Corcoran Consulting Group

A Division of Ardare Corporation

Forms for Medicare Reimbursement for YAG Laser Floater Treatment

Prepared for

ellex

February 2018

Pre-Laser Floater Treatment
Patient Questionnaire

Patient
Name _____
Chart Number _____
Eye Being Evaluated □RT □LT

Response	Scale
Yes, and am unable to do the activity	0
Yes, with great difficulty	1
Yes, with moderate difficulty	2
Yes, with a little difficulty	3
No	4
Not applicable	---

VISUAL FUNCTIONING

Do you have difficulty with the following activities? ***(Please circle)***

1. Reading (*e.g.,* newspaper, books, smartphone, computer, etc.) **0 1 2 3 4 n/a**
2. Doing fine handwork like sewing, knitting, or carpentry?□ **0 1 2 3 4 n/a**
3. Sports (*e.g.,* golf, tennis, baseball, bowling, etc.) **0 1 2 3 4 n/a**
4. Playing games (*e.g.,* cards, checkers, dominos, etc.) **0 1 2 3 4 n/a**
5. Driving and seeing traffic signs □ **0 1 2 3 4 n/a**
6. Watching television? **0 1 2 3 4 n/a**
7. Navigating steps, stairs, curbs? **0 1 2 3 4 n/a**

Average Score: _____

Degree of Hindrance of Activities of Daily Living
Normal = 4 Mild = 3 Moderate = 2 Severe = 0 or 1

SYMPTOMS

Have you been bothered by: ***(Please circle)***

1. Seeing persistent floaters **YES NO**
2. Seeing floating "spider webs" **YES NO**
3. Blurred vision or hazy vision **YES NO**
4. Double vision **YES NO**
5. Eye pain **YES NO**
6. Flashes of light **YES NO**
7. Glare **YES NO**

8. Poor color vision	**YES**	**NO**
9. Poor night vision	**YES**	**NO**
10. Poor vision in low or dim light	**YES**	**NO**
11. Seeing a “curtain coming down” over one eye	**YES**	**NO**
12. Sudden change in vision	**YES**	**NO**
13. Unusual, even painful, sensitivity to light	**YES**	**NO**

YAG laser floater treatment can almost always be safely postponed until you feel you cannot perform normal activities of daily living and need better vision. If the only way to help you see better is laser floater treatment do you feel your vision problem is bad enough to consider laser surgery now?

☐ **YES** **NO**

Patient Signature _____ Date _____

Witness _____ Date _____

Print your name, address and telephone number. Logo is optional.

Patient Name: **Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for the items or services below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items or services below.

Items or Services	Reason Medicare May Not Pay:	Estimated Cost:
Nd:YAG laser to treat vitreous floater(s)	**1. The procedure is not covered because it is considered experimental or investigational. AND/OR 2. Minimal or no hindrance of activities of daily living does not support medical necessity for the procedure.**	

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions you may have after you finish reading.
- Choose an option below about whether to receive the items or services listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: **Check only one box. We cannot choose a box for you.**

[ ] OPTION 1. I want the items or services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

[ ] OPTION 2. I want the items or services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment, and **I cannot appeal if Medicare is not billed.**

[ ] OPTION 3. I don't want the items or services listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227 / **TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date:

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(Customize top of form with name, address & phone) *(Provide 1 copy to patient; keep original in your files.)*

Patient's Name:

Notice of Exclusion from Health Plan Benefits

You need to make a choice about having your floaters treated with laser surgery. This service is not covered under your health plan benefits and consequently your health plan will not pay for it. When you receive an item or service that is not a covered benefit, you are responsible to pay for it in full. Any elective surgery, and particularly noncovered elective surgery, should only be undertaken after careful consideration of all the risks and benefits.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully. ***Ask us to explain, if you don't understand why your health care service plan won't pay.***

Description of procedure: YAG Laser Floater Treatment □ OD □ OS

Your doctor has recommended treatment of floaters and/or opacities with a YAG laser after determining that you are a good candidate for the procedure, and we expect that your health care service plan will deny the service. You do not need to have this laser surgery; it is optional.

If you decide to have this surgery, you will be asked to pay for it and we will not file a claim for reimbursement with any third party payer, including Medicare. We may notify your health plan that the procedure was performed, but with no expectation of reimbursement.

You are responsible for all of the fees associated with this non-covered laser procedure. The charge is $_____.

Beneficiary Agreement

Accordingly, the undersigned accepts full financial responsibility for the non-covered services described above.

_____ _____

Signature of patient or person acting on patient's behalf Date

_____ _____

Witness Date

GENERAL CONSENT FOR YAG LASER FLOATER TREATMENT

You have been given information about your condition and the recommended surgical procedure(s) to be performed. This consent form is designed to provide a written confirmation of such discussions by recording some of the more significant medical information given to you. It is intended to make you better informed so that you may give or withhold your consent to the proposed procedure(s).

1. **Condition:** Your ophthalmologist has explained that the following condition(s) exist:

   Reduced functional vision secondary to vitreous floaters and/or opacities.

2. **Proposed Procedure(s):** I understand that the procedure(s) proposed for treating my condition is/are:

   YAG LASER FLOATER TREATMENT Right eye ____ Left eye _____

3. **Risks/Benefits of Proposed Procedure(s):**
   Just as there may be benefits to the procedure(s) proposed, I also understand that medical and surgical procedure(s) involve risks. These risks include the following:
   - Inaccessible floaters resulting in the inability to treat all of the floaters.
   - Recurrence of floaters.
   - Temporary elevation of intraocular pressure. Patients with pre-existing increased pressures are predisposed to this complication.
   - Cataract development in patients who have not had cataract surgery.
   - Damage to the intraocular lens in pseudophakic patients.
   - Damage to the retina by the laser being fired directly at the retina or secondary to the laser "shock wave". The damage could include a hemorrhage or retinal-hole creation.
   - Retinal detachment
   - Infection
   - Inflammation
   - Blindness
   - Loss of eye

4. **Complications; Unforeseen Conditions; Results:** I am aware that in the practice of medicine, other unexpected risks or complications not discussed may occur. I also understand that during the course of YAG LASER FLOATER TREATMENT, unforeseen conditions may be revealed requiring the performance of additional procedures, and I authorize such procedures to be performed. I further acknowledge that no guarantees or promises have been made to me concerning the results of any procedure or treatment.

5. **Acknowledgments:** The available alternatives of no treatment, pars plana vitrectomy, and the potential benefits and risks of YAG LASER FLOATER TREATMENT and the likely result without such treatment have been explained to me. I understand what has been discussed with me as well as the contents of this consent form, and have been given the opportunity to ask questions and have received satisfactory answers.

6. **Consent to Procedure(s) and Treatment:** Having read this form and talked with my surgeon, my signature below acknowledges that: I voluntarily give my authorization and consent to the performance of YAG LASER FLOATER TREATMENT described above by my surgeon and/or his/her associates assisted by facility personnel and other trained persons as well as the presence of observers.

Patient (or person authorized to sign for patient)	Date
Witness	Date