



Cataract Co-Management Billing for Medicare

By Drs. Harvey Richman and Rebecca Wartman



Dr. Harvey Richman

Medicare defined the specific components of major surgery included in the “global surgery package” in guidelines published in 1992. The components they identified included pre-operative care, intraoperative services, post-operative care (90 days), and in-office care for any post-operative 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.



Dr. Rebecca Wartman

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 article:

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 – post-operative 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 the patient has been seen. 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 patient’s 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 postoperative 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.

Intraoperative and Post-op Care and Billing of Monofocal IOL

Dr. Jones, the cataract surgeon, performs procedure code 66984 on March 1 and cares for the patient through March 2. Dr. Smith, the optometrist, assumes responsibility for the patient on March 3 for the remainder of the global period.

Dr. Jones' claim contains the following:

03/01/2010 66984 54

03/01/2010 66984 55 assumed 03022010 relinquished 03022010

Diagnosis: 366.16, Nuclear Sclerosis (Surgeon's Billing)								
	Dates of Service		Place of Service	Type of Service	Procedures, Services, Supplies (Explain Unusual Circumstances)	Diagnosis Code	Charges	Days or Units
	From MMDDYY	To MMDDYY			CPT-HCPCS - Modifier			
1	3/1/2010		11		66984-54-RT	1	XXX.XX	1
2	3/1/2010		11		66984-55-RT	1	XXX.XX	1
3								
4								
5								
6								

Dr. Smith's claim contains the following:

03/01/2010 66984 55 assumed 03032010 relinquished 05302010

Diagnosis: 366.16, Nuclear Sclerosis (O.D. Post-Operative Portion)								
	Dates of Service		Place of Service	Type of Service	Procedures, Services, Supplies (Explain Unusual Circumstances)	Diagnosis Code	Charges	Days or Units
	From MMDDYY	To MMDDYY			CPT-HCPCS - Modifier			
1	3/1/2010		11		66984-55-RT	1	XXX.XX	1
2								
3								
4								
5								
6								

Reimbursement of post-operative 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: 1/90th of 20% to the surgeon (1 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 co-managing doctor as follows: 89/90th of the 20% to the optometrist (89 days).

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 direction provided in this document relates 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 additional questions related to Medicare billing procedures, you can visit their website, www.cms.gov, www.aoa.org/coding or contact your surgeon's office for assistance.

About our Authors

Dr. Harvey Richman is a graduate of the New England College of Optometry where his education emphasized the evaluation of children with behavioral and perceptual difficulties. After several years of pediatric practice and research, Dr. Richman achieved the credentials of Fellow of the College of Optometrists in Vision Development. This was immediately followed by earning the credentials of Fellow of the American Academy of Optometry. In 2011, Dr. Richman became one of the first Diplomates of the American Board of Optometry.

In 2006, Dr. Richman was asked to join the American Optometric Association's Third Party Executive Committee to work on the Coding Committee due to his work for the state of New Jersey. Dr. Richman has lectured nationally on billing and coding, electronic health records, and PQRS. He has published work on Coding for Vision Therapy and Vision Rehabilitation for the AOA and COVD.

Dr. Rebecca Wartman is a 1987 graduate of the University of Missouri School of Optometry and a 1979 graduate of The University of the South (BA Psychology). Dr. Wartman resides in North Carolina. She received the 2012 John D. Costabile Distinguished Service Award for her service to optometry. Dr. Wartman has served on the American Optometric Association's Third Party Executive Center Committee since 2003. She serves as an Alternate Advisor for the AOA on CPT. She has lectured nationally on managed care and Third Party Coding. Dr. Wartman has published works on Physicians Quality Reporting Initiative and is a contributing author to Coding Abstract Column, Review of Optometry.

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To receive one hour of continuing education credit, those taking the quiz must be an AOA Associate member paraoptometric and answer 7 of the 10 questions correctly. This exam consists of multiple-choice questions designed to measure the level of understanding of the material covered in the continuing education article "Cataract Co-management Billing for Medicare."

If you are renewing a CPO, CPOA or CPOT certification this year, proof of 18 earned credits and your \$95 renewal payment will be due to the CPC by November 1. All quizzes submitted by October 1 will be graded and CE verification forms will be emailed to the paraoptometric by October 15 so that the November 1 renewal deadline can be met. **Please note that quizzes submitted after October 1 will not be processed in time for you to meet the November 1 deadline.**

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Credit Card Number _____

Authorized Signature _____

Select the option that best answers the question.

1. The post-operative period for cataract surgery is how many days?

- A. 14
- B. 90
- C. 10
- D. 120

2. What percent value of the surgical fee is placed on the post op care?

- A. 10%
- B. 20%
- C. 40%
- D. 30%

3. What modifier is used by the surgeon and the Optometrist when billing post op care?

- A. 55
- B. 57
- C. 59
- D. 54

4. When can the Optometrist bill for the post op care?

- A. The date of the transfer of care
- B. 30 days after the transfer of care
- C. End of the post op period
- D. The date the Optometrist first sees the patient for care

5. The transfer of surgical care:

- A. Is automatically pre-arranged by the surgeon
- B. Is automatically pre-arranged by the surgeon and the optometrist
- C. Is determined by the surgeon when it is most appropriate for the patient
- D. Is determined by the number of days the surgeon performs post op care

6. The post op payment to the Optometrist:

- A. Is calculated automatically for the full 90 days
- B. Is split 50% to the surgeon and 50% to the optometrist
- C. Is split 80% to the surgeon and 20% to the optometrist
- D. Is calculated based on the number of days the Optometrist cares for the patient

7. What modifier is used by the surgeon or the Optometrist when the second eye surgery falls within the 90 post op period of the first eye?

- A. 76
- B. 78
- C. 81
- D. 79

8. Who determines the date of the transfer of care to the Optometrist?

- A. The Optometrist
- B. The surgeon
- C. The Surgical Staff
- D. The Optometrist Staff

9. The transfer of care to the Optometrist should be determined by:

- A. A phone call
- B. A written statement by the Optometrist
- C. A written statement by the Surgeon
- D. A prearranged agreement by the Optometrist and the Surgeon

10. What is not considered required in a transfer of care document?

- A. Insurance information and billed codes
- B. Clinical Findings and Transfer Date
- C. Patient name and operative eye
- D. Nature of Operation and Discharge instructions

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