1 QUESTION: What is the Abbott TECNIS Symfony® IOL?

ANSWER: The Abbott TECNIS Symfony® IOL is a posterior chamber IOL designed to provide an extended range of high-quality vision at all distances. In addition to presbyopia correction by means of extended depth of focus (EDOF), the TECNIS Symfony® IOL has spherical aberration- and chromatic aberration-correcting functions. 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.”

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.

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

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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REIMBURSEMENT FOR
ABBOTT TECNIS Symfony® IOL

5 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 these noncovered items to track them internally. In some situations, it may be necessary to include these items or services 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 have been told by a staff member.

For Medicare claims filed by the physician, use HCPCS A9270 (Noncovered item or service) or 66999 (miscellaneous services anterior chamber) for the noncovered extended care package for refractive error. Another HCPCS code, S9986 (Not medically necessary service, patient is aware that service is not medically necessary) is useful for non-Medicare claims to identify a package of physician services that constitute extended care for refractive error that are likewise noncovered. In lieu of A9270 or S9986, some third party payers may dictate more specific codes for the noncovered services.

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.

6 QUESTION: How does the facility report the upgrade lens charge on a claim form?

ANSWER: HCPCS code V2788, presbyopia-correcting function of IOL, distinguishes the noncovered portion from the covered portion of the IOL. It may be used by the facility (ASC or HOPD) to report the noncovered portion of a presbyopia-correcting IOL on a CMS-1500 or UB-04 claim form.

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7 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.

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.


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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