## Question 1

**Question:** What is the Abbott TECNIS Symfony® Toric IOL?

**Answer:** The Abbott TECNIS Symfony® Toric IOL is a posterior chamber IOL designed to provide an extended range of high-quality continuous vision at all distances. In addition to presbyopia-correction by means of extended depth-of-focus (EDOF), the TECNIS Symfony® Toric IOL also provides astigmatism-correction in a variety of cylinder powers (1.50, 2.25, 3.00, 3.75 D). All IOLs in the TECNIS Symfony® family have spherical aberration- and chromatic aberration-correcting functions, as well. Abbott states, “…Correction of chromatic aberration results in a sharper focus of light and increased image contrast, which is especially important in low light conditions. When combined with the existing TECNIS® technology to correct spherical aberration, it further increases retinal image quality, without negatively affecting depth of focus.”

## Question 2

**Question:** Does Medicare differentiate between EDOF and conventional IOLs for reimbursement purposes?

**Answer:** Yes. Medicare covers conventional IOLs, but does not cover the presbyopia-correcting functionality of an EDOF IOL because “it does not fall into the benefit category” as set forth in the 2005 CMS Ruling 05-01.

## Question 3

**Question:** Are there other noncovered expenses associated with presbyopia-correcting IOLs?

**Answer:** Yes, many. They might include:

- Corneal pachymetry
- Corneal topography
- Extended postop care after 90 days
- Refraction
- Refractive keratoplasty (LRI, LASIK, etc.)
- Screening SCODI-P
- Wavefront aberrometry

## Question 4

**Question:** How should we tell Medicare beneficiaries about the noncovered charges associated with an EDOF IOL?

**Answer:** Because noncovered items are the financial responsibility of the Medicare beneficiary, it is appropriate to notify the patient prior to surgery about the anticipated out-of-pocket expense and to collect payment in advance. A financial waiver can take several forms, depending on insurance.

- An Advance Beneficiary Notice of Noncoverage (ABN) is required for services where Part B Medicare coverage is ambiguous or doubtful, and may be useful where a service is never covered. You may collect your fee from the patient at the time of service or wait for a Medicare denial. If both the patient and Medicare pay, promptly refund the patient or show why Medicare paid in error.

- For Part C Medicare (Medicare Advantage), determination of benefits is required to identify beneficiary financial responsibility prior to performing noncovered services; MA Plans may have their own waiver forms.

- For non-Medicare insurance beneficiaries, a Notice of Exclusion from Health Plan Benefits (NEHB) is an alternative to an ABN. This helps prevent misunderstandings and “buyer’s remorse” afterwards. The facility and surgeon should each execute an ABN.

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The reader is strongly encouraged to review federal and state laws, regulations and official instructions promulgated by Medicare and other payers. This document is not an official source nor is it a complete guide on all matters pertaining to reimbursement. The reader is also reminded that this information, including references and hyperlinks, can and does change over time, and may be incorrect at any time following publication.

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### QUESTION: Are specific codes assigned and reported to Medicare or other payers to describe the noncovered items or services?

**ANSWER:** For the sake of clarity and line item bookkeeping, it is useful to assign codes to noncovered items and services. It may be necessary occasionally to include them on the claim for reimbursement. A commercial payer may require it, or the patient may desire a denial from Medicare or another payer for submission to a secondary payer or something official on an Explanation of Benefits to corroborate what they been told by a staff member.

HCPCS A9270 (Noncovered item or service) is a suitable all purpose code, and an alternate choice is HCPCS S9986 (Not medically necessary service, patient is aware that service is not medically necessary). Some payers cannot accept HCPCS codes and may insist on a CPT code; then, a miscellaneous code such as 66999 or 92499 may be used. In lieu of these choices, some third party payers may dictate other codes.

Modifier –GY (Item or service statutorily excluded or does not meet the definition of any Medicare benefit or, for non medicare insurers, is not a contract benefit) should be appended to whichever code you use.

### QUESTION: How does the facility report the upgrade lens charge for a combined P-C and A-C IOL on a claim form?

**ANSWER:** HCPCS code V2788, presbyopia correcting function of IOL, distinguishes the noncovered portion from the covered portion of the IOL. Importantly, the astigmatism-correcting functionality is not reported separately on the claim but is treated as secondary to the presbyopia-correcting functionality.

V2788 may be used by the facility (ASC or HOPD) to report the noncovered portion of an EDOF IOL on a CMS-1500 or UB-04 claim form.

### QUESTION: Is it necessary to segregate the ASC charges from the surgeon’s charges?

**ANSWER:** Yes. Each entity (i.e., clinic and facility) should separate covered and noncovered charges for the patient and file its own claim, even if owned by the same person(s) or corporation. Medicare separates the clinic and the ASC by unique identification numbers. Contracts with other payers are discrete. Funds should not be commingled.

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Notice: This document, prepared for Abbott Medical Optics, is not intended to cover all issues and questions relating to the reimbursement of AMO EDOF IOLs or constitute legal advice. If you have questions, you should contact Corcoran Consulting Group or your healthcare attorney.

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