INFOBulletin

Keeping health care providers informed of payment, policy or program changes

To: Physicians, Hospitals and Independent Health Facilities

Published by: Health Services Branch

Date Issued: January 26, 2016 **Bulletin #:** 4665

Re: **Cataract and Lens Insertion Surgery**

This INFOBulletin replaces Bulletins #**4521** and **2064** issued October 15, 2010.

The Ministry of Health and Long-Term Care continues to receive a significant number of inquiries from patients about charges for services associated with the provision of insured cataract surgery, including charges for tests, intraocular lenses and laser surgery.

The Ministry investigates possible instances of:

- extra-billing and queue-jumping (by the authority of, and by the process set out in the *Commitment to the Future of Medicare Act*); and
- prohibited charges and payments of facility fees (under the *Independent Health Facilities Act*)

This INFOBulletin reminds providers of the payment rules and laws regarding patient charges for cataract and lens insertion surgery.

Providers can help reduce the number of complaints by ensuring that patients:

- understand that they can receive cataract and lens insertion surgery without charge or other barrier to access; and
- provide informed consent for the purchase of any uninsured services.

Cataract surgery is insured when provided by any method

Cataract and lens replacement surgeries are insured under OHIP when provided by any method. This includes, but is not limited to, phacoemulsification, laser surgery and the services, tests or technologies necessary to remove the cataract or insert or/or position the lens.

For example, in femtosecond laser-assisted cataract surgery – all parts of the cataract surgery (corneal cataract incisions, capsulorhexis and nucleus removal) are parts of an insured service under OHIP. Femtosecond laser-assisted cataract surgery may integrate a docking system with ocular imaging (by optical coherence tomography [OCT] or other techniques) as a guidance system for the surgery, and includes video imaging and automated measurements that would also be included if used for routine cataract surgery.

Insured components include laser-assisted corneal cataract incisions, capsulotomy and lens fragmentation. All components of femtosecond laser-assisted cataract surgery are insured, regardless of the type or cost of IOL used (i.e. regardless of whether or not the chosen lens includes non-medically necessary features). While non-medically necessary IOLs used for refractive correction may depend on the more precise alignment for optimal visual outcome offered by femtosecond laser, the use of femtosecond laser and all of its components remain an insured service as cataract surgery by any method. Refractive surgeries performed in conjunction with cataract surgery, such as those to manage astigmatism through separate corneal incisions / markings (and the imaging required to perform them) are uninsured and cannot be billed to OHIP.

No person or entity can charge a patient for medically necessary physician or hospital services.

No person or entity can charge a patient a facility fee for services that are required to provide cataract surgery provided by any method. This applies regardless of:

- the type of setting in which the service is provided;
- whether or not the facility is licensed under the Independent Health Facilities Act to provide cataract surgery; and
- the type of lens that is inserted.

Physician services

Cataract and IOL insertion surgery is an insured physician service when provided by any method, including laser surgery. OHIP coverage includes the necessary tests and assessments, and the common and specific elements of these insured services.

A patient cannot be required to purchase an uninsured service. The physician must give the patient the option of receiving cataract and lens insertion surgery, including the medically necessary lenses and tests, without charge.

Full OHIP coverage for these services should be clearly communicated to the patient.

There is no “standard” lens. The medically necessary lens is determined for each patient based on individual patient assessment, diagnosis, treatment plan and current medical practice standards and must be documented in the individual patient medical record.

Any charge to the patient by the physician, or any other person or entity, for the insured physician service, including the common and specific elements of the physician service, violates the *Health Insurance Act* and the *Commitment to the Future of Medicare Act*.

When service is provided in a hospital

When cataract surgery is provided in a hospital, the patient is entitled to receive the hospital services, including the surgery and medically necessary lens, without charge. Costs for hospital services are paid from the hospital’s global budget.

Any charge to a patient for the insured hospital services violates the *Health Insurance Act* and the *Commitment to the Future of Medicare Act*.

When services are provided in a non-hospital setting

When cataract surgery is provided in any non-hospital setting, the patient cannot be charged for any service or operating cost that supports, assists and/or is a necessary adjunct to the provision of the insured physician service (the “facility fee”). Facility fees are the costs of the premises, equipment, supplies and personnel that are required to provide the insured physician service. For example, this includes, but is not limited to, the cost of surgical equipment to support insured services, including laser, positioning devices for surgery, and measuring devices used during surgery. Facilities that are licensed under the *Independent Health Facilities Act* may submit claims for facility fees to, and receive payment from, the Minister of Health and Long-Term Care, or a prescribed person under the *Independent Health Facilities Act*.

The *Independent Health Facilities Act* prohibition against charging patients facility fees applies equally to facilities and providers regardless of whether or not the facility is licensed under the *Independent Health Facilities Act*.

Uninsured services

In the provision of insured cataract surgery, a physician, hospital or facility might offer a patient lenses with features that are not medically necessary, such as toric or multifocal lenses to correct refractive errors, or femtosecond laser or blade corneal incisions to correct astigmatism and/or tests that are not medically necessary but required to perform those non medically necessary procedures.

The physician, hospital or facility is required to provide the patient with sufficient information to make an informed decision about the purchase of any uninsured service and to obtain the patient's agreement. Patient consent must be documented in the patient care record.

A patient cannot be required to purchase an uninsured service, and access to cataract surgery cannot be made conditional on, or otherwise linked to, a patient's purchase of, or payment for, any uninsured service. Such actions contravene the *Commitment to the Future of Medicare Act*.

The physician, hospital or facility is required to provide the patient with sufficient information to make an informed decision about the purchase of any uninsured service and obtain the patient's agreement. When a patient makes a voluntary choice to purchase an uninsured lens (i.e. one with features that are not medically necessary), test or other service:

- The physician, hospital or other facility is required to apply the cost of the medically necessary lens against the cost of the elective lens (i.e. to credit the patient for the cost of the medically necessary lens).

- The physician, hospital or facility is required to provide the patient with an itemized invoice that shows the amounts charged for each uninsured service and, if applicable, that credit was given for the cost of the medically necessary lens.

Physicians who sell and charge patients for uninsured services may wish to review their legal obligations set out in Regulation 856 "Professional Misconduct" under the *Medicine Act*, and The College of Physicians and Surgeons of Ontario policy statements #3-10 "Block Fees and Uninsured Services," and #3-15"Consent to Treatment" (available at www.cpso.on.ca)

Legal framework

Cataract and lens replacement surgery by any method, and the medically necessary tests and assessments, are insured physician service as listed in the Schedule of Benefits for Physician Services under the *Health Insurance Act*. The provision of the common and specific elements of these services as set out in the General and Surgical Preambles to the Schedule are included in OHIP payment to the physician. Any charge by any person or entity for the insured physician service contravenes section 15 of the *Health Insurance Act* and section 10 of the *Commitment to the Future of Medicare Act*.

When the service is provided in a hospital, the patient is entitled to receive the hospital services, including the medically necessary lens and eye tests, without charge as provided in section 7 or subsection 8(1) of Regulation 552 under the *Health Insurance Act* as the case may be. Any charge by any person or entity for the medically necessary lens, diagnostic test or other hospital service is contravenes section 7 or 8(1) of the *Health Insurance Act* and subsection 10(5) of the *Commitment to the Future of Medicare Act*.

When the service is provided in any non-hospital setting, no person or entity can charge the patient for the facility's costs for the premises, equipment, supplies and personnel necessary to provide the insured service. These facility costs are facility fees that are only payable to licensed facilities by the Minister or prescribed person under the *Independent Health Facilities Act*. A facility fee that is charged to a patient contravenes section 3 of the *Independent Health Facilities Act* regardless of whether or not the facility is licensed under the *Independent Health Facilities Act*.

In any setting, access to insured cataract or lens insertion surgery cannot be conditional on a person's decision to pay for an uninsured service. For any person or entity to pay or confer a benefit, or to charge or accept payment or other benefit in exchange for preference in obtaining or providing access to an insured service is a contravention of section 17 of the *Commitment to the Future of Medicare Act*.

For information regarding charges for uninsured services, please refer to sections 17 and 18 of the *Commitment to the Future of Medicare Act*, Regulation 856 under the *Medicine Act*.

Advisement

This INFOBulletin is a general summary provided for information purposes only. In the event of a discrepancy between this INFOBulletin and the *Health Insurance Act*, *Commitment to the Future of Medicare Act*, *Independent Health Facilities Act* and Regulations, the text of the law prevails. For complete text, health care providers are directed to review the *Health Insurance Act*, Regulation 552 under the Act, the Schedules under Regulation 552, the *Commitment to the Future of Medicare Act* and the *Independent Health Facilities Act*.

All Ontario law and regulations are available on the government website at: www.e-laws.gov.on.ca.