

Cataract Controversies—Answers to Contentious Coding Questions

There are a lot of opinions on key coding issues regarding cataract surgery. Those opinions, however, don't always coincide with the policies of third-party payers. David Glasser, MD, in his capacity as Secretary for Federal Affairs, addresses some contentious coding questions.

Interim Exams

Q. "Is the interim exam between cataract surgeries billable?"

A. The interim exam involves a post-op visit for the first eye and paperwork for the second. It is billable when the patient has a problem unrelated to the cataract surgery, in which case you would use the ICD-10 code to convey that fact to the payer. It also might be billable if there is a significant change in the status of the eye that warrants further examination. Otherwise, the exam typically is not billable. But what if your documentation indicates that this visit also included an exam that confirmed the need for cataract surgery in the second eye? Would you be able to bill for that exam by use of modifier -24 *Unrelated E/M service during global period*? No. The Office of Inspector General has stated that such documentation would not justify the use of modifier -24.

Testing Before Surgery

Q. "Physicians may choose to perform a series of tests on cataract patients,

particularly topography and OCT of the retina, to help obtain a better outcome. When patients elect to have a standard IOL implanted, can I ask the patient to pay out of pocket, particularly if I have them sign an Advance Beneficiary Notice (ABN)?"

A. Those tests are not billable to the patient or the payer. Their costs are absorbed by the practice. CMS has specified that the only expenses that you can ask a patient to pay out of pocket are associated with premium IOLs or when astigmatism-correcting corneal incisions are performed.

ORA During Surgery

Q. "Can I charge patients out of pocket if I use the Optiwave Refractive Analysis (ORA) system?"

A. The ORA system provides surgeons with real-time measurements of a patient's eye during his or her cataract procedure. Typically, it isn't covered by insurance. When you use ORA during cataract surgery, it is appropriate to charge patients out of pocket only in these three scenarios:

1. When used as part of the premium IOL package
2. When the patient had given consent to a premium IOL, but intraoperatively the surgeon had to convert to a standard IOL (rare)
3. When the patient had previously undergone refractive surgery

Further ORA considerations. Keep in mind the following:

- Scenarios 2 and 3 are expected to be unusual rather than routine.
- An ABN is not required for Medicare Part B patients.
- Your practice should develop its own written explanation of ORA that specifies associated costs. Ask patients to sign it, indicating their agreement.
- Patients can—and have—filed complaints of inappropriate billing with the Academy's Ethics department, as well as with Medicare Administrative Contractors and commercial payers.
- Incorrect billing is a violation of payer contracts and may be perceived as defrauding beneficiaries.

Conventional IOL and Femto

Q. "What if a patient requests use of the femtosecond laser for removal of his or her cataract but does not want a premium IOL and does not need or want astigmatism correction?"

A. An out-of-pocket fee for the technique used—in this case, use of the laser—is not permissible. The practice must absorb the cost.

Nonmydriatic Photography

Q. "Can we charge patients out of pocket for use of a nonmydriatic camera in lieu of dilation?"

A. Nonmydriatic photos may provide a lot of information, but when they are performed as part of an exam, the practice must absorb the cost. It is worth noting that photos are not a substitute for a dilated fundus examination.

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