

# COMANAGEMENT & BILLING *for Multifocal Lens Implants*

## IOL OPTIONS

Several presbyopia-correcting lens implants are available that replace vision lost to presbyopia. Each has strengths and weaknesses, but these implants are options for cataract patients who are motivated to reduce dependency on glasses.

## PATIENT-SHARED BILLING

Surgeons pay over \$1000 each for presbyopia-correcting lens implants. Because they are substantially more expensive than standard single-focus IOLs, and involve more patient care, Medicare has given special thought to the billing process. Medicare will pay for the standard cataract portion of the lens and procedure and patients can pay out-of-pocket for additional costs associated with upgrading to a presbyopia-correcting IOL. This is known as patient-shared billing.

A ground breaking ruling by the Centers for Medicare and Medicaid Services (CMS) makes it possible for Medicare beneficiaries with cataracts to pay extra for CMS-designated presbyopia-correcting IOLs.

*In determining the physician service charge, the physician may take into account the additional physician work and resources required for insertion, fitting, and vision acuity testing of the presbyopia-correcting IOL compared to the insertion of a conventional IOL. The beneficiary is responsible for payment of the charges for physician services that exceeds the physician charge for insertion of a conventional IOL following cataract surgery.*  
—CMS Ruling No. 05-01. May 3, 2005

A well established precedent for patient-shared billing exists with eyeglass frames where payers have preset limits on the fees they cover. With Medicare and some payers, beneficiaries may select deluxe frames that cost more than what is covered, and providers are permitted to accept payment from the beneficiary for the additional amount to upgrade. The deluxe frame includes covered and non-covered elements. Claim submissions include separate lines for

covered and non-covered portions of the charge. This is not balance billing. Similar billing is allowed for cataract patients electing to upgrade to presbyopia-correcting IOLs.

## OTHER THIRD PARTY PAYERS

Third party payers are not obligated to agree with the CMS ruling that allows for patient-shared billing. Some insurance carriers have modified their approach and others have rejected the concept completely. So, some beneficiaries who have been diagnosed with visually significant cataracts and want presbyopia-correcting IOLs may have to pay out-of-pocket for the entire procedure. Certainly, these beneficiaries will be unhappy with such a restrictive policy and may wish to contact their health plan directly to gain some leeway.

To avoid allegations of balance billing with health care providers that may not allow patient-shared billing, educate payers before proceeding with referrals for cataract surgery with presbyopia-correcting IOLs. Get written authorization to bill patients for your non-covered services.

## PATIENTS MUST BE INFORMED

Patients must be informed that cataract surgery with a presbyopia-correcting lens implant includes covered and non-covered items and services. Medicare will pay for the standard cataract portion of the lens and procedure but patients must pay out-of-pocket for services associated with upgrading to a presbyopia-correcting IOL. It is recommended that they be provided a written estimate of your fees for non-covered services.

## PACKAGE OF REFRACTIVE SERVICES

Typically, packages of refractive services related to presbyopia-correcting IOLs are created rather than presenting patients with a list of all the additional services you may provide.

These non-covered pre-operative services may include one or more of the following:

- Education and personality screening to determine if patients are potential candidates for this lens and possible LASIK enhancement
- Refraction to determine refractive error
- Contact lens trial fitting to assess refractive error
- Pupillometry to measure pupil size in dim and bright light conditions
- Corneal topography to assess corneal shape
- Corneal pachymetry to determine corneal thickness should LASIK enhancement be needed

A post-operative package of refractive services might include:

- Routine eye care, wellness care, or preventative care (e.g. to cope with refractive error)
- Post-operative education and counseling to help patients adjust to their new vision
- Additional post-operative care if LASIK enhancement or IOL exchange is required

## ESTABLISH YOUR FEES

Each practice must establish its own fees for non-covered items and services associated with presbyopia-correcting lens implants. Your fees for non-covered services should be reasonable and based on usual and customary charges for similar covered services. In many practices an actuarial approach works well for determining fees. This involves estimating the percentage of patients who will need specific services to obtain the desired outcome. A weighted average is calculated based on your usual and customary fees.

To determine your package fees for non-covered refractive services associated with presbyopia-correcting IOLs:

1. List every aspect of care you expect to provide pre and post-operatively and assign your usual and customary fee to each service in the package.
2. If you will provide personality screening and extra counseling to determine best candidates for these lens implants, list a reasonable fee for your additional time.
3. Determine the frequency each service is likely to occur within the population of patients desiring presbyopia-correcting IOLs.
4. Multiply the frequency times the usual and customary fee to arrive at a weighted average fee for each service. For example, if 100% will receive pre-operative personality screening and counseling, and your fee for this is \$50, then add \$50 to the package.
5. Total the weighted average fees to establish the package charge.

The value of your package is the sum of the component charges weighted according to the likelihood of delivering that service. This is similar to how CMS uses estimates for providers' time and effort to establish relative value units for various procedures. This approach allows you to provide each patient desiring presbyopia-correcting IOLs the same package fees while giving you the flexibility to determine which services are appropriate for each individual.

Medicare's comanagement rules only provide instruction for covered services using the 80/20 concept with post-op care being 20% of the surgeon's fee. However, it is unwise to extrapolate this split for non-covered services. Instead, the comanaging physician should make a discrete charge for services rendered, consistent with usual and customary charges.

In anticipation of the comanaged care, the surgeon should then reduce his package charge by the amount that represents services he will not render.

## CREATE A BILLING CODE

Although billing code V2788 has been created for presbyopia-correcting IOLs, CMS has not established new codes for surgery and services related to these implants. There is no benefit category for coverage so Medicare does not require reporting of these items or services. However, for the sake of clarity and line item bookkeeping, it is useful to assign codes to your non-covered items to track them internally.

In some situations, it may be necessary to include non-covered items or services on the claim. A commercial payer may require it, or the patient may desire a denial from Medicare or another payer for submission to a secondary payer. Some patients may just want something official to corroborate what your staff has explained about patient-shared billing. In these cases, code A9270 GY for non-covered services may be useful. The GY modifier identifies services that are excluded as Medicare benefits and may speed processing.

## BOOKKEEPING

Office staff should make clear distinction of covered and non-covered services when posting charges and payments. Use appropriate CPT and HCPCS codes to identify the pertinent items and services. Good record keeping entails a paper trail of patient consents for payment of non-covered items, financial waivers, and contract amendments.

## HOW TO BILL PATIENTS

When patients elect to purchase your package of refractive services, in anticipation of cataract surgery with presbyopia-correcting IOLs:

- Provide a written estimate of your fees for non-covered services.
- Provide an estimate of the surgery center's fees for non-covered items and services (see our Cataract Surgery Fee Schedule).
- Have patients sign an *Advance Beneficiary Notice of Noncoverage* (ABN) form. A sample is available from PCLI. By doing so, beneficiaries accept financial responsibility for your non-covered services. Give them a copy and keep the original in your files.
- Unless requested to do so by patients, do not submit non-covered charges to their insurance.
- Use your unique billing code.
- Collect the fee for your package of services.

## YOUR RESPONSIBILITY

This printed material is intended to help the reader better understand the rules and regulations regarding reimbursement for services relating to cataract surgery with multifocal lens implants. However, the responsibility for appropriate usage, adequate documentation, and proper coding are always the physician's.

## ADDITIONAL RESOURCES

Copies of this publication and helpful comanagement resources are available on our website—visit [www.odpcli.com](http://www.odpcli.com).