

MEDICARE BILLING

CATARACT CO-MANAGEMENT BILLING FOR MEDICARE

As per guidelines published by Medicare in 1992, specific components of major surgery were defined as the “global surgery package.” The components they identified included pre-operative care, intraoperative services, post-operative care (90 days), and in-office care for any postoperative complications. In addition, the value of post-operative care for surgical procedures was standardized and post-operative care for ophthalmic surgery was valued at 20% of the global surgery package.

Medicare also published instructions to Medicare carriers on split billing of post-operative care, also known as post-operative co-management, within eye care. These instructions incorporated the following points, which are further defined in this section of our co-management manual:

1. Co-management requires a written transfer agreement between the surgeon and the receiving doctor(s).
2. Specific modifiers must be used on claims (54 - surgical care only; 55 - postoperative management only).
3. The receiving doctor cannot bill for any part of the service included in the global period until he/she has provided at least one service.

WRITTEN TRANSFER AGREEMENT

The transfer agreement between the surgeon and the co-managing doctor (optometrist) contains the surgeon's discharge instructions and the effective transfer date. According to current Medicare policy, the transfer date is “determined by the date of the physician's transfer order.”

The responsibility for post-operative care may be transferred on or before the patient's appointment for the subsequent follow-up visit with the receiving doctor, who may submit a claim for services once he has seen the patient.

The split of post-operative care cannot be done or pre-arranged in advance of the surgery. Instead, a unique transfer agreement should be constructed for each patient. The essential elements of the Transfer of Care Form from the surgeon to the optometrist should include the following:

1. Patient Name
2. Operative Eye
3. Nature of Operation
4. Date of Surgery
5. Clinical Findings
6. Discharge Instructions
7. Transfer Date

The optometrist should assume care of the patient on the following day. This form determines the “transfer date,” as well as corresponding reimbursement for claims submitted. Because the surgeon cannot be certain the patient will actually keep the appointment with the optometrist, communication from the optometrist is necessary and is evidence that the optometrist actually saw the patient, and is in compliance with CMS's requirement that the optometrist “...has provided at least one service.”

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Essential elements of the transfer agreement from the optometrist should include the following:

1. Patient Name
2. Operative Eye
3. Nature of Operation
4. Transfer Date
5. Results of First Post-Operative Visit

Both doctors should retain copies of this documentation as part of the patients permanent records. They may also serve as a useful attachment on claims, as necessary.

MODIFIERS FOR CLAIMS SUBMISSION

Immediately following surgery, the surgeon can submit a claim for the surgical component of care using the appropriate CPT Code, i.e. 66984, and Modifier 54. This modifier is used to indicate the surgical event in a co-managed case. Medicare assigns 80% of the global fee to the intraoperative service.

Later the surgeon will submit a claim for his/her portion of post-operative care. In order for this claim to be accurate, the surgeon needs to know the date the optometrist assumed responsibility for the remaining post-operative care (the transfer date noted above). This claim will be filed using the appropriate CPT Code, i.e. 66984, and Modifier 55, which indicates post-operative management only.

After the optometrist has seen the patient for post-operative care, he/she will submit a claim for the post-operative care provided, using the appropriate CPT Code, i.e, 66984, and Modifier 55. Again, in order for the claim to be accurate the optometrist must know the date he/she assumed responsibility for post-operative care (the transfer date).

Medicare uses chronology and number of days to calculate payment for care rendered by each doctor during the post-operative period (90 days). The fees submitted by the surgeon and optometrist will be different, depending on the number of days of post-operative care each one provided. An example of billing by the surgeon and optometrist follows.

SAMPLE MEDICARE BILLING

Surgeon’s Care		PECP (OD’s) Care	
<u>Date</u> January 1: January 2 - 10:	<u>CPT Code</u> 66984-54 66984-55	<u>Date</u> January 11-April 1:	<u>CPT Code</u> 66984-55
Reimbursement of care is valued at 20% of the global surgery fees. In this example, value of the post-op care is apportioned to the surgeon as follows: 10/90th of 20% to the surgeon (10 days)		Reimbursement of care is valued at 20% of the global surgery fees. In this example, value of the post-op care is apportioned to the PECP (OD) as follows: 80/90th of the 20% to the optometrist (80days)	

When submitting claims, many Medicare carriers instruct providers to write a comment in the body of the claim form, as follows:

Surgeon: “Assumed post-operative care on January 2, relinquished care on January 10”

Optometrist “Assumed post-operative care on January 11, relinquished care on April 1.”

Many patients will have cataract surgery performed on the second eye shortly after their first surgery, in which case post-operative care may overlap temporarily. When these patients are co-managed, claims for each surgery are handled separately. The surgeon will file the second claim with Modifier 79, to indicate the second surgery is unrelated to the first (different eye). Both surgery claims will also be filed using Modifier 54, to indicate post-operative care is being co-managed. The post-op care claims will include both Modifiers 55 and 79 for the surgeon and the optometrist.

The chronology and windows of time on which payment is determined (as outlined above) are still relevant and the claims will be concurrent. The surgeon will determine if the transfer of care for the first surgery occurs before or after the second surgery.

If the transfer of care for the first surgery occurs before the second surgery, then two transfers of care letters or forms and transfer agreement letters must be prepared, establishing a unique transfer date for each surgery.

The comments provided herein relate to billing for cataract co-management for Medicare patients. Commercial carrier policies will vary. Should you have questions about a specific carrier’s policy, we recommend you contact them directly. Also, if you have questions related to Medicare billing procedures, you can visit their website, www.cms.gov, or contact our office for assistance.