Medicare Learning Network
MLN Matters
CMS
Information for Medicare Fee-for-Service Health Care Professionals

News Flash - **Test Your Medicare Claims Now! After you have submitted claims containing both National Provider Identifiers (NPIs) and legacy identifiers and those claims have been paid, Medicare urges you to send a small batch of claims now with only the NPI in the primary provider fields. If the results are positive, begin increasing the number of claims in the batch. (Reminder: For institutional claims, the primary provider fields are the Billing and Pay-to Provider fields. For professional claims, the primary provider fields are the Billing, Pay-to, and Rendering Provider fields. If the Pay-to Provider is the same as the Billing Provider, the Pay-to Provider does not need to be identified.)**

MLN Matters Number: MM5853
Related Change Request (CR) #: 5853
Related CR Release Date: February 1, 2008
Effective Date: January 1, 2008
Related CR Transmittal #: R1430CP
Implementation Date: March 3, 2008

Use of Healthcare Common Procedure Coding System (HCPCS) V2787 When Billing Approved Astigmatism-Correcting Intraocular Lens (A-C IOLs) in Ambulatory Surgery Centers (ASCs), Physician Offices, and Hospital Outpatient Departments (HOPDs)

Provider Types Affected

Physicians and providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for IOL related services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 5853 which provides instructions regarding the use of HCPCS Code V2787 when billing for intraocular lens procedures and services involving recognized Astigmatism-Correcting Intraocular Lens (A-C IOLs) and taking place in Ambulatory Surgery Centers (ASCs), Physician Offices, or Hospital Outpatient Departments (HOPDs).

CAUTION – What You Need to Know

Effective for dates of service January 1, 2008 and later, when providing services to a Medicare beneficiary that involve the insertion of recognized A-C IOLs, and the service/procedure takes place in an ASC, HOPD, or physician office, then HCPCS Code V2787 should be billed to report the non-covered charges for the A-C IOL functionality of the inserted intraocular lens. V2788 should not be used to report non-covered charges of the A-C IOLs on or after January 1, 2008.

GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) previously announced in CR 5527 (Transmittal 1228, April 27, 2007) a new administrator ruling regarding the insertion of astigmatism-correcting intraocular lens (A-C IOLs) following cataract surgery. In that CR, CMS provided payment policies and billing instructions for services related to Intraocular Lens (IOL) procedures preformed with approved conventional IOLs or Astigmatism-Correcting Intraocular Lens (A-C IOLs) in Ambulatory Surgery Centers (ASCs), Hospital Outpatient Departments (HOPDs), or Physician offices. In addition, that CR instructed providers to:

- Bill the non-covered charges of the A-C IOL functionality of the lens using HCPCS Code V2788 when inserting an A-C IOL, and
- Continue to bill HCPCS Code V2632, as appropriate, for the charges associated with the insertion of a conventional lens or the conventional functionality when an A-C IOL was inserted.

You can review CR 5527 at *http://www.cms.hhs.gov/transmittals/downloads/R1228CP.pdf* on the CMS website and its corresponding MLN Matters article, MM 5527, at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5527.pdf* on the CMS website.

CR 5853 instructs that, effective for dates of service on or after January 1, 2008, services provided to Medicare beneficiaries involving the insertion of an recognized A-C IOL in an ASC, HOPD, or physician office, HCPCS Code V2787 should be billed to report the non-covered charges for the A-C IOL functionality of the inserted intraocular lens.

Note that (effective for dates of service on or after January 1, 2008) HCPCS Code V2788:

- Is no longer valid to report non-covered charges associated with the A-C IOL, but
- Continues to be valid to report non-covered charges associated with the Posterior Chamber IOL (P-C IOL).

Physician offices should continue to bill HCPCS Code V2632 for the payable conventional IOL functionality of the A-C IOL. The payment for the conventional lens portion of the A-C IOL lens continues to be bundled with the facility procedure payment for ASCs and HOPDs.

As of March 3, 2008, your Medicare contractor(s) will accept HCPCS Code V2787 for dates of service on or after January 1, 2008 to report non-covered charges incurred for services provided to a Medicare beneficiary involving the insertion an A-C IOL in a physician's office, an ASC facility, or a hospital outpatient setting. The annual HCPCS update will include the definition of HCPCS Code V2787 as follows:

HCPCS Code	Descriptor
V2787	*Astigmatism correcting function of intraocular lens. Non-covered by Medicare statue.*

When Medicare denies A-C IOLs billed with V2787, they will return remittance reason code 96 (Non-covered charges) and remark code N425 (Statutorily excluded service(s)) or they may use reason code 204 (This service/equipment/drug is not covered under the patient's current benefit plan).

Note that your Medicare contractor will not search their files to reprocess claims for HCPCS Code V2787 that may have been denied prior to the implementation date for this change. However, they will adjust such claims if you bring them to the contractor's attention.

Additional Information

The official instruction, CR 5853, issued to your Medicare carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1430CP.pdf* on the CMS website.

If you have any questions, please contact your Medicare carrier, FI, or A/B MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

News Flash - It's Not Too Late to Give and Get the Flu Shot! In the U.S., the peak of flu season typically occurs anywhere from late December through March; however, flu season can last as late as May. Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a one time pneumococcal vaccination. Protect yourself, your patients, and your family and friends by getting and giving the flu shot. **Don't Get the Flu. Don't Give the Flu. Get Vaccinated!** Remember - Influenza and pneumococcal vaccinations and their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are NOT Part D covered drugs. You and your staff can learn more about Medicare's coverage of adult immunizations and related provider education resources, by reviewing Special Edition MLN Matters article SE0748 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0748.pdf* on the CMS website.