

Premium IOLs—A Legal and Ethical Guide to Billing Medicare Beneficiaries

If you regularly attend the Academy's Codequest meetings, you may have noticed an uptick in questions about out-of-pocket expenses. Here's what you need to know regarding what can and can't be billed out of pocket in conjunction with cataract surgery.

Billing Medicare Patients for the Noncovered Portion

On May 3, 2005, the Centers for Medicare & Medicaid Services (CMS) published a ruling that reversed decades of policy.¹ Previously, services were either covered or not, with no middle ground. Under the 2005 ruling, if a Medicare beneficiary wants a presbyopia-correcting intraocular lens (IOL), Medicare will pay what it would cost to restore functional vision—i.e., the fee for replacing the cataractous lens with a conventional IOL, which is currently \$105—and you can bill the patient for additional costs associated with the new lenses.

On Jan. 22, 2007, CMS issued a similar ruling for toric astigmatism-correcting IOLs.²

Billing Do's and Don'ts

When a Medicare beneficiary agrees to have a presbyopia- or astigmatic-correcting IOL, rather than a conventional

IOL, you need to be careful with your billing.

What not to bill Medicare. Under the 2005 and 2007 rulings, Medicare will not cover the following:

- physician services and resources associated with the examination/fitting of premium lenses that exceed coverage for cataract surgery with insertion of a conventional IOL;
- physician services and resources related to refractive examinations specifically associated with insertion of a presbyopia- or astigmatic-correcting IOL;
- subsequent examinations (excluding the 1-time postcataract surgery exam); and
- changes in eyeglasses or lens power needed to accommodate the progression of postoperative presbyopia.

Here's what you can bill to the Medicare beneficiary. You can directly bill the patient for the services and resources that are listed above. You also can bill the patient for the following services:

- Correction of the patient's natural astigmatism with either a blade or a laser. For tracking purposes, practices may create an internal code for this noncovered procedure.
- Optiwave Refractive Analysis (ORA)

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Premium Lenses

Presbyopia-correcting IOLs. HCPCS code V2788 can be used when billing for the IOLs listed below:

- Abbott Medical Optics
 - Tecnis Multifocal 1-Piece (models ZKB00, ZLB00, and ZMB00)
 - Tecnis Multifocal Acrylic (model ZMA00)
 - Tecnis Multifocal Silicone (model ZM900)
- ReZoom
- Alcon
 - AcrySof IQ ReStor (models SN6AD1, SN6AD3, MN6AD1, and SV25T0)
- Bausch + Lomb
 - Crystalens

Astigmatic-correcting IOLs. HCPCS code V2787 can be used when billing for the IOLs listed below:

- Abbott Medical Optics
 - Tecnis Toric 1-Piece (models ZCT150, ZCT225, ZCT300, and ZCT400)
- Alcon
 - AcrySof IQ Toric (models SN6AT3 through SN6AT9; collectively referred to as SN6ATT)
- Bausch + Lomb
 - Trulign Toric (models AT50T, BL1AT, and BL1UT)
- Staar Surgical
 - Silicone 1-Piece Toric (models AA4203TF and AA4203TL)

Note: This list was current at time of press, but new lens models can come on the market at any time.

System Intraoperative Wavefront Aberrometry, but only when a presbyopia- or astigmatic-correcting IOL is implanted and the patient has given his or her consent.

What can ambulatory surgery centers (ASCs) charge? ASCs may bill the patient for the dollar difference between the \$105 that Medicare pays for standard cataract surgery and the additional cost of the premium IOL, plus a small handling fee. ASCs may also charge a fee for use of the aberrometer when premium IOLs are used.

What about non-Medicare payers? The CMS rulings for presbyopia- and astigmatic-correcting IOLs apply to Medicare Part B only. Medicare Advantage Plans and commercial plans may have the same coverage, or they may offer more benefits to cover the additional costs. It is imperative that you verify the coverage policy for each individual payer.

Which Codes to Use When Billing for Premium Lenses

Procedure codes. Regardless of what surgical method you use for cataract surgery, you should use CPT code 66984 or, if the surgery qualifies as complex, CPT code 66982. (Note: If you bill the latter code, make sure your documentation clearly indicates what it is that makes the case complex.)

In December 2005, CMS clarified that CPT codes 66985, for a secondary IOL, and 66986, for exchange of an IOL, may be used to report the insertion or replacement of presbyopia- or astigmatic-correcting lenses as well as conventional lenses.³ However, when using these 2 codes, you can't bill the patient for the extra expense associated with a premium lens.

HCPCS codes. Practices can report the noncovered charges associated with premium IOLs using HCPCS code V2788³ for a presbyopia-correcting IOL and V2787⁴ for an astigmatic-correcting IOL.

However, as a noncovered benefit, physicians are not required to submit these HCPCS codes unless the patient requests that it be submitted.

Furthermore, because you are billing for noncovered service, V2788 and

Femto and Cataract Patients' Best Interests

Protecting patients from unethical practices and acting in their best interests is the primary tenet of the Academy Code of Ethics. Both the Principles and the Rules of the Code address the ophthalmologist's responsibility to act in this way.

When an ophthalmic surgeon has a professionally related commercial interest—such as sole or joint ownership of a femtosecond laser device—the potential exists for a conflict of interest in patient care. It is essential that conflicting commercial interests not interfere with appropriate care.

Femto with a conventional IOL. A surgeon may use a femtosecond laser during cataract surgery when a conventional IOL is implanted (rather than a presbyopia- or astigmatic-correcting IOL), but neither the surgeon nor the facility may obtain additional reimbursement from either Medicare or the Medicare beneficiary over and above the Medicare-allowable amount. Leading patients to believe that you can charge them for this use of the femtosecond laser—for example, via advertisements or in-office financial-aid forms—misrepresents both the services to be performed and the charges made for those services. This misrepresentation limits the patient's autonomy in making appropriate informed decisions for his or her eye care. In the event of an unexpected surgical outcome, the fact of this misrepresentation will weigh heavily against the ophthalmologist if the patient initiates a medicolegal liability action. Charging the patient for this particular use of the femtosecond laser may violate several rules of the Academy's Code of Ethics. The rules concerned with conflict of interest and potential misrepresentation in the above scenario include the following rules: 2. Informed Consent; 9. Medical and Surgical Procedures; 11. Commercial Relationships; 13. Communications to the Public; and 15. Conflict of Interest.

MORE ONLINE. To read the Code of Ethics, visit aao.org/ethics-detail/code-of-ethics. You also can read Guidelines for Billing Medicare Beneficiaries When Using the Femtosecond Laser, published in 2012 by the Academy and the American Society of Cataract and Refractive Surgery. It is available at aao.org/practice-management/coding/updates-resources.

V2787 do not need to have modifier –GY appended to them.

Further Tips

Create a fact sheet. Some practices develop patient information fact sheets that detail the out-of-pocket expenses associated with a premium IOL. Patients can sign this to acknowledge that they understand those costs.

No ABN is needed. Because the premium component of the IOL is statutorily excluded from Medicare coverage, no Advance Beneficiary Notice (ABN) is required.

Medicare patients must be able to opt for the standard IOL. When you are discussing IOL options with cataractous Medicare beneficiaries, you can't tell them that you will only perform surgery if they request a premium lens.

What about additional charges associated with monovision or blended vision?

One eye corrected for distance and one eye corrected for near has been an option since aphakic contact lenses were developed. There is no extra allowed billing when conventional IOLs are used.

1 CMS Ruling 05-01 May 3, 2005. www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/downloads/CMSR0501.pdf.

2 CMS Ruling 1536-R. Jan. 22, 2007. www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/downloads/CMS1536R.pdf.

3 CMS Transmittal 801. Dec. 30, 2005. www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R801CP.pdf.

4 CMS Transmittal 1430. Feb. 1, 2008. www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1430CP.pdf.