Update on Reimbursement Pathways

CMS's guidance directs surgeons on how and when to bill for the use of femtosecond lasers in cataract surgery.

BY ALAN REIDER, JD, MPH

The femtosecond laser's ability to create incisions during refractive and cataract surgery has resulted in new clinical benefits for ophthalmologists and their patients. At the same time, however, the dilemma of how to pay for the technology has been controversial. Although Medicare and other third-party payers recognize arcuate incisions performed at the time of a refractive procedure as a noncovered service, and, therefore, billable to the patient, the analysis is more difficult when incisions are performed during cataract surgery.

IS THE SERVICE COVERED OR NONCOVERED?

Some physicians believed that, because the femtosecond laser provides an enhanced refractive benefit regardless of the type of IOL that is implanted, it was acceptable to charge patients for this noncovered service. Others, however, took a more conservative view, noting that the femtosecond laser performs components of the covered cataract surgical procedure, and, therefore, no additional fee should be charged to the patient. Finally, some advanced a middle-ground position. These surgeons acknowledged that the femtosecond laser did, in fact, perform part of the covered procedure in connection with conventional IOL implants. Yet, because the laser is used to enhance the refractive functionality of premium IOLs, they felt use of the femtosecond laser fell within the policies articulated in the Centers for Medicare & Medicaid Services (CMS) Rulings 05-01 (issued May 3, 2005) and 1536-R (effective for services on and after January 22, 2007) for presbyopia- and astigmatism-correcting IOLs, respectively. Under that analysis, use of the femtosecond laser when implanting a premium IOL could be charged to patients.

> "The guidelines acknowledged that patients could be billed for use of the femtosecond laser when a refractive procedure was performed."

The debate concerning the proper reimbursement policy continued for more than 1 year. Dueling presentations at professional meetings as well as point/counterpoint articles in ophthalmic newsletters argued for or against each of the three positions. Early in 2012, the American Academy of Ophthalmology and the American Society of Cataract and Refractive Surgery issued, "Guidelines for Billing Medicare Beneficiaries When Using the Femtosecond Laser." In this document, the professional societies adopted the conservative position that Medicare beneficiaries could not be billed in connection with a medically necessary cataract surgery, regardless of the type of IOL that was implanted. The guidelines, however, were deemed subject to modification based on new regulations put forth by the CMS or its contractors. At the same time, however, the Guidelines acknowledged that patients could be billed for use of the femtosecond laser when a refractive procedure was performed.

CMS GUIDANCE

On November 16, 2012, the CMS posted guidance entitled, "Laser-Assisted Cataract Surgery and CMS Rulings 05-01 and 1536-R." In this document, the CMS acknowledged the need for guidance and explained that the agency developed the policy in response to a press release issued by an ophthalmology practice that described the use of the femtosecond laser for cataract removal. The CMS stated that the press release implied that Medicare beneficiaries may be charged when the femtosecond laser is used, regardless of the type of IOL that is implanted. The guidance states that: "Medicare coverage and payment for cataract surgery is the same irrespective whether the surgery is performed using conventional surgical techniques or [a] bladeless computer-controlled laser. Under either method, Medicare will cover and pay for the cataract removal and insertion of the conventional intraocular lens."

The guidance went on to reference the rulings that apply when presbyopia- or astigmatism-correcting IOLs are implanted and noted that, in such cases, the beneficiary may be charged for noncovered services. The CMS acknowledged that noncovered services could include imaging, which may be necessary to implant these premium lenses. Essentially, the CMS confirmed that imaging, which is a component of the femtosecond laser, constitutes a service that is not performed when a conventional IOL is implanted. As a result, the imaging component is not covered and may be charged to the patient.

WHAT DOES THE CMS GUIDANCE MEAN?

The CMS guidance makes it clear that physicians and facilities may not bill a patient for use of a femtosecond laser when such use is limited to cataract surgery with a conventional IOL implant. Furthermore, the guidance permits physicians and facilities to bill for the use of a femtosecond laser in connection with premium IOL implantation. Certain limitations, however, apply.

The CMS guidance effectively created a "two-aspect rule" for the femtosecond laser, just as it did with its policy on premium IOLs. In this case, the cutting component is a covered service, whereas the imaging component is a noncovered service. Physicians and surgery centers, therefore, may charge patients an additional amount that relates to the noncovered, or imaging component, only. Although the CMS has no role in judging the propriety of a charge for a noncovered service, physicians and facilities should be aware of this limitation when establishing an appropriate fee for patients.

The CMS guidance is based on the presumption that a physician would not use a femtosecond laser for implanting a conventional IOL, as the imaging component is not used in this clinical situation. Using a femtosecond laser on a routine basis to implant a conventional IOL would reflect that physician's standard of care, and, therefore, use of the femtosecond laser would no longer be noncovered. As a result, according to the guidance, if a physician uses a femtosecond laser for implanting conventional IOLs as well as premium IOLs, the physician is precluded from billing patients for use of a femtosecond laser, regardless of the type of IOL that is implanted.

> "The CMS guidance provided industry and the medical ophthalmic community with substantial certainty about how to properly bill for use of the femtosecond laser."

The guidance does, however, provide for some flexibility: "Performance of such additional services by a physician on a limited and nonroutine basis in conventional IOL cataract surgery would not disqualify such services as non-covered services."

Although not further defined, the term "nonroutine" encompasses cases that are not typical, and may include patients who seek to have astigmatic correction. Therefore, as long as these cases do not become so numerous as to become "routine" for any physician, the physician should not risk disqualification when using a femtosecond laser in connection with the implant of a conventional IOL. In other words, when a femtosecond laser is used both in connection with implanting a conventional IOL and for creating arcuate incisions to correct astigmatism, the physician should be free to charge the patient for femtosecond laser use for the arcuate incisions.

CONCLUSION

The CMS guidance provided industry and the medical ophthalmic community with substantial certainty about how to properly bill for use of the femtosecond laser. Given the uncertainty and disagreements that frustrated the professional community and industry for more than a year, CMS's guidance is a welcome clarification. ■

Alan E. Reider, JD, MPH, is a partner with Arnold & Porter LLP in Washington, DC. Mr. Reider may be reached at (202) 942-6496; alan.reider@aporter.com.