AMERICAN ACADEMY OF OPHTHALMOLOGY
The Eye M.D. Association

ASCRS
AMERICAN SOCIETY OF CATARACT AND REFRACTIVE SURGERY

Guidelines for Billing Medicare Beneficiaries When Using the Femtosecond Laser

The allowable Medicare reimbursement for cataract surgery does not change according to the surgical methods used. For example, the reimbursement is the same whether a cystotome or femtosecond (FS) laser makes the capsulotomy. Providers may not "balance bill" a Medicare patient or his or her secondary insurer for any additional fees to perform covered components of cataract surgery with an FS laser.

Medicare Part B permits patients to be billed for additional services used specifically to implant premium refractive IOLs (presbyopia-correcting and toric) for medically-necessary cataract. The surgeon and facility may charge the patient for premium refractive IOLs (presbyopia-correcting and toric) and the associated incremental professional and technical services. The patient, however, must be informed about, and consent to, the additional out-of pocket-costs in advance.

Refractive Lens Exchange

A refractive lens exchange is not medically necessary and therefore is not covered under Medicare Part B. The surgeon and the facility may bill the patient. Tiered pricing is allowed (e.g., additional fee for premium refractive IOL; additional fee to use the FS laser for lens removal steps), subject to properly documented informed consent.

Medically-Necessary Cataract Extraction with a Conventional IOL (No astigmatic keratotomy)

Medicare Part B covers the cataract surgery and the implantation of a conventional IOL without regard to the technology used. A surgeon may use the FS laser for the cataract surgery, but neither the surgeon nor the facility may obtain additional reimbursement from either Medicare or the patient over and above the Medicare-allowable amount.

Medically-Necessary Cataract Extraction with a Premium Refractive IOL (No astigmatic keratotomy)

Neither the surgeon nor the facility should use the differential charge allowed for implantation of a premium refractive IOL to recover all or a portion of the costs of using the FS laser for cataract surgical steps. As set forth above, Medicare Part B covers the cataract surgery and the implantation of a conventional lens without regard to the technology used.

Revised November 2012

Imaging performed as part of the FS laser surgery, which is necessary to implant premium refractive IOLs, is considered a non-covered service as long as these services are not used routinely when implanting conventional IOLs. A separate charge for the imaging is allowed with that consideration. However, as set forth above, Medicare Part B covers the cataract surgery without regard to the technology used. The Medicare beneficiary receiving a premium refractive IOL may be charged for non-covered services (such as imaging), but not for using the FS laser to perform covered steps of cataract surgery, such as the phaco incision, capsulotomy, and lens fragmentation.

Medically-Necessary Cataract Surgery Plus Astigmatic Keratotomy Performed for Refractive Indications

Medicare will cover medically-necessary cataract surgery, but not concurrent correction of astigmatism performed for refractive indications. Medicare patients may be charged a fee for performing astigmatic keratotomy, assuming that they were informed about, and consented to, the non-covered charges in advance. Because astigmatic keratotomy for refractive indications is a non-covered service, a higher fee can be charged for performing it using the FS laser, instead of with a metal or diamond blade. As with premium IOLs, however, the patient should not be charged an additional amount to concurrently perform the cataract surgical steps with the FS laser. While most astigmatism treatment is not covered, Medicare does cover the treatment of large degrees of astigmatism that were the result of previous ocular surgery. Local coverage determinations may apply. In this situation, neither the surgeon nor the facility may obtain additional reimbursement from either Medicare or the patient over and above the Medicare allowable amount.

Additional Considerations

Advertising: Promotional claims must be consistent with the best available clinical evidence and should not be deceptive or misleading to patients. Caution should be exercised with advertising or public media statements that describe why patients must pay additional out-of-pocket fees. Balance billing Medicare beneficiaries to use the FS laser for covered steps of cataract surgery is prohibited. Extra charges to the beneficiary can only be billed when a premium refractive IOL is used, and when the same imaging services are not used by the surgeon when implanting conventional IOLs. Statements that imply otherwise should be avoided.

CMS has provided an example of what it considers a misleading representation: *"While traditional cataract surgery is fully covered by most private medical insurance and Medicare, bladeless cataract surgery requires patients to pay out-of-pocket for the portion of the procedure that insurance does not cover".*

Transparency: Patient-shared pricing should be discussed openly with the patient. Increased charges should be explained and documented.

Note: The guidelines presented in this advisory represent the best effort of AAO and ASCRS, as of November 2012, to determine when Medicare and its beneficiaries can be billed for using the FS laser during cataract surgery. They are subject to modification based on any new regulations issued by the Centers for Medicare and Medicaid Services or its contractors. The organizations suggest that ophthalmologists seek additional guidance directly from their Medicare carriers for coverage determinations under Medicare Part C or through commercial carriers.