MARKET ACCESS AND REIMBURSEMENT SERVICES

Femtosecond Laser System for Cataract Surgery: Billing Guide

Overview

In 2012, the Centers for Medicare and Medicaid Services (CMS) released a guidance document addressing the use of a femtosecond laser system (FLS) in cataract procedures performed for Medicare beneficiaries.[1]

The guidance applies the principles of CMS rulings for presbyopia-correcting intraocular lenses (PC-IOLs) and astigmatism-correcting intraocular lenses (AC-IOLs) to the use of certain functions of an FLS when used in cataract procedures with conventional or advanced technology intraocular lenses (AT-IOLs).

	Covered	Noncovered	Patient's Responsibility
Physician	Surgery for treatment of cataract (66982 or 66984)	• Physician services attributable to the noncovered functionality of the astigmatism-correcting IOL (AC-IOL) and presbyopia-correcting IOL (PC-IOL) • Additional physician work and resources required for insertion, fitting, and vision acuity testing	Payment of charges for the physician services that exceed the physician charge for insertion of a conventional IOL
Facility	Surgery for treatment of cataract (66982 or 66984)	• Astigmatism-correcting or presbyopia-correcting function of an IOL and any additional resources required for insertion, fitting, and vision acuity testing	Payment of charges for the facility charges that exceed the facility charge for insertion of a conventional IOL, including costs of the IOL

Established by CMS Ruling 05-01 (May 2005) and 1536-R (January 2007).

The American Academy of Ophthalmology (AAO) and the American Society of Cataract and Refractive Surgery (ASCRS) jointly issued guidelines for billing Medicare beneficiaries when using FLS in 2012. It indicated that "the allowable Medicare reimbursement for cataract surgery does not change according to the surgical methods used.... Providers may not 'balance bill' a Medicare patient or his/her secondary insurer for any additional fees to perform covered components of cataract surgery with an FLS."

See Important Product Information on last page.

Frequently Asked Questions

1. How does this CMS guidance affect my practice?

- Imaging performed as part of the femtosecond laser surgery, which is necessary to implant premium refractive IOLs, is considered a noncovered service
- The Medicare beneficiary receiving an AT-IOL may be charged for noncovered services (such as imaging) but not for using the FLS to perform covered steps of cataract surgery, such as the phaco incision, capsulotomy, and lens fragmentation

2. Can surgeons charge patients additional fees for using the LenSx® Laser?

- Yes, if the charge is related to the additional service of imaging (and the integrated computations) used to determine the size, shape, and location of a capsulotomy when implanting an AT-IOL
- Creating a capsulotomy, primary and secondary incision, and fragmenting the nucleus with the FLS are steps of cataract surgery, which is a covered procedure, and are not separately billable to cataract patients

3. Can surgeons charge a conventional IOL patient for the imaging provided by the LenSx® Laser without an arcuate incision?

- No, if a conventional IOL patient is not also undergoing an additional refractive procedure, such as astigmatic keratotomy, then the patient should not be charged for the imaging function of the laser
- The patient may only be billed for the co-pay and deductible for the cataract surgery

Patient Documentation and Advanced Beneficiary Notice of Noncoverage (ABN)

- The provider should fully educate and inform the patient about the out-of-pocket responsibility prior to treatment.
- Patients are responsible for the charges of tests, services, and items used for their refractive treatment that are considered not medically necessary for treatment of a cataract

For Original (Fee-for-Service) Medicare Patients:

- A voluntary ABN can be used by providers when Medicare payment is expected to be denied; this would include refraction services
- When an ABN is used as a voluntary notice, the patient should not be asked to choose an option box or sign the notice
- When a noncovered service is provided at the same time as a covered benefit (eg, cataract surgery), it is recommended that the patient's understanding of their financial responsibility be documented with an ABN

For Medicare Advantage and Commercial Patients:

- A predetermination can be submitted to the payer to document noncovered services
- Providers should review each individual plan contract and follow the appropriate process specific to that payer

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

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Laser-Assisted Cataract Surgery and CMS Rulings 05-01 and 1536-R

Per CMS Ruling 05-01, issued May 3, 2005, Medicare will allow beneficiaries to pay additional charges (which are non-covered by Medicare as these additional charges are not part of a Medicare benefit category) associated with insertion of a presbyopia correcting intraocular lens (PC-IOL) following cataract surgery. Per CMS-Ruling 1536-R, effective for services on and after January 22, 2007, Medicare will allow beneficiaries to pay additional charges (which are non-covered by Medicare as these additional charges are not part of a Medicare benefit category) for insertion of an astigmatism correcting intraocular lens (AC-IOL). These rulings allow the beneficiary to pay additional charges for two specific categories of non-covered services:

- The portion of the facility or physician's charge for the PC-IOL or AC-IOL that exceeds the facility or physician's charge for insertion of a conventional intraocular lens (IOL) following cataract surgery.
- Facility or physician charges for resources required for fitting and vision acuity testing of a PC-IOL or AC-IOL that exceeds the facility or physician charges for resources furnished for a conventional IOL following cataract surgery.

These rulings allow facilities and physicians to charge patients only for the non-covered portion of a service that is furnished at the same time as a covered service. Services that are part of cataract surgery with a conventional lens, including but not necessarily limited to the incision by whatever method, capsulotomy by whatever method, and lens fragmentation by whatever method, may not be charged to the patient. The beneficiary may only be charged for those non-covered services specified above.

We are providing this guidance because of a recent press release from an ophthalmology practice that described use of bladeless, computer-controlled laser surgery for cataract removal. The press release may imply a different Medicare policy regarding non-covered services that may be charged to the beneficiary if the cataract surgery is performed using a bladeless, computer-controlled laser. The press release states:

> 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.

Medicare coverage and payment for cataract surgery is the same irrespective of whether the surgery is performed using conventional surgical techniques or a bladeless, computer controlled laser. Under either method, Medicare will cover and pay for the cataract removal and insertion of a conventional intraocular lens. If the bladeless, computer controlled laser cataract surgery includes implantation of a PC-IOL or AC-IOL, only charges for those non-covered services specified above may be charged to the beneficiary. These charges could possibly include charges for additional services, such as imaging, necessary to implant a PC-IOL or an AC-IOL but that are not performed when a conventional IOL is implanted. Performance of such additional services by a physician on a limited and non-routine basis in conventional IOL cataract surgery would not disqualify such services as non-covered services. This guidance does not apply to the use of technology for refractive keratoplasty.

LenSx® Laser Important Patient Product Information

CAUTION

The LenSx® Laser is restricted by law to the sale and use by, or on the order of, a physician.

DESCRIPTION

The LenSx® Laser is for use in patients undergoing cataract surgery. The laser is used as a tool to break up a cataract and to create incisions in the cornea. The LenSx® Laser may also be used for the creation of corneal flaps in LASIK surgery. The LenSx® Laser may also be used for the creation of corneal pockets or tunnels for the placement of corneal devices. The LenSx® Laser uses accessories called Patient Interfaces to hold the eye steady during a procedure.

WARNINGS / PRECAUTIONS

The LenSx® Laser Patient Interface and the LenSx® Laser SoftFit®Patient Interface hold an eye by applying light suction. Some bleeding and foreign body sensation may occur. As with any cataract surgery, there are risks involved. These risks may include but are not limited to infection, pain, corneal abrasion and capsular tear.

Surgery with the LenSx® Laser is not for everyone. Conditions such as corneal opacity, glaucoma, a poorly dilating pupil and previous corneal surgery may preclude use of theLenSx® Laser. Your doctor can determine if the LenSx® Laser is right for you.

References: 1. Department of Health and Human Services. Laser-assisted cataract surgery and CMS Rulings 05-01 and 1536-R. Centers for Medicare and Medicaid Services website. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/Downloads/CMS-PC-AC-IOL-laser-guidance.pdf. Published November 16, 2012. Accessed October 20, 2021. **2.** Guidelines for billing Medicare beneficiaries when using the femtosecond laser. American Academy of Ophthalmology website. https://www.aao.org/newsroom/news-releases/detail/aao-ascrs-guidance-re-medicare-billing-laser-catar. Accessed October 20, 2021..

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(866) 457- 0277 | ARS.SupportUS@alcon.com | ars.alcon.com

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