CMS Manual System	**Department of Health & Human Services**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services**
Transmittal 1430	**Date: February 1, 2008**
	Change Request 5853

SUBJECT: Use of HCPCS V2787 When Billing Approved Astigmatism-Correcting Intraocular Lens (A-CIOLs) in Ambulatory Surgery Centers (ASCs), Physician Offices, and Hospital Outpatient Departments (HOPDs)

I. SUMMARY OF CHANGES: Effective for dates of service January 1, 2008 and later, when inserting an approved A-C IOL in an ASC, HOPD, or physician office, V2787 should be billed to report the non-covered charges for the A-C IOL functionality of the inserted intraocular lens.

NEW / REVISED MATERIAL
**EFFECTIVE DATE: ***January 1, 2008
IMPLEMENTATION DATE: March 3, 2008

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	32/120/120.1/Payment for Services and Supplies
R	32/120/120.2/Coding and General Billing Requirements

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1430	Date: February 1, 2008	Change Request: 5853

SUBJECT: Use of HCPCS V2787 When Billing Approved Astigmatism-Correcting Intraocular Lens (A-CIOLs) in Ambulatory Surgery Centers (ASCs), Physician Offices, and Hospital Outpatient Departments (HOPDs)

EFFECTIVE DATE: January 1, 2008

IMPLEMENTATION DATE: March 3, 2008

I. GENERAL INFORMATION

A. Background: In transmittal 1228, CR 5527, dated April 27, 2007, we announced a new administrator ruling regarding astigmatism-correcting intraocular lens (A-C IOLs) following cataract surgery. The CR iterated CMS payment policies and billing instructions when performing IOL procedures with approved conventional or A-C IOLs in ASCs, hospital outpatient departments or physician offices. Providers were instructed, when inserting an A-C IOL, to bill the non-covered charges of the A-C IOL functionality of the lens using HCPCS V2788. Providers were also instructed to continue to bill 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.

B. Policy: Effective for dates of service January 1, 2008 and later, when inserting an approved A-C IOL in an ASC, HOPD, or physician office, **V2787** should be billed to report the non-covered charges for the A-C IOL functionality of the inserted intraocular lens. Additionally, note that V2788 is no longer valid to report non-covered charges associated with the A-C IOL. However, this code continues to be valid to report non-covered charges of a P-C IOL. Also, physician offices will continue to bill 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.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5853.1	Effective for dates of services on or after January 1, 2008, contractors and CWF shall accept claims with V2787 to report non-covered charges incurred when inserting an A-C IOL in a physician's office, an ASC facility or hospital outpatient setting. This code will be a part of the annual HCPCS update.	X		X	X		X			X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	V2787 - *Astigmatism correcting function of intraocular lens. Non-covered by Medicare statue.* **NOTE**: V2788 is NO longer valid for AC-IOL services effective with dates of service on or after January 1, 2008.										
5853.1.1	Contractors shall line deny lines that contain V2787 that include covered charges.	X		X			X				
5853.2	Carriers and CWF shall use type of service indicator 'Q' for V2787.	X			X					X	
5853.2.1	Contractors shall use MSN 16.10 ("*Medicare does not pay for this item of service"*) when denying A-C IOLs billed with V2787.	X		X	X						
5853.3	Contractors should use Reason Code 96 *("Non-covered charges*") and remark code N425 ("*Statutorily excluded service(s)"*) or alternatively may use Reason Code 204 *("This service/equipment/drug is not covered under the patient's current benefit plan"*) when denying the non-covered A-C IOL billed as V2787.	X		X	X						
5853.4	Contractors shall advise providers via the MLN Matters Article that they should report HCPCS V2787 for non-covered charges associated with the insertion of the A-C IOL services effective for dates of service on or after January 1, 2008.	X		X	X						
5853.5	Contractors need not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors shall adjust claims brought to their attention.	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5853.6	A provider education article related to this instruction	X		X	X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Chuck Braver (payment policy) at chuck.braver@cms.hhs.gov , 410-786-6719; Yvette Cousar (Part B claims processing) at yvette.cousar@cms.hhs.gov , 410-786-6120 or Bill Stojak (Part B claims processing) at william.stojak@cms.hhs.gov 410-786-6984; and Antoinette Johnson (Part A claims processing) at antoinette.johnson@cms.hhs.gov , 410-786-9326

Post-Implementation Contact(s): appropriate regional office

VI. FUNDING

A. ***For Fiscal Intermediaries and Carriers,*** **use the following statement*:***
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*** **use the following statement:**
The Medicare Administrative Contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

120.1 - Payment for Services and Supplies

(Rev. 1430; Issued: 02-01-08; Effective: 01-01-08; Implementation: 03-03-08)

For an IOL inserted following removal of a cataract in a hospital, on either an outpatient or inpatient basis, that is paid under the hospital Outpatient Prospective Payment System (OPPS) or the Inpatient Prospective Payment System (IPPS), respectively; or in a Medicare-approved ambulatory surgical center (ASC) that is paid under the ASC fee schedule:

- Medicare does not make separate payment to the hospital or ASC for an IOL inserted subsequent to extraction of a cataract. Payment for the IOL is packaged into the payment for the surgical cataract extraction/lens replacement procedure.

- Any person or ASC, who presents or causes to be presented a bill or request for payment for an IOL inserted during or subsequent to cataract surgery for which payment is made under the ASC fee schedule, is subject to a civil money penalty.

For a P-C IOL or A-C IOL inserted subsequent to removal of a cataract in a hospital, on either an outpatient or inpatient basis, that is paid under the OPPS or the IPPS, respectively; or in a Medicare-approved ASC that is paid under the ASC fee schedule:

- The facility shall bill for the removal of a cataract with insertion of a conventional IOL, regardless of whether a conventional, P-C IOL, or A-C IOL is inserted. When a beneficiary receives a P-C or A-C IOL following removal of a cataract, hospitals and ASCs shall report the same CPT code that is used to report removal of a cataract with insertion of a conventional IOL. Physicians, hospitals and ASCs may also report an additional HCPCS code, V2788, to indicate any additional charges that accrue when a P-C IOL or A-C IOL is inserted in lieu of a conventional IOL *until Janaury 1, 2008*. *Effective for A-C IOL insertion services on or after January 1, 2008, physicians, hospitals and ASCs should use V2787 to report any additional charges that accrue. On or after January 1, 2008, physicians, hospitals, and ASCs should continue to report HCPCS code V2788 to indicate any additional charges that accrue for insertion of a P-C IOL.* See Section 120.2 for coding guidelines.

- There is no Medicare benefit category that allows payment of facility charges for services and supplies required to insert and adjust a P-C or A-C IOL following removal of a cataract that exceed the facility charges for services and supplies required for the insertion and adjustment of a conventional IOL.

- There is no Medicare benefit category that allows payment of facility charges for subsequent treatments, services and supplies required to examine and monitor the beneficiary who receives a P-C or A-C IOL following removal of a cataract that exceeds the facility charges for subsequent treatments, services and supplies required to examine and monitor a beneficiary after cataract surgery followed by insertion of a conventional IOL.

A - For a P-C IOL or A-C IOL inserted in a physician's office

- A physician shall bill for a conventional IOL, regardless of a whether a conventional, P-C IOL, or A-C IOL is inserted (see section 120.2, General Billing Requirements)

- There is no Medicare benefit category that allows payment of physician charges for services and supplies required to insert and adjust a P-C or A-C IOL following removal of a cataract that exceed the physician charges for services and supplies for the insertion and adjustment of a conventional IOL.

- There is no Medicare benefit category that allows payment of physician charges for subsequent treatments, service and supplies required to examine and monitor a beneficiary following removal of a cataract with insertion of a P-C or A-C IOL that exceed physician charges for services and supplies to examine and monitor a beneficiary following removal of a cataract with insertion of a conventional IOL.

B - For a P-C IOL or A-C IOL inserted in a hospital

- A physician may not bill Medicare for a P-C or A-C IOL inserted during a cataract procedure performed in a hospital setting because the payment for the lens is included in the payment made to the facility for the surgical procedure.

- There is no Medicare benefit category that allows payment of physician charges for services and supplies required to insert and adjust a P-C or A-C IOL following removal of a cataract that exceed the physician charges for services and supplies required for the insertion of a conventional IOL.

C - For a P-C IOL or A-C IOL inserted in an Ambulatory Surgical Center

- Refer to Chapter 14, Section 40.3 for complete guidance on payment for P-C IOL or A-C IOL in Ambulatory Surgical Centers.

120.2 - Coding and General Billing Requirements

(Rev. 1430; Issued: 02-01-08; Effective: 01-01-08; Implementation: 03-03-08)

Physicians and hospitals must report one of the following Current Procedural Terminology (CPT) codes on the claim:

- 66982 - Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic development stage.

- 66983 - Intracapsular cataract with insertion of intraocular lens prosthesis (one stage procedure)

- 66984 - Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)

- 66985 - Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract extraction

- 66986 - Exchange of intraocular lens

In addition, physicians inserting a P-C IOL or A-C IOL in an office setting may bill code V2632 (posterior chamber intraocular lens) for the IOL. Medicare will make payment for the lens based on reasonable cost for a conventional IOL. Place of Service (POS) = 11.

Effective for dates of service on and after January 1, 2006, physician, hospitals and ASCs may also bill the non-covered charges related to the P-C function of the IOL using HCPCS code V2788. Effective for dates of service on and after January 22, 2007 *through January 1, 2008*, non-covered charges related to A-C function of the IOL can be billed using HCPCS code V2788. The type of service indicator for the non-covered billed charges is Q. (The type of service is applied by the Medicare carrier and not the provider). *Effective for A-C IOL insertion services on or after January 1, 2008, physicians, hospitals and ASCs should use V2787 rather than V2788 to report any additional charges that accrue.*

When denying the non-payable charges submitted with *V2787 or* V2788, contractors shall use an appropriate Medical Summary Notice (MSN) such as 16.10 (Medicare does not pay for this item or service) and an appropriate claim adjustment reason code such as 96 (non-covered charges) for claims submitted with the non-payable charges.

Hospitals and physicians may use the proper CPT code(s) to bill Medicare for evaluation and management services usually associated with services following cataract extraction surgery, if appropriate.

A - Applicable Bill Types

The hospital applicable bill types are 12X, 13X, 83X and 85X.

B - Other Special Requirements for Hospitals

Hospitals shall continue to pay CAHs method 2 claims under current payment methodologies for conditional IOLs.