Date:
Doctor's Name:
Address:

Dear Doctor:

We understand that we are performing cataract or other eye surgery on one or more of your patients who may desire that you participate in the post-operative portion of such eye surgery. To comply with various governmental and payor rules applicable to post-operative co-management arrangements, this letter outlines the policy that we will follow in transitioning the patient(s)'s post-operative care to you.

The patient's right to choose the method of post-operative care will be recognized and will be consistent with the best medical interests of the patient. To achieve this goal, prior to surgery, we will provide the patient with an information sheet on "Shared Post-Operative Care" and a "Consent for Shared Post-Operative Care" which will be signed by the patient, the surgeon and you as the co-managing provider.

Following surgery, the transfer of care from the surgeon to you will occur when and if clinically appropriate at a mutually agreed upon time. This information will be included in the "Transfer Agreement" we provide you at the time of transfer of care and will be signed by you and the surgeon. You should, of course, also document appropriate post-operative care in the patient's record.

For procedures covered by Medicare or another third party insurance carrier ("Covered Procedures"), you will bill and collect for your services directly from Medicare and/or any other payor(s) who permit direct billing in compliance with their policies. If a payor does not permit you to bill separately for post-operative care, we will bill and collect globally for the services (including collection of any co-payment or deductible from the patient). We will pay your fee from collections received by the payor(s) and patient. Unless an alternative allocation is established by the payor or applicable governing authority, we will pay you twenty percent (20%) of the collections received from the payor/patient for the global professional fee (based on the post-operative allocation of the global surgery payment established by Medicare). The patient shall be informed, prior to giving consent to surgery, of the applicable fee collection process and allocation of those fees between the surgeon and co-managing provider.

For any Covered Procedure which may require more or less post-operative care from you, we will pay you a mutually agreed amount set in advance (and communicated to patients) that is commensurate with the number, fair market value, and intensity of the services you provide. Note that, in order to co-manage Covered Procedures, you must be credentialed with the applicable payor and permitted to provide services to that payor's beneficiaries.

For all procedures, items and services that are not covered by Medicare or the patient's applicable insurance carrier (including, without limitation, LASIK and PRK procedures and premium intraocular lens implantation) ("Non-Covered Services"), we will use CoFi, a cloud-based collaboration platform, to facilitate payment communication and financial record keeping. Through CoFi, we will each separately charge and collect the fees for our respective Non-Covered Services directly from the patients. You are responsible for establishing the applicable fees for the non-covered post-operative care provided to the patient. Such fees should be determined in advance, communicated to the patient prior to surgery and commensurate with the Non-Covered Services to be performed by you.

We will be reviewing our co-management arrangements on an annual basis and will notify you of any change in our policy at that time. If you are willing to participate in the post-operative co-management of our mutual patients for the next year or until there is a change in our co-management policy, please sign this letter and return it to us. If you have any questions, please do not hesitate to contact our office. We look forward to working with you for the mutual benefit of our patients.

Very truly yours,

New Jersey Eye and Ear, LLC

By: _____

Daniel Stegman, M.D., President

Agreed and accepted:

_____   _____

Signature   Date

_____

Print Name