Corcoran Consulting Group
A Division of Ardare Corporation

CO-MANAGEMENT OF CATARACT SURGERY WITH PREMIUM IOLS

1 ***QUESTION:*** Is co-management permitted when patients undergo cataract surgery with premium IOLs?

ANSWER: Cataract surgery that includes implantation of a presbyopia-correcting IOL (P-C IOL) or astigmatism-correcting IOL (toric IOL) is often referred to as "premium". It treats two conditions: one medical – cataract impairing vision, and the other refractive – presbyopia or astigmatism. Treatment of the medical condition is covered, while the refractive treatment is non-covered and payable by the patient. These lenses are frequently referred to as "premium" IOLs. For additional discussion of premium IOLs, please request our FAQ and/or monograph on the topic.

Co-management of these cases is permitted because Medicare's guidelines for co-management of postsurgical care do not depend on the type of IOL used. Follow existing co-management protocols for the *covered portion* of these procedures.

2 ***QUESTION:*** May the non-covered physician services be co-managed?

ANSWER: Yes. While Medicare did not address this in either of its rulings regarding premium IOLs (CMS Ruling 05-01, May 3, 2005 and CMS Ruling 1536-R, January 22, 2007), both physicians can participate in providing the non-covered services that accompany the use of P-C IOLs or toric IOLs. Typically, a package of refractive services is identified rather than presenting the patient with an *a la carte* list of services.

Each party – the surgeon and the co-managing doctor – should obtain a financial waiver from the patient prior to surgery, indicating the patient's willingness to assume financial responsibility for the non-covered services.

3 ***QUESTION:*** What is included in the package of non-covered physician services?

ANSWER: The package of non-covered physician services is comprised of those additional tests, exams and procedures that are not related to the performance of traditional cataract surgery with an IOL, or are defined as non-covered anyway (*e.g.,* refraction and refractive procedures). Each surgeon will determine what services to provide, but the list might include the following services, among others.

- Refraction to determine refractive error
- Contact lens trial fitting to assess refractive error
- Wavefront aberrometry testing to assess refractive error
- Corneal topography associated with refractive surgery
- Corneal pachymetry associated with refractive surgery
- Routine eye care, wellness care, or preventive care (*i.e.,* to cope with refractive error)
- Refractive keratoplasty for the purpose of reducing dependence on eyeglasses or contact lenses (*e.g.,* limbal relaxing incisions, LASIK, enhancements, etc.)
- IOL exchange in extraordinary cases

4 ***QUESTION:*** How is the value of this package determined?

ANSWER: As a starting point, the surgeon should refer to his existing professional fee schedule for these tests, exams and procedures. The value of the package will be the sum of the component charges weighted according to the likelihood of delivering that service.

January 11, 2019

Corcoran Consulting Group
A Division of Ardare Corporation

CO-MANAGEMENT OF CATARACT SURGERY WITH PREMIUM IOLS

5 ***QUESTION:*** In a co-management situation how is the value of this package divided between the two physicians?

ANSWER: Medicare's co-management rules only provide instruction for covered services, not non-covered services. Consequently, it is unwise to extrapolate Medicare's 80/20 concept to the non-covered physician services. Instead, the receiving physician should make a discrete charge(s) for services rendered, consistent with usual and customary charges (*e.g.,* exams, refractions).

In anticipation of the co-managed care, the surgeon should reduce his package charge by an amount that represents services he will not render. This way, co-management will not result in the patient paying much greater fees for the non-covered care.

6 ***QUESTION:*** May the surgeon collect a single fee for the noncovered services and pay the referring doctor for his services?

ANSWER: This approach is fraught with trouble and not recommended. To avoid any appearance of "payment for referrals" (*aka* kickback), each provider should charge and collect for his respective services. For the patient's convenience, the surgeon may act as a collection agent for the co-managing physician – the patient makes out two checks (*i.e.,* one check for the surgeon, and one check for the co-managing physician).

7 ***QUESTION:*** Is the co-managing physician entitled to any part of the additional payment for the premium IOL?

ANSWER: No. Charges and payments for the premium intraocular lens are handled at the HOPD or ASC. Neither the surgeon nor the co-managing physician is involved in this payment.

8 ***QUESTION:*** Who should obtain a financial waiver in reference to non-covered services?

ANSWER: Both the surgeon and the receiving physician are strongly encouraged (although not required) to obtain financial waivers in connection with providing non-covered services to Medicare beneficiaries receiving a P-C IOL or toric IOL.

- An Advance Beneficiary Notice of Noncoverage (ABN) is required for services where Part B Medicare coverage is ambiguous or doubtful, and may be useful where a service is never covered. You may collect your fee from the patient at the time of service or wait for a Medicare denial. If both the patient and Medicare pay, promptly refund the patient or show why Medicare paid in error.
- For Part C Medicare (Medicare Advantage), determination of benefits is required to identify beneficiary financial responsibility prior to performing noncovered services. MA Plans have their own waiver processes and are not permitted to use the Medicare ABN form.
- For commercial insurance beneficiaries, a Notice of Exclusion from Health Plan Benefits (NEHB) is an alternative to an ABN.

January 11, 2019