

Coding and Billing for Toric IOLs

A primer for ophthalmologists that are using these lenses.

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In cataract surgery procedures (CPT codes 66984 and 66982), an IOL is implanted to replace the natural lens. A conventional IOL is focused to correct the patient's distance vision but not other refractive errors such as astigmatism. A toric IOL replaces the natural lens and corrects astigmatism as well as distance vision, resulting in patients' decreased postoperative dependence on glasses or contact lenses. Medicare and most other insurance carriers specifically exclude coverage for the surgical correction of refractive errors, including astigmatism.

This article describes the proper coding for astigmatism-correcting IOLs and the related procedures, and it describes how to charge patients for this type of lens.

THE RULING

On January 22, 2007, the Centers for Medicare & Medicaid Services (CMS) issued Ruling No. CMS-1536-R,¹ which defines the CMS' payment policy for toric IOLs for Medicare beneficiaries. The ruling reiterates that Medicare covers cataract surgery, including the cost of a conventional IOL, which is bundled into the payment for either a hospital outpatient department or a Medicare-approved ASC. Medicare also pays the surgeon's fees for standard cataract surgery.

The CMS' ruling allows a Medicare beneficiary to choose an astigmatism-correcting IOL instead of a conventional IOL. The patient is then responsible for paying any additional facility or physician charges for resources and services related solely to the IOL. Because these items and services are not covered, the CMS will not address the amount that facilities or physicians may charge for the lens.

DETERMINING FEES

The ruling states that the beneficiary is "responsible for payment of that portion of the facility charge that exceeds the facility charge for insertion of a conventional IOL following cataract surgery." In determining these additional fees, the facility should decide upon its usual and

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customary charge of the surgery with a monofocal lens (calculating the costs of clerical and administrative costs) and the charge of surgery with an AcrySof Toric IOL (Alcon Laboratories, Inc., Fort Worth, TX), taking into consideration any additional handling and other operational costs. The patient should be charged the difference between the cost of cataract surgery with a standard IOL and that with an AcrySof Toric IOL.

The ASC's fee schedule includes an allowance of \$150.00 per procedure to cover the costs of a conventional IOL. Under the Hospital Outpatient Prospective Payment System, IOL charges are bundled into the total payment for a cataract surgery procedure. The Ambulatory Payment Classification's fee schedule does not itemize the allowance for the cost of a conventional IOL.

Patients are also responsible for charges associated with additional work by the physician and extra resources required for the insertion and fitting of and visual acuity testing after the implantation of an astigmatism-correcting IOL versus a conventional IOL.¹

The physician should calculate the added costs for patients that choose an astigmatism-correcting IOL, including extra pre-, intra-, and postoperative work and testing, in order to determine the additional charges to the patient appropriately.

DOCUMENTING PATIENTS' CHARTS

Physicians should expect the CMS to audit medical charts carefully to ascertain that there is no "balance billing" involved in out-of-pocket costs to the patient. Medical charts should therefore clearly show the added

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CATARACT SURGERY FOCUS ON TORIC IOLs

CODING

Currently, there is no HCPCS code for an astigmatism-correcting IOL. One will likely be added in the 2008 updates. In the meantime, any one of the following codes is appropriate:

- V2797 vision supply, accessory, and/or service component of another HCPCS vision code;
- A9270 uncovered item or service; or
- S9986 not medically necessary service (patient is aware that service [is] not medically necessary) with modifier GY Item or service statutorily excluded or does not meet the definition of any Medicare benefit.

The diagnostic codes should include the physician-designated codes for the cataract (366.xx) and astigmatism (367.2x).

Because Medicare does not cover the added charges for astigmatism-correcting IOLs, patients need not sign an Advance Beneficiary Notice. They should be given a Notice of Exclusion from Medicare Benefits form.

CONCLUSION

Physicians and staff should be aware of the CMS' ruling and the proper billing requirements for patients who choose an astigmatism-correcting IOL. Additional information will be available when the CMS issue the related transmittal instructions to carriers and fiscal intermediaries, and the MedLearn. ■



1. CMS Rulings. Available at: www.cms.hhs.gov/Rulings/downloads/CMS1536R.pdf. Accessed April 16, 2007.