 SECOND EYE				
Claim	**Surgeon**		**Optometrist**	
Surgical	5/22	66984-54-79	N/A	N/A
Post-op	5/23	66984-55-79	5/24-8/20	66984-55-79

The chronology and windows of time on which payment is determined (as outlined above) are still relevant and the claims will be concurrent. The surgeon will determine if the transfer of care for the first surgery occurs before or after the second surgery.

If the transfer of care for the first surgery occurs before the second surgery, then two transfer of care letters or forms and transfer agreement letters must be prepared, establishing a unique transfer date for each surgery.

The comments provided herein relate to billing for cataract co-management for Medicare patients. Commercial carrier policies will vary. Should you have questions about a specific carrier's policy, we recommend you contact them directly. Also, if you have questions related to Medicare billing procedures, you can visit their website, www.cms.gov, or contact our office for assistance.

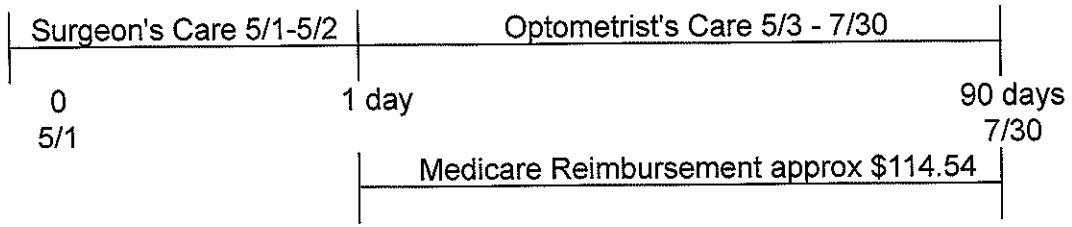
PREMIUM IOLs AND UPGRADES

Premium intraocular lenses and other available upgrades are generally not covered by insurance and patients must pay for these services out of pocket. Because premium IOLs often require more involved post-operative care and additional testing, co-managing optometrists are entitled to a portion of this out-of-pocket fee. This fee is in addition to insurance reimbursement for co-managed post-operative care and is collected from the patient directly.

Standard Cataract Implant

Example 1

Date of Surgery 5/1



Surgeon's Care		Optometrist's Care	
5/1	66984-54		
5/2	66984-55	5/3-7/30	66984-55

Ophthalmic Physician's postop care is 20% of global package
Value of postop care apportioned in accordance with expected usual and customary office visit charges

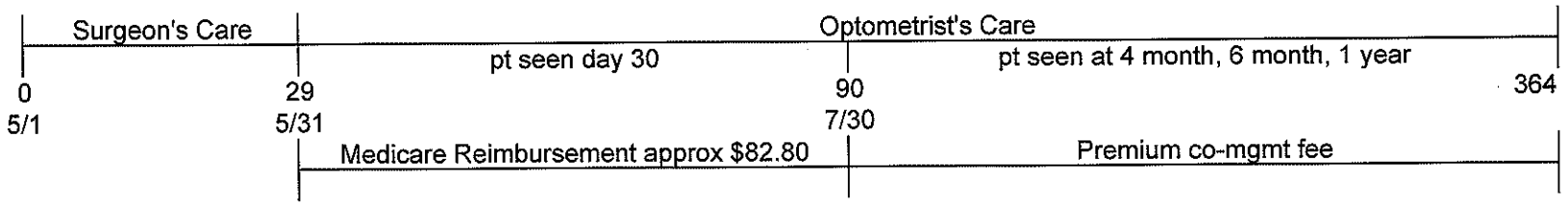
In this example:

7/90th of 20% to the surgeon
83/90th of 20% to the optometrist

Premium IOL Implant

Example 2

Date of Surgery 5/1



Surgeon's Care		Optometrist's Care	
5/1	66984-54		
5/2-5/30	66984-55	5/31-7/30	66984-55

Ophthalmic Physician's postop care is 20% of global package.
Value of postop care apportioned in accordance with expected usual and customary office visit charges.

In this example:

29/90th of 20% to the surgeon
61/90th of 20% to the optometrist

Commercial Insurance:

Can Bill office visits after our 1st 1-Day Post-operative visit

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1-13: Patient Demographics

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
OTHER [X] (ID#)	999999999
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN SBK	3. PATIENT'S BIRTH DATE: 01011990 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN SBK	
5. PATIENT'S ADDRESS (No., Street): 2100 WETGATE PLAZA	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): 2100 WETGATE PLAZA	
CITY: GRAPEVINE STATE: TX	8. RESERVED FOR NUCC USE
CITY: GRAPEVINE STATE: TX	
ZIP CODE: 76051 TELEPHONE (Include Area Code): (8174102030	
ZIP CODE: 76051 TELEPHONE (Include Area Code): (8174102030	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH: 01011990 SEX: M [X] F [ ]	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, complete items 9, 9a, and 9d.	

12. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 02152018

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

17: Surgeon Name **17b: Surgeon NPI**

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) QUAL.	15. OTHER DATE QUAL.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN PHILLIPS K LABOR MD	17a. 17b. NPI 1528011244	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind 0		22. RESUBMISSION CODE ORIGINAL REF. NO.
A. H25.12 B. E. F. I. J. K.		23. PRIOR AUTHORIZATION NUMBER

21: ICD-10: Must match surgeon's diagnostic code

24 E: Diagnosis pointer: must be linked to ICD-10 code in box 21

24G: number of units patient was seen (1 = 1 day)

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 02152018 02152018	11		92014		A	250.00	1		NPI	1528011244
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

24A. Date of Service

24B: Place of Service (11-in office)

24D: Office Visit Code (92014)

24F: Charges: Pick your own amount

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
[X]	8830734C	[X] YES [ ] NO	$ 250.00	$ 0.00	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
SIGNED DATE	a. b.	a. b.

OD information: Signature, address, phone #, Tax ID, NPI

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

MEDICARE

PO BOX 660156
DALLAS, TX 75266-0156

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1-13: Patient demographics

1. MEDICARE (Medicare#) / MEDICAID (Medicaid#) / TRICARE (ID#/DoD#) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (ID#) / FECA BLK LUNG (ID#) / OTHER (ID#)	X
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	123456789A
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	DOE, JOHN SBK
3. PATIENT'S BIRTH DATE MM DD YY / SEX	01011990 / M X / F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	DOE, JOHN SBK
5. PATIENT'S ADDRESS (No., Street)	2100 WETGATE PLAZA
6. PATIENT RELATIONSHIP TO INSURED	Self X / Spouse / Child / Other
7. INSURED'S ADDRESS (No., Street)	2100 WETGATE PLAZA
CITY	GRAPEVINE
STATE	TX
8. RESERVED FOR NUCC USE	
CITY	GRAPEVINE
STATE	TX
ZIP CODE	76051
TELEPHONE (Include Area Code)	(8174102030
ZIP CODE	76051
TELEPHONE (Include Area Code)	(8174102030
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
10. IS PATIENT'S CONDITION RELATED TO:	
11. INSURED'S POLICY GROUP OR FECA NUMBER	ABC
a. OTHER INSURED'S POLICY OR GROUP NUMBER	
a. EMPLOYMENT? (Current or Previous)	YES / X NO
a. INSURED'S DATE OF BIRTH MM DD YY / SEX	01011990 / M X / F
b. RESERVED FOR NUCC USE	
b. AUTO ACCIDENT? PLACE (State)	YES / X NO
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	
c. OTHER ACCIDENT?	YES / X NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	
10d. CLAIM CODES (Designated by NUCC)	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	YES / X NO — If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE 08222016

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

17: Surgeon Name

17b: Surgeon NPI

19: Date of Assumed Care until end of 90 Day global period

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY / QUAL.	
15. OTHER DATE QUAL. MM DD YY	
CURRENT OCCUPATION MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	DN PHILLIP KIRK LABOR MD
17a.	
17b. NPI	1528011244
ED TO CURRENT SERVICES MM DD YY FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	POST OP DATE RANGE 8-20-2016 THRU 11-20-2016
20. OUTSIDE LAB? $	YES / X NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind.	0
22. RESUBMISSION CODE / ORIGINAL REF. NO.	
A.	H25.12
B. C. D.	
E. F.	
I. J. K.	
ON NUMBER	

21: ICD-10: Must match surgeon's diagnostic code

24 E: Diagnosis pointer: must be linked to ICD-10 code in box 21

24G: number of units patient was seen (some insurances require number of days rather then units)

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 08192016	08192016	24		66984	55 LT	A	2450.00	1		NPI	1427010263
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

24A. Date of Surgery

24B: Place of Surgery: Code 24: Ambulatory Surgical Center

24D: Procedure Code: Must match surgeon's code

24D: Co-management Modifier 55

24D: Which eye (RT/LT modifier)

24F: Charges: Pick your own amount (rec: no less than $3 dollars/day)

25. FEDERAL TAX I.D. NUMBER SSN EIN	– X
26. PATIENT'S ACCOUNT NO.	8725415G
27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	X YES / NO
28. TOTAL CHARGE	$ 2450.00
29. AMOUNT PAID	$ 0.00
30. Rsvd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	SIGNED
32. SERVICE FACILITY LOCATION INFORMATION	LONESTAR ASC 2201 WESTGATE PLAZA GRAPEVINE, TX 760518037
a.	1679804355
b.	
33. BILLING PROVIDER INFO & PH #	
a.	1[illegible]6588461
b.	

OD information: Signature, address, phone #, Tax ID

NUCC Instruction Manual available at: [illegible] PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

EYE CONSULTANTS
OF TEXAS

CO-MANAGEMENT FEE JUSTIFICATION

MEDICARE REIMBURSEMENT: The total post-operative care percentage for ophthalmic procedures has been set at 20 percent of the surgical fee allowance. In cases where more than one physician furnishes post-operative services, the payment will be divided between the physicians based on the number of days for which each doctor is responsible for furnishing post-operative care.

Commercial payors may have different guidelines with regard to co-management, and some payors may not permit co-management at all. Providers are encouraged to contact commercial payors on how to handle billing co-management services for your specific area.

CO-MANAGING PREMIUM IOLs: Recent advancements in astigmatism-correcting and presbyopia-correcting intraocular lenses (IOLs) give patients an opportunity to lessen their dependence on glasses following cataract surgery. CMS permits providers to bill Medicare beneficiaries a separate charge for these refractive non-covered services (this is aside from the 20 percent surgical fee allowance). **Co-managing providers are responsible for determining what fees are appropriate and reasonable to collect from a patient.** We highly suggest that you justify the collection of these fees by using a similar breakdown as we have used in the example below.

Justification of $600 Co-Management Fee

(for all premium IOLs: Light Adjustable, PanOptix/PanOptix Toric, Crystalens/Trulign, Restor/Restor Toric, Symfony/Symfony Toric, etc.)

Revenue covered by patient reimbursement:

4 month postoperative visit revenue to OD*	$150
6 month postoperative visit revenue to OD*	$150
12 month postoperative visit revenue to OD*	$150
Extended Ophthalmoscopy at 1 year post-operative appointment ($75/eye)	$150
	$600

*includes office visit ($89.34), refraction ($50) and corneal topography ($37.20) based on estimated usual and customary charges for routine post-operative visits to the optometric physician.

Justification of $300 Co-Management Fee

(for Toric IOLs, monovision, and modified mini-monovision)

Revenue covered by patient reimbursement:

6 month postoperative visit revenue to OD*	$150
12 month postoperative visit revenue to OD*	$150
	$300

*includes office visit ($89.34), refraction ($50) and corneal topography ($37.20) based on estimated usual and customary charges for routine post-operative visits to the optometric physician.

PENALTIES ASSOCIATED WITH MEDICARE AND INSURANCE FRAUD: There is a statute that states it is a felony for individuals or entities to knowingly and willfully make or receive payment for patient referrals or other items or services paid for by Medicare of Medicaid. The statute holds both parties culpable and states that "payment" can be anything of value. The violations are punishable by significant fines, imprisonment, and/or large civil monetary penalties.

–Corcoran Consulting Group, 2009