Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Cataracts: Break Down Your Coding for Best PC-IOL Payments

Medicare won't cover the full cost, but splitting the bill into covered and non-covered portions will help you get the reimbursement you deserve.

After cataract surgery, an ophthalmologist inserts a Crystalens intraocular lens to correct a Medicare patient's presbyopia. Can you code for the physician's services and supplies? The answer is yes -- with these exceptions.

Presbyopia-correcting (P-C) IOLs address the eye's inability to focus on near objects, says **Riva Lee Asbell**, ophthalmic coding and reimbursement educator and principal of Riva Lee Asbell Associates in Ft. Lauderdale, Fla. PC-IOLs can improve the quality of life for cataract patients who would otherwise need to rely on bifocals for near vision.

Medicare typically covers the insertion of a conventional, clear IOL to replace the cataractstricken lens that the ophthalmologist removes. Medicare has ruled that cataract patients who request a P-C IOL, such as the Crystalens or AcrySof RESTOR lenses, can have them -- if they are willing to pay the extra cost.

The problem: Medicare only partially covers P-C IOLs. Although it does consider a conventional IOL medically necessary after cataract surgery, there is "no benefit category" for the presbyopia correction itself.

"A single presbyopia-correcting IOL essentially provides what is otherwise achieved by two separate items: an implantable conventional IOL (one that is not presbyopia-correcting), and eyeglasses or contact lenses," states CMS Ruling 05-01, released in May 2005. Medicare does cover one pair of eyeglasses or contact lenses for each patient following cataract surgery, but, "although presbyopia-correcting IOLs may serve the same function as eyeglasses or contact lenses furnished following cataract surgery, IOLs are neither eyeglasses nor contact lenses. Therefore, the presbyopia-correcting functionality of an IOL does not fall into the benefit category and is not covered."

This leaves coders with a unique dilemma: how to code for each portion of the IOL. Read on for our expert advice. Report Cataract Codes for Covered Portion Although Medicare has no immediate plans to establish new codes for the presbyopia-correcting (non-covered) portion of the P-C IOL, coding for the portion that Medicare does cover is fairly straightforward: Code for "a conventional IOL, regardless of whether a conventional or presbyopia-correcting IOL is inserted," directs an Aug. 5, 2005, CMS change request, "Instructions for Implementation of CMS Ruling 05-01: Presbyopia-Correcting Intraocular Lens."

For a cataract surgery with a P-C IOL insertion, report one of the following to Medicare:

- 66982 -- Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage
- 66983 -- Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)

Warning: Although selecting, inserting, and visionacuity testing of a P-C IOL does involve more pre- and postoperative work by the ophthalmologist than a conventional IOL, don't be tempted to use that as a basis for reporting complex cataract surgery with 66982. "The insertion of a presbyopia-correcting accommodating device itself does not qualify to meet the level of work required to bill this code," says Part B carrier Blue Cross and Blue Shield of Kansas.

Resist Reporting Supplies Separately

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Don't code separately for the IOL itself if the ophthalmologist inserted the IOL in a hospital or ASC, since Medicare includes the payment for the lens (generally $150) in the payment made to the facility for the entire procedure.

"The beneficiary is responsible for payment of the portion of the facility charge which exceeds the charge for the ... non-presbyopia correcting IOL," says the Blue Cross and Blue Shield of Kansas LCD. The patient will have to pay the facility for the lens (typically over $800), minus the $150 that Medicare will cover.

Shun Unlisted-Procedure Code for Extra Services

The beneficiary is responsible for what Medicare doesn't cover if he has decided he wants the PC-IOL instead of the non-PCIOL, clarifies **Maggie M. Mac, CPC, CEMC, CHC, CMM, ICCE,** director of Best Practices-Network Operations at Mount Sinai Hospital in New York City. "The patient is under no obligation to accept the recommendation of the physician to have the PC-IOL and may elect to have the non-PC-IOL," she explains. CMS offers no clear advice on what code to use to bill the patient for these extra services, which can include testing like corneal topography or corneal pachymetry as well as added E/M time for pre- and postoperative care.

Experts warn: Don't be tempted to turn to the code for unlisted procedure (66999, Unlisted procedure, anterior segment of eye). That code is for services assumed to be covered by the carrier for which no other CPT code is available. Since you know that the extra services are not covered, don't submit 66999 to Medicare or any other carrier for the portion of the service deemed to be noncovered.

For non-Medicare carriers, you can code these services with HCPCS code S9986 (Not medically necessary service [patient is aware that service not medically necessary]) linked to ICD-9 code 367.4 (Presbyopia). The "S" code is not covered by Medicare statute and, therefore, should not be submitted to your Medicare carriers.

Best approach: Submit a claim to the carrier for the cataract surgery with 66982, 66983, or 66984. Collect the amount for the extra services directly from the patient -- preferably before the surgery.

Note: To read the original ruling, go online to www.cms.gov/Rulings/downloads/CMSR0501.pdf. For the Medicare transmittal with additional coding guidance, visit

www.cms.gov/Transmittals/downloads/R636CP.pdf.

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