Corcoran Consulting Group
A Division of Ardare Corporation

NONCOVERED SERVICES WITH CATARACT SURGERY

1

QUESTION: Does Medicare cover all items and services associated with cataract surgery?

ANSWER: No. Items and services associated with routine cataract surgery are covered under Medicare's national policies (NCD 10.1 and NCD 80.8). There are some things that are not covered and the beneficiary is financially responsible for payment.

2

QUESTION: Some ophthalmologists offer blended vision or monovision to patients. Are there any noncovered charges for this?

ANSWER: Yes. The patient completes a questionnaire designed to assess the vision requirements in the normal activities of daily living, and the extent of the patient's desire for spectacle independence. Next, the surgeon performs a battery of preoperative tests to measure ametropias, ocular dominance, stereopsis, and interocular defocus threshold. All of the tests are refractive in nature and the unit of measurement is diopters. Refractions, as well as related refractive tests, are not covered by Medicare and most third party payers.

3

QUESTION: What other diagnostic tests are noncovered?

ANSWER: Screening for potential disease, such as macular degeneration or epiretinal membrane, using scanning computerized ophthalmic diagnostic imaging of the posterior segment (SCODI-P) is not covered because prophylactic testing is not a Medicare benefit, unless specifically authorized by Congress.

Screening for dry eye syndrome, in patients with no history or symptoms of the disease, prior to cataract surgery using tear osmolarity or other diagnostic test is likewise not covered.

4

QUESTION: Are there any noncovered charges for evaluation and treatment of astigmatism at the time of cataract surgery?

ANSWER: Yes, corneal topography is helpful for assessing corneal astigmatism hinted at by lensometry or detected by keratometry prior to cataract surgery. It is considered a covered test for indications such as post-penetrating keratoplasty, keratoconus, corneal dystrophy or keratopathy, but not for preoperative cataracts. To achieve excellent unaided vision following cataract surgery, astigmatism must be minimized. The surgical correction of pre-existing astigmatism is another noncovered service which should be considered for patients with more than 0.50D of cylinder.

5

QUESTION: Are there any noncovered services associated with conventional IOLs in an ambulatory surgery center (ASC)?

ANSWER: The facility fee associated with performing limbal or corneal relaxing incisions for the surgical correction of pre-existing, clinically significant, regular, corneal astigmatism is noncovered as is the non-covered portion of astigmatism-correcting or presbyopia-correcting IOLs.

6

QUESTION: When diagnostic tests are performed during the global surgery period, aren't they bundled with the surgery?

ANSWER: Usually not. The Medicare Claims Processing Manual (MCPM), Chapter 12 §40.1B, describes services not included in Medicare's global surgery package, and covered diagnostic tests are mentioned as services that are paid separately.

November 11, 2021

The reimbursement information is provided by Corcoran Consulting Group based on publicly available information from CMS, the AMA, and other sources. The reader is strongly encouraged to review federal and state laws, regulations, code sets, and official instructions promulgated by Medicare and other payers. This document is *not an official source* nor is it a complete guide on reimbursement. Although we believe this information is accurate at the time of publication, the reader is reminded that this information, including references and hyperlinks, changes over time, and may be incorrect at any time following publication.

© 2021 Corcoran Consulting Group. All rights reserved. No part of this publication may be reproduced or distributed in any form or by any means, or stored in a retrieval system, without the written permission of the publisher. CPT is a registered trademark of the American Medical Association.

Corcoran Consulting Group
A Division of Ardare Corporation

NONCOVERED SERVICES WITH CATARACT SURGERY

7 ***QUESTION:*** What about postcataract eyeglasses and a final refraction?

ANSWER: Under Medicare law, beneficiaries are covered for postcataract eyeglasses following cataract surgery with implantation of an IOL. See: SSA 1861(s)(8). However, Medicare does not pay for the refraction to prescribe those eyeglasses as mentioned earlier.

8 ***QUESTION:*** Why doesn't Medicare cover everything related to cataract surgery?

ANSWER: The Medicare law (Social Security Act, Title XVIII) limits health care coverage. Medicare does not pay for everything, even care that beneficiaries or their doctors have good reason to think is necessary. Although Medicare beneficiaries may be disappointed, the fact is that Medicare does not cover routine eye care, specifically refractions. See: 1862(a)(7). Also, they do not cover cosmetic surgery including most refractive procedures. See: SSA 1862(a)(10).

9 ***QUESTION:*** What is the benefit to the patient of noncovered services?

ANSWER: Cataract surgery has evolved tremendously since the first IOL was implanted in 1949. Modern techniques combine noncovered refractive services with cataract extraction. Surgeons achieve better patient outcomes with reduced reliance on postcataract eyeglasses due to reduced residual refractive errors.

10 ***QUESTION:*** Some noncovered services are indispensable to the surgeon. Does the patient get to choose whether to have them?

ANSWER: Yes, patients do get to choose. Patients need to be fully informed about their care and any financial obligations. It is the patient's choice whether to proceed – the patient cannot be forced. If the patient places too many limitations or unreasonable expectations on the surgeon, the ophthalmologist has the option to refuse to provide care.

11 ***QUESTION:*** Must a Medicare beneficiary sign an ABN before receiving any non-covered items or services?

ANSWER: Maybe. An Advance Beneficiary Notice of Noncoverage (ABN) is only required if something *might* be covered. However, items and services that are *never* covered by virtue of exclusions in the Medicare law do not require an ABN.

Nevertheless, to avoid buyer's remorse, it's a good idea to obtain proof that the beneficiary accepts financial responsibility for noncovered items and services. A financial waiver, such as an ABN or a Notice of Exclusion from Health Plan Benefits (NEHB) may be used for this purpose.

For Medicare Advantage beneficiaries, predetermination of (noncovered) benefits is strongly recommended. Simultaneously, get payment from the patient prior to rendering care.

November 11, 2021

The reimbursement information is provided by Corcoran Consulting Group based on publicly available information from CMS, the AMA, and other sources. The reader is strongly encouraged to review federal and state laws, regulations, code sets, and official instructions promulgated by Medicare and other payers. This document is *not an official source* nor is it a complete guide on reimbursement. Although we believe this information is accurate at the time of publication, the reader is reminded that this information, including references and hyperlinks, changes over time, and may be incorrect at any time following publication.

© 2021 Corcoran Consulting Group. All rights reserved. No part of this publication may be reproduced or distributed in any form or by any means, or stored in a retrieval system, without the written permission of the publisher. CPT is a registered trademark of the American Medical Association.