Monovision – Medicare – Money – and You

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INTRODUCTION

One of the current controversies circulating in cataract surgery circles is whether or not one can bill the patient for extra charges associated with a standard cataract surgery with insertion of a non presbyopia correcting intraocular lens.

Seminars and list serves have been trying to tackle this question. Some of it is really rather black and white whereas other aspects are gray – let's take a look at the challenges.

CAN YOU BILL THE PATIENT OR MEDICARE FOR THE EXTRA CHARGES ASSOCIATED WITH THE COUNSELING WHEN PERFORMING THE SECOND SURGERY?

The case scenario would be that the surgery on the first eye consisted of surgery with insertion of a presbyopia correcting intraocular lens (P-C IOL) and a cataract extraction with insertion of a non presbyopia correcting intraocular lens in the second eye. The physician wants to bill for the extra time involved in counseling and explaining to the patient the intricacies of monovision.

Billing the patient or Medicare. You cannot bill the patient since the entire service is a covered service for Medicare and balance billing is prohibited. However, assuming the patient is out of the global period of the P-C IOL surgery on the first eye, you may bill Medicare for the medically necessary office visit(s) related to scheduling/evaluating/examining the second non-P-C IOL cataract surgery with insertion of intraocular lens.

Not only are you be prohibited from billing Medicare, doing so would be a serious error and, would be considered as not medically necessary, resulting in a refund as a minimum under audit.

"Chair time". Many physicians want to bill Medicare for the extra explaining, counseling, and hand-holding that is required as well as the extra testing that may be necessary in coordinating and determining the best outcome for the surgery. When you are doing a P-C IOL insertion, reimbursement for this additional work may be captured in your "P-C surgery package"; however, when inserting a standard intraocular lens in conjunction with cataract surgery there is no mechanism for obtaining additional reimbursement.

EXCHANGE AND INSERTION OF SECONDARY INTRAOCULAR LENSES

Can I or Can't I bill Medicare when these procedures are performed in the same eye after P-C IOL insertion?

Well, it depends!

Insertion of secondary IOL's. Since the December 30, 2005 transmittal (CR 4184, Transmittal 801), Medicare allows use of P-C IOL's for secondary intraocular lens placement. The usual rules governing P-C IOL's applied.

Exchange of IOL's. The reimbursement issues surrounding Medicare coverage for the intraocular lens exchange are less well defined. Foremost is the issue of medical necessity for the procedure. Here are my thoughts.

There are some related precedents. CPT code 65772 (corneal relaxing incision for correction of surgically induced astigmatism) describes a procedure that may be used following prior surgery or trauma for correction of a refractive error (non-covered procedure) and will paid for by Medicare. Your Medicare carrier may have a LCD (Local Coverage Determination) regarding parameters for this surgery.

If, following a cosmetic blepharoplasty, a cicatricial ectropion develops, then Medicare will pay for the resultant surgery, even though it was necessitated by a non-covered, statutorily excluded procedure.

If a patient returns with any medical/surgical complication following cataract surgery with a P-C IOL insertion that requires surgical intervention, the second surgery will be covered by Medicare. Examples of this would be repositioning of the intraocular lens requiring and incision and removal of the intraocular lens.

The difficulty arises when one must determine whether a refractive complaint or problem merits consideration as a covered surgical intervention – ie, exchanging the intraocular lens.

Well, again it depends! Certainly the surgery for correction of any physical problems related to the intraocular lens itself would be covered (haptic or lens malpositioning).

I personally would feel comfortable in billing Medicare for an intraocular lens exchange if the patient expresses significant visual difficulties interfering with his ADL (Activities of Daily Living) activities and daily functioning. After all,

we have been doing this for problems associated with standard intraocular lens insertion since the inception of cataract with intraocular lens insertion surgery.

The problem is should you bill Medicare when the complaint is totally related to the refractive error – such as a small power difference? Probably not.

These decisions are difficult at best and subject to various interpretations. Your local Medicare carrier will have the final adjudication.

Financial considerations regarding who should pay when using a standard intraocular lens in an IOL exchange procedure include co-payments, payment of deductibles, and cost of the intraocular lens. Medicare's standard regulations would apply.

TORIC INTRAOCULAR LENSES – NEW CMS RULING

Toric intraocular lenses had received NTIOL (New Technology Intraocular Lens) status and the facility may bill an additional $50 when one so approved for payment is used. This may be subject to change in view of the new CMS ruling.

I have encountered numerous instances where the physician wanted to charge the patient additionally for the lens and/or wanted the facility to charge the patient the difference between the cost of the toric intraocular lens and the facility's $150 intraocular lens allowance. Both of these activities are prohibited if performed prior to January 22, 2007.

CMS ruling 1536-R was issued January 22, 2007 and states from that date forward the differential in price between the $150 IOL allowance and the cost of the astigmatism-correcting intraocular lense is considered a non-coverered service and the difference in price may be billed to the patient. As with insertion of Presbyopic-Correcting Intraocular Lenses, in determining the physician service charge, the physician may take into account the additional physician work and resources required for insertion, fitting, and visual acuity testing of the astigmatism-correcting IOL compared to insertion of a conventional IOL. This applies to facility charges as well. You should follow the policies set for P-C IOL reimbursement for NEMBs (Notice of Exclusion of Medicare Benefits), glasses/contact lenses after surgery, etc.

CONCLUSION

In these times of reimbursement difficulties, many policies may not seem fair – or worse may actually be punitive; nevertheless, it is important to remember that Medicare sets the rules and it is dangerous to try to skirt around them.

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