

CO-MANAGEMENT OF CATARACT SURGERY WITH PRESBYOPIA-CORRECTING IOLS

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QUESTION: Is co-management permitted when patients undergo cataract surgery using a presbyopia-correcting IOL?

ANSWER: Yes. Medicare's guidelines for co-management of post-surgical care do not depend on the type of IOL used. Follow existing co-management protocols for the *covered portion* of these procedures.

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QUESTION: Is the co-managing physician entitled to any part of the additional payment for the P-C IOL?

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

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QUESTION: Can the non-covered physician services be co-managed?

ANSWER: Yes. While Medicare did not address this in either the May 2005 or August 2005 regulations, both physicians can participate in providing the non-covered services that accompany the use of a P-C IOL. Typically, a package of refractive services is identified rather than presenting the patient with an *a la carte* list of services.

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QUESTION: What is included in this 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 procedures, among others.

- Refraction to determine refractive error
- Contact lens trial fitting to assess refractive error
- Wavefront aberration 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

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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 1, 2006

The reader is strongly encouraged to review official instructions promulgated by Medicare and other payers; this document is *not an official source* nor is it a complete guide on all matters pertaining to reimbursement. The reader is also reminded that this information can and does change over time, and may be incorrect at any time following publication.

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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.

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QUESTION: May the surgeon collect a single fee for the non-covered 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 receiving physician).

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QUESTION: Who should obtain a Notice of Exclusion from Medicare Benefits (NEMB) in reference to non-covered services?

ANSWER: Both the surgeon and the receiving physician are strongly encouraged (not required) to obtain an NEMB in connection with providing non-covered services to Medicare beneficiaries receiving a P-C IOL. The NEMB should identify which services the patient is expected to pay for, the reason why the services are not covered, and the associated professional fees.

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