What Could Possibly Go Wrong With Refractive Cataract Surgery?

Mary Louise Parisi, BA, Bed, COE
Chief Executive Officer
Clemson Eye, SC

Kevin J. Corcoran, COE, CPC, CPMA, FNAO
President, Corcoran Consulting Group
Founder, Corcoran Compliance Connection

Financial Disclosures

- Mary Louise Parisi, BA, Bed, COE
  - CEO, Clemson Eye
  - Speaker for Alcon
- Kevin Corcoran, COE, CPC, CPMA, FNAO is President of Corcoran Consulting Group and founder of Corcoran Compliance Connection, LLC. He acknowledges a financial interest in the subject matter of this presentation.

Objective of this Presentation

Learn to identify potential problems associated with refractive cataract surgery and how to mitigate risk.

Objective of refractive cataract surgery: better visual outcomes for patient, fair and reasonable compensation, and increased market share.

Outline

1. Medical problems
2. Follow-up care
3. Informed consent
4. Insurance
5. Recommendations

Business Model

1. Meet patient demand for better refractive outcomes
2. Create a simple, fair, compliant, model based on covered vs. non-covered services; professional services vs. IOL material
3. Adopt an integrated and complementary pricing model for practice and ASC
4. Document patient choice and financial understanding – update your ABN, NEHB
5. Adopt compliance program and quality assurance for refractive cataract surgery

Outline

1. Medical problems

Dry Eye Syndrome

- 62 yo female has unilateral cataract surgery with a multifocal IOL.
- At the Long Post Op, her vision is 20/20 but she is 20/Unhappy and complains of fluctuations in vision.
- DX: Dry Eye. Recommend a course of aggressive dry eye therapy and asked to return monthly until her vision is improved.
- After 3 months, her visual quality improves as her dry eye condition improves and she neuro-adapts to her new vision.

Dry Eye Syndrome

- What went wrong?
- Failed to treat dry eye pre-operatively
- Failed to set expectation of healing time.
- It's different for everyone, so shouldn't give impression that vision returns immediately! It may take 3-6 months.

Dry Eye Syndrome

- Lessons learned
- Identify dry eye pre-operatively. IOLs are often blamed for poor visual quality when culprit is ocular surface disease.
- Treat dry eye patients prior to and after surgery and emphasize the importance of compliance.
- Put consults on artificial tears before visit.
- Keep unhappy patients returning frequently. Ensure they know that you are there to work with them side by side until they are satisfied with their vision.

Outline

1. Medical problems
2. Follow-up care

Maladaptive After 1st Multifocal IOL

- Patient has laser cataract surgery with a multifocal lens implant. After first eye surgery, very unhappy with near vision and concerned about proceeding.
- Post op: UCVA is 20/25, J3. Surgeon reassures patient that after second eye procedure, she will be happier with her near and bilateral vision.
- Patient seeks second opinion. Another doctor confirms prognosis, but she has surgery with this doctor instead because the first surgeon was not supportive enough.

Maladaptive After 1st Multifocal IOL

- What went wrong?
- We didn't establish realistic expectation that multifocal IOLs work best after bilateral implantation.
- We failed to confirm patient understanding.
- Patient lost confidence in our advice due to anxiety about their near vision and went elsewhere.

Maladaptive After 1st Multifocal IOL

- Lessons learned
- Educate all patients in advance that multifocal works best in both eyes. After the first surgery, they may experience some doubt and disappointment.
- Set the expectation that healing takes time and bilateral implants work best.
- If patient is extremely anxious, have them return often until you work through the challenge together.
- Don't YAG prematurely.

Myope Loses Near Vision

- 68 y/o man who reads without glasses undergoes laser cataract surgery.
- Pre-op: RX: -2.00 -1.00 x 90 L: -2.50 -0.75 x 85
- Post-op: RX: +0.25 -0.50 x 95 L: Plano -0.50 x 85
- Miserable because cannot read. OD prescribes progressive lenses.
- He returns to surgeon demanding a refund because it didn't work. Paid $3,000 + $1,000 for glasses and lost near vision.
- His friends tell him they had basic surgery without any additional cost and don't wear glasses for distance.

Myope Loses Near Vision

- What went wrong?
- Buyer's remorse due to unrealistic expectations
- Comanaging optometrist didn't send the unhappy patient back to surgeon
- Tech didn't document in cataract work-up near UCVA.
- Techs didn't document patient's visual lifestyle; he loved to read without glasses.
- Counselor should emphasize need for glasses after cataract surgery with a Toric IOL.

Myope Loses Near Vision

- Lessons learned
- Ensure comanaging OD returns any unhappy patient to surgeon.
- Listen to patient's goals for surgery.
  - So focused on correcting astigmatism, missed key point; patient loved near vision. Patient should have been given option to remain myopic and wear glasses for distance, if multifocal not an option.
- Confirm that laser cataract surgery is not guaranteed to eliminate all astigmatism and might need glasses in the future.

Residual Astigmatism

- 70 y/o male won't pay for Toric IOL to correct astigmatism, but opts for the LenSx laser.
  - R: +3.00 -1.50 x 90
  - L: +3.25 -2.00 x 95
- Surgeon recommends Toric IOLs, but patient sees counselor and elects LenSx to correct his astigmatism because it's cheaper.
- After surgery, he is unhappy with his residual astigmatism and says the laser doesn't work.
  R: +0.50 -0.75 x 90 L: +0.50 -1.00 x 90
- Surgeon recommends LASIK to correct residual astigmatism and attempts to charge the patient.

Residual Astigmatism

- What went wrong?
- Failed to emphasize that laser-assisted cataract surgery doesn't guarantee full astigmatism correction.
- Didn't warn about the cost of LASIK for full astigmatism correction, because it's rare to treat post monofocal patients.
- We didn't emphasize the potential need for glasses post-operatively.

Residual Astigmatism

- Lessons learned?
- Train counselors about astigmatism correction options.
- Educate patient about astigmatism correction options. Toric lens is more precise, particularly >1 D. Residual astigmatism may need further correction.
- Don't guarantee glasses independence after laser cataract surgery.
- Avoid surprises. Identify cost of LASIK treatment (if needed) prior to cataract surgery.
- Don't deploy "caveat emptor".

Diopter Surprise

- 67 y/o female has laser cataract surgery RE with Toric IOL.
- Post-op, a myopic surprise is noted and patient is very dissatisfied. Biometry and IOL calcs are confirmed. Surgeon recommends IOL exchange at the same time as the 2nd eye (LE) cataract procedure.
- Surgeon bills Medicare for 66986, Lens Exchange for RE and 66984 for LE. Patient has to pay co-insurance for both procedures due to a change in benefits and new high deductible.
- Postoperatively patient is UCVA 20/20 OU, but unhappy about her $1,300 bill for the re-do surgery.

Diopter Surprise

- Patient's letter to surgeon demands refund for IOL exchange expense because she paid for Toric IOLs and the lens exchange was due to surgeon error.
- Surgeon forwards letter to insurance department to handle it. *"There was no pain and it was done at a convenient time when she was at ASC for 2nd eye surgery anyway? She's 20/20 – the result was perfect."*
- They speak with patient and claim she is relentless and crazy.
- When ignored, she sues for "pain and suffering" due to surgeon error.
- OMIC recommends $100,000 settlement with patient.

Diopter Surprise

- What went wrong?
- Practice should not ignore a patient complaint.
- Didn't make refund. A refund of $1,300 would have been a deal in hindsight.
- Surgeon should not have billed Medicare for an IOL exchange because it is built into pricing model for Refractive Cataract Surgery.

Diopter Surprise

Lessons learned

- Do not bill for IOL exchange for refractive reasons.
- Consider an occasional refund as the cost of doing business.
- Build the cost of all postop care into your pricing model.
- Informed consent should always include the possible need for a lens exchange.
- Be vigilant of a patient's disposition and comfort. Unhappy patients do not just "go away." They go somewhere: to another surgeon or to a lawyer.

Diopter Surprise

Lessons learned

- Realize that when patients are paying for refractive surgery, the overall expectations are higher.
- Refunds are less expensive than legal defense.

Outline

1. Medical problems
2. Follow-up care
3. Informed consent

Informed Consent Errors & Omissions

- 70 y/o female, cataracts OU. Surgeon recommends multifocal lens, based on her lifestyle (loves flying and reading). She elects to have cataract surgery, first OD, but is undecided about the multifocal.
- Surgeon advises her to consider ATIOL and let clinic know if she changes his mind. Meanwhile, surgeon documents plan to proceed with basic cataract surgery explaining the risks and benefits.
- Patient schedules surgery OU (1 week apart) and surgical coordinator obtains signature on an Informed Consent for a monofocal lens implant OD.
- A week later, patient calls receptionist requesting the multifocal lens implant instead of the basic IOL.

Informed Consent Errors & Omissions

- Continued….
- Fortunately, surgeon found a note in the medical record of the request to change the IOL from basic to multifocal and implanted the correct lens.
- Next day, patient returns for post-op visit and elects to proceed with second eye surgery. Optometrist in practice examines patient, documents medical necessity, and reassures the patient that she is doing great after her 1st eye procedure.
- It's a busy clinic session, with dozens of patients, so she leaves ready for his second procedure in a few days.

Informed Consent Errors & Omissions

What went wrong?

- OD
  - Clinic failed to document informed consent for multifocal lens implant
  - Clinic failed to collect payment in advance for multifocal
  - OS cannot be booked before determination of medical necessity for 2nd eye
- OS (2nd Eye)
  - OD cannot determine medical necessity for cataract surgery.
  - Surgeon and staff failed to document, orally or in writing, Informed Consent for 2nd eye cataract surgery

Informed Consent Errors & Omissions

Lessons learned:

- Informed consent must be performed orally and in writing for the *appropriate lens implant selection*
- Patient ATIOL changes must be well documented to ensure correct lens implanted
- You cannot perform 2nd eye surgery based on the first eye exam…Informed Consent is *per eye*
- Surgeon and practice must not neglect to obtain Informed Consent for 2nd eye
- Optometrist cannot provide informed consent

Outline

1. Medical problems
2. Follow-up care
3. Informed consent
4. Insurance

Insurance Pays for PC IOL

- Patient with cataracts calls their private insurance carrier (BCBS) asking if a lens implant for near and far is covered. Yes, the carrier tells them.
- Surgical counselor educates patient that a multifocal IOL is noncovered despite what their carrier told them because it's considered cosmetic.
- Patient wants insurance billed
- Practice bills S9986 (not medically necessary service) for *"multifocal lens implant services: DX: presbyopia"*
- Patient signs Informed Consent documents, including NEHB and finances the multifocal with Care Credit.

Insurance Pays for PC IOL

- Instead of denying claim, the carrier pays surgeon a small sum, $400 per eye for S9986.
- Patient refuses to pay Care Credit the balance of $2600 per eye (total balance of $5200).
- Practice contact Care Credit who adjusts the contract for the patient to reflect the adjustment, but bills practice for interest at 6% on $5200.

Insurance Pays for PC IOL

- What went wrong?
- Did not get prior authorization.
- Did not get BCBS to declare the noncovered service.
- Did not get BCBS to affirm beneficiary financial responsibility.

Insurance Pays for PC IOL

- Lessons learned
- Realize that when patients are paying for refractive surgery, they try to shift financial responsibility.
- Don't proceed with surgery until other third party payers have clearly stated who is responsible for what.

Outline

1. Medical problems
2. Follow-up care
3. Informed consent
4. Insurance
5. Recommendations

Key Points

- Manage patient expectations
- Document lifestyle (*e.g.,* loves near vision)
- Make no guarantees that patient will be glasses free.
- Address, prior to cataract operation, that further refractive surgery might be required (*e.g.,* IOL exchange, LASIK)
- Careful patient selection

Medical Pointers

- Look for medical issues that might compromise results (*e.g.,* DES, AMD, etc.) Address them.
- FS laser arcuate incisions are no guarantee for astigmatism reduction.
- Get good results and make it right with the patient if the results are an (unpleasant) surprise or undesirable.

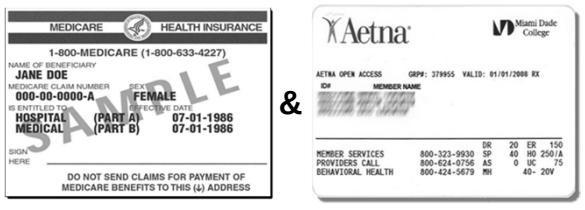
Best Practices

- **Transparency** – clearly inform patients of financial responsibility: for what, how much, why, and when
- **Documentation** – use a financial waiver, ABN or similar instrument to document financial responsibility
- **Separation** – segregate professional and facility fees and monies
- **Compliance** – follow CMS guidelines, and recommendations of AAO & ASCRS

Patient Understanding

- While payment for non-covered services is the beneficiary's responsibility, **Medicare Law (§1879) contains a provision that waives that liability** if the beneficiary is not likely to know and did not have a reason to know that the services would not be covered.

Before Coding, Consider Coverage



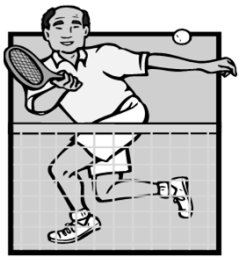
&

Part C Medicare

- Get prior authorization
- Obtain a determination of benefits for each patient
- Don't use ABN form – use MA Plans financial waiver form
- Don't pretend that Part B and Part C are identical.

Payments

- Cataract surgery (covered)
  - Surgeon, facility fee, IOL
  - A) Patient: deductible, copayments
- Refractive services (non-covered)
  - B) Patient: Patient Shared Responsibility
- Patient Responsibility:
  - A + B = Patient out of pocket



Refractive Cataract Surgery
Reimbursement Grid

Fee	MD	Facility
Covered	Assigned	Assigned
Non-covered	Patient Pays	Patient Pays

Patient shared billing: covered & non-covered services
LRI – Limbal relaxing incisions, refractive keratoplasty

Refractive Cataract Surgery
Reimbursement Grid

Fee	MD	Facility
Covered	Cataract surgery	Cataract surgery
Non-covered	Refractive testing	ATIOL, Laser LRI

Patient shared billing: covered & non-covered services
LRI – Limbal relaxing incisions, refractive keratoplasty

More help…

For additional assistance or confidential consultation, please contact us at:

Mary Louise Parisi – (864) 633-1063
mlparisi@clemsoneye.com

Kevin J. Corcoran – (800) 399-6565
www.CorcoranCCG.com