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. Patient-shared pricing with one cost for a premium IOL, and a higher cost for the additional use of the FS laser to perform the cataract surgical steps, should not be offered. This would amount to charging the patient to use the FS laser to perform covered components of the procedure.

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.

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 January 2012, to determine when Medicare and its beneficiaries can be billed for using the femtosecond 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.