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Comanagement of Surgical Patients

[Introduction](#)[Why Is It In The News](#)[Facts & Statistics](#)[Conclusions](#)[References](#)

Introduction

Comanagement occurs when a surgical patient receives surgical care from one physician and postoperative care from another healthcare provider. This type of arrangement most commonly occurs with cataract and refractive surgery.



Why Is It In The News?

The American Academy of Ophthalmology and the American Society of Refractive & Cataract Surgery have issued voluntary guidelines for physicians considering comanaging patients.

Legislation to limit comanagement was introduced in Florida and Missouri in 2001.



Facts & Statistics

American Medical Association and American College of Surgeons guidelines disapprove of comanagement arrangements that exist if economic considerations drive the arrangement.^{1,2}

The Office of the Inspector General of the Dept. of Health and Human Services has expressed concern about comanagement based on economic considerations rather than clinical appropriateness and has refused to provide safe harbor protections (from anti-kickback regulations) for such arrangements, preferring to review cases on an individual basis.

In 2000, the American Academy of Ophthalmology and the American Society of Cataract & Refractive Surgery issued voluntary guidelines for surgeons engaging in comanagement arrangements. Key provisions of the guidelines state:

- The surgeon has primary responsibility for preoperative assessment and postoperative care for patients, regardless of the type of surgery.
- Comanagement of patients is ethical and appropriate in some circumstances, such as:

The surgeon is unavailable to provide postoperative care (due to travel, illness, leave, itinerant surgery in a rural area or surgery performed in a

designated physician shortage area.)

The patient cannot travel to the surgeon's office because of distance or the development of another illness.

- When comanagement is practiced for economic reasons (specifically as an inducement for surgical referrals) or is the result of coercion by the referring practitioner, it is unethical, and in many jurisdictions, illegal.
- The surgeon, **prior to surgery**, must inform the patient if there are any prearranged postoperative management plans, and the patient must voluntarily consent to this in writing. This consent process, which should be documented in the medical record, should include the reason for the transfer of care, the qualifications of the health care provider who will render the postoperative care and any special risks that may result from this arrangement.

If an unanticipated transfer of postoperative care is required, the patient should be informed and this information documented in the medical record.

- The surgeon should inform the patient of the financial implications resulting from the comanagement arrangement, particularly with regard to the patient's payment obligations and the postoperative provider's reimbursement.
- The transfer of care must not occur unless it is clinically appropriate and in the patient's best interest.
- The surgeon should confirm that the comanager is legally entitled and professionally trained to provide the particular services.
- The comanagement must not be done as a matter of routine policy on all patients.
- The surgeon should follow the patient until postoperatively stable, and there is no fixed time when the patient is sent back to the referring provider.
- The patient should be reassured that he/she has access to the surgeon, if necessary, during the postoperative period at no additional cost. (If a Medicare/Medicaid patient returns to the surgeon, both the surgeon and postoperative care provider must file a corrected claim.)
- Any fees must reflect an appropriate fair market value for the services performed.



Conclusions

Quality medical care can only be achieved when the welfare of the patient is placed above all other considerations. Patients' interests must never be compromised as a result of comanagement.

References

1. American Medical Association. Ethical Opinion 8.043: *Ethical Implications of Surgical Co-Management*. Chicago: American Medical Association; 2000.
2. American College of Surgeons. [ST-25] *Statement on Principles Underlying Perioperative Responsibility*. Bulletin of the American College of Surgeons 1996; 81 (9): 39.



