

REIMBURSEMENT FOR AMO ReZoom™ IOL

1

QUESTION: What documents does Medicare require when the patient elects implantation of the ReZoom™ IOL?

ANSWER: Other than the usual medical records, patients must be notified in advance of financial responsibility, and agree to pay for the non-covered items and services associated with this IOL. For Medicare beneficiaries with visually significant cataract, the August 5, 2005 CMS Transmittal 636 advocates the use of a Notice of Exclusion from Medicare Benefits (NEMB) to clearly identify the non-covered items and services and the associated fees. The facility and surgeon should each execute an NEMB. Do not include these forms with the claim for reimbursement.

For sample forms, please contact your AMO representative or visit our web site and download the ReZoom™ IOL Tool Kit.

www.corcoranccg.com/default.asp?Location=AMO

3

QUESTION: What non-covered refractive services might be charged by the surgeon for correcting presbyopia?

ANSWER: Each surgeon needs to construct an individual protocol for refractive services and determine which are appropriate on a case-by-case basis. These services are non-covered whether the patient receives a conventional IOL or a presbyopia-correcting IOL. They might include:

- Refraction
- Contact lens trial fitting
- Wavefront aberration testing
- Corneal topography
- Corneal pachymetry
- Routine eye care
- Refractive keratoplasty (LRI, LASIK, etc)
- IOL exchange in extraordinary cases

Once constructed, the surgeon needs to establish a reasonable fee for the refractive package considering the services included, and also taking into account what the local market will accept.

2

QUESTION: What documents do non-Medicare payers require?

ANSWER: Prior to surgery, the third party payer must give permission to the surgeon and the hospital or ASC to bill beneficiaries for presbyopia correction and a deluxe IOL as non-covered services.

Secondarily, the beneficiary must agree to pay for the additional services and the upgrade to a deluxe IOL. A Notice of Exclusion from Health Plan Benefits (NEHB) serves this purpose. The facility and surgeon should each execute an NEHB.

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4

QUESTION: What should we tell patients about the out-of-pocket expense for the non-covered items and services?

ANSWER: Because patients are concerned about their financial obligations, but oftentimes too proud or too embarrassed to ask for a detailed explanation, it is helpful to anticipate this desire for information and break down the fees in a readily understandable fashion. A solitary all-inclusive number incorporating both covered and non-covered charges does not segregate the charges that will be reimbursed by insurance for the non-covered fees. This raises the specter of balance billing violations. Most importantly, the patient wants to know what he/she owes, and the provider should take the opportunity to collect payment for the non-covered items and services in advance of the procedure. Patients pay the physician for non-covered services and pay the facility for the non-covered portion of the presbyopia-correcting IOL and refractive keratoplasty facility fee (if applicable).

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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5

QUESTION: If the surgeon owns the ASC, is it necessary to segregate the ASC charges from the clinic charges?

ANSWER: Yes. Each entity (*i.e.*, clinic and facility) should separate covered and non-covered charges for the patient and file its own claim, even if owned by the same person or corporation. Medicare separates the clinic and the ASC by unique identification numbers. Contracts with other payers are discrete. Funds should not be commingled.

6

QUESTION: What's the charge for the presbyopia-correcting IOL?

ANSWER: There are two pieces: one part covered, and one part non-covered. As a point of reference, Medicare has valued IOLs at \$150 in its determination of ASC payment rates, so the covered portion is part of the standard facility fee. Therefore, the non-covered charge to upgrade to a deluxe IOL is any additional charge beyond \$150. If there is any mark-up on the IOL, it should be very modest to account for shipping, handling, sales tax, etc. Unrealistic markups raise balance billing questions.

7

QUESTION: How does the facility represent the lens charge on a claim form?

ANSWER: Facilities describe the covered portion of the lens on the claim form with the HCPCS code and usual and customary fee used for conventional IOLs. Medicare does not require reporting of the non-covered items on the claim form. However, if required for tracking purposes, to secure a denial, or if a non-Medicare payer requires inclusion on the claim form, an additional line-item with a different HCPCS code and the dollar amount charged to the patient for the upgrade is reported.

8

QUESTION: Are specific codes assigned and reported to Medicare or other payers to describe the non-covered items or services?

ANSWER: CMS Transmittal 636 states, "No new codes are being established at this time to identify a presbyopia-correcting IOL or procedures and services related to a presbyopia-correcting IOL." There is no benefit category for coverage of these services and supplies; therefore, Medicare does not require reporting of these items or services.

For the sake of clarity and line item bookkeeping, it is useful to assign codes to these non-covered items to track them internally. In some situations, it may be necessary to include these items or services on the claim for reimbursement. A commercial payer may require it, or the patient may desire a denial from Medicare or another payer for submission to a secondary payer or something official on an Explanation of Benefits to corroborate what they been told by a staff member.

For Medicare claims filed by the physician, use HCPCS A9270 (*Non-covered item or service*) for the non-covered extended care package for refractive error. Another HCPCS code, S9986 (*Not medically necessary service, patient is aware that service is not medically necessary*) is useful for non-Medicare claims to identify a package of physician services that constitute extended care for refractive error that are likewise non-covered. In lieu of A9270 or S9986, some third party payers may dictate more specific codes for the non-covered services.

HCPCS code V2788, *presbyopia correcting function of IOL*, first published in January 2006, distinguishes the non-covered portion of the IOL from the covered portion. This code may be used by the facility (ASC or HOPD) to report the non-covered or deluxe portion of a presbyopia-correcting IOL.

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