SECOND REGULAR SESSION

SENATE BILL NO. 1097

91ST GENERAL ASSEMBLY

INTRODUCED BY SENATORS KENNEDY AND STOLL.

Read 1st time February 4, 2002, and 1,000 copies ordered printed.

TERRY L. SPIELER, Secretary.

4378S.01I

AN ACT

To amend chapter 334, RSMo, by adding thereto one new section relating to surgical comanagement arrangements.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section A. Chapter 334, RSMo, is amended by adding thereto one new section, to be known as section 334.109, to read as follows:

334.109. 1. As used in this section, the following terms shall mean:

(1) "Ancillary personnel", a person who is not an ophthalmologist or an optometrist working under the direction of an ophthalmologist or an optometrist;

(2) "Comanagement safe harbor", protection from disciplinary proceedings against an eye care provider with respect to comanagement of an eye surgery patient when the eye care provider adheres to the parameters established by this section;

(3) "Eye care provider", a physician who is an ophthalmologist or a doctor of optometry licensed pursuant to chapter 336, RSMo;

(4) "Ophthalmologist", a physician who has graduated from an accredited ophthalmology residency;

(5) "Optometrist", a doctor of optometry who has graduated from an accredited school of optometry;

(6) "Surgical comanagement", the collaboration and sharing of responsibilities among eye care providers with respect to the preoperative or postoperative care of an eye surgery patient. Surgical comanagement does not include delegating tasks

relating to the care of a surgical patient to ancillary personnel working under the direct supervision of an eye care provider.

2. Surgical comanagement is permitted when the following are met:

(1) The patient has indicated a preference to have preoperative or postoperative care furnished by an eye care provider other than the operating surgeon; or

(2) The distance from the patient's home to the operating surgeon's office would result in an unreasonable hardship for the patient; or

(3) Extenuating circumstances exist which prevent the patient from visiting the surgeon's office for routine preoperative or postoperative care and such care can be provided by another qualified eye care provider; or

(4) The surgeon chosen by the patient is not available to perform the operation and associated care within a reasonable proximity to the patient's home; or

(5) The operating surgeon will not be available to provide postoperative care after the surgery provided that the absence of the operating surgeon does not fall within rules pertaining to patient abandonment or improper itinerant surgery; and

(6) The patient chooses to have preoperative or postoperative care furnished by an eye care provider other than the operating surgeon after being fully informed about the proposed comanagement arrangement as described in subsection 5 of this section.

3. None of the comanaging eye care providers shall receive a percentage of the global surgical fee that exceeds the relative value of services provided to the patient which are reasonable and necessary for the patient's care.

4. Each comanaging eye care provider shall be licensed or certified and qualified for the services they provide to the patient. If surgical intervention is required during the postoperative period for medically necessary reasons, the patient shall be referred back to the original operating surgeon or to another surgeon with comparable skills.

5. A patient or legal guardian shall be fully informed in writing about the surgical comanagement arrangement and shall sign and receive a statement acknowledging that the details of the surgical comanagement arrangement have been fully explained to the patient, including all of the following:

(1) The licensure and qualifications of the comanaging eye care providers who will be managing the patient's care preoperatively, during the operation and postoperatively;

(2) The financial arrangement between the comanaging eye care providers, including the division of the global surgical fee among the providers participating in

the surgical comanagement arrangement;

(3) The patient's right to receive care from any of the comanaging eye care providers that they are licensed and qualified to provide; and

(4) The patient's right to accept or decline to participate in the surgical comanagement arrangement.

The comanagement informed consent shall be documented in the patient's medical records maintained by each of the comanaging eye care providers, including the patient's acknowledgment of and agreement to the surgical comanagement arrangement.

6. The comanaging eye care providers shall establish written protocols governing the manner in which care will be provided to the patient, including but not limited to:

(1) The nature of routine care expected;

(2) Who will deliver each aspect of care;

(3) How complications will be handled;

(4) The parameters which will determine when a patient is fully healed and may be released from further care, and how the release will be accomplished; and

(5) The manner in which communication between the eye care providers will occur.

To comply with this subsection, it is necessary to establish a separate or unique protocol for each patient.

7. Comanaging eye care providers shall communicate regularly and in a timely manner consistent with the comanagement surgical protocol procedures established under subsection 6 of this section regarding the patient's care and progress during the postoperative period or until the patient is released from further care.

8. Any person who engages the following acts shall not receive the protection of the comanagement safe harbor:

(1) Entering into a surgical comanagement arrangement for the purpose of splitting a fee without providing a commensurate medically necessary service to the patient;

(2) Demanding to manage the postoperative care in return for making a surgical referral;

(3) Threatening to withhold referrals to a surgeon who does not agree to comanage a patient;

(4) Offering to comanage a patient in return for receiving a surgical referral;

(5) Intentionally referring a patient for surgery in a manner that has no other legitimate purpose than to justify a surgical comanagement arrangement;

(6) Initiating a surgical comanagement arrangement when the patient otherwise would have been released from further care following surgery;

(7) Failing to fully inform the patient about the surgical comanagement arrangement or failing to obtain a signed informed consent statement as defined under subsection 5 of this section;

(8) Misleading a patient as to the appropriateness of surgical comanagement for their particular circumstances or leading a patient to believe that he or she does not have the right to receive postoperative care from the operating surgeon or other comanaging providers;

(9) Failing to engage in regular and timely communication among the comanaging eye care providers;

(10) Failing to establish a written protocol for comanaged patients; or

(11) Any other act that is not in the best interest of the patient as determined by the eye care provider's respective licensing board.

Nothing in this subsection shall be construed to infringe upon an eye care provider's prerogative to recommend a surgeon or refer a patient to a surgeon based on that provider's opinion or assessment of the surgeon's ability or fitness to provide appropriate surgical care to a patient.

9. The board of healing arts shall be responsible for enforcement of the provisions of this chapter for those licensed pursuant to this chapter.

10. The board of optometry shall be responsible for enforcement of the provisions of this chapter for those licensed pursuant to chapter 336, RSMo.

11. The board of registration for the healing arts may promulgate rules to implement the provisions of this section as it affects licensees pursuant to this chapter. The board of optometry may promulgate rules to implement the provisions of this section as it affects licensees pursuant to chapter 336, RSMo. To the extent possible and appropriate, the board of registration for the healing arts and the board of optometry shall coordinate the content of any rules they may adopt. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2002, shall be invalid and void.

12. Nothing in this section shall be construed to infringe upon the right of any

eye care provider to decide whether or not to participate in comanagement arrangements either as a matter of policy or in a particular instance.

13. Nothing in this section shall be construed to limit tort liability of a physician or an optometrist with respect to any aspect of patient care.

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