CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1228	**Date: APRIL 27, 2007**
	Change Request 5527

Subject: Instructions for Implementation of CMS 1536-R; Astigmatism-Correcting Intraocular Lens (A-C IOLs)

I. SUMMARY OF CHANGES: This instruction announces a new CMS Administrator Ruling regarding astigmatism-correcting intraocular lenses (A-C IOLs) following cataract surgery. The new policy is effective for dates of service on and after January 22, 2007.

New / Revised Material
Effective Date: January 22, 2007
Implementation Date: May 29, 2007

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	32/Table Of Contents
R	32/120/Presbyopia-Correcting (P-C IOLS) and Astigmatism-Correcting Intraocular Lenses (A-C IOLs) (General Policy Information)
R	32/120/120.1/Payment for Services and Supplies
R	32/120/120.2/Coding and General Billing Requirements
R	32/120/120.3/Provider Notification Requirements
R	32/120/120.4/Beneficiary Liability

III. FUNDING:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment – Business Requirements

Pub. 100-04	Transmittal: 1228	Date: April 27, 2007	Change Request: 5527

SUBJECT: Instructions for Implementation of CMS 1536-R; Astigmatism-Correcting Intraocular Lens (A-C IOLs)

Effective Date: **January 22, 2007**
Implementation Date: May 29, 2007

This CR reiterates our policy that was published in CR 3927, Transmittal 636, except that the subject of this CR is the A-C IOL rather than the P-C IOL. There are no systems changes or new HCPCS coding required in this CR

I. GENERAL INFORMATION

A. Background: The CMS rulings are decisions of the Administrator that serve as precedent final opinions and orders and statements of policy and interpretation. They provide clarification and interpretation of complex or ambiguous provisions of the law or regulations relating to Medicare, Medicaid, utilization and peer review by Quality Improvement Organizations, private health insurance, and related matters.

The CMS rulings are binding on all CMS components, Medicare contractors, the Provider Reimbursement Review Board, the Medicare Geographic Classification Review Board, and Administrative Law Judges who hear Medicare appeals. These rulings promote consistency in interpretation of policy and adjudication of disputes.

This ruling sets forth CMS policy concerning the requirements for determining payment for insertion of intraocular lenses that replace beneficiaries' natural lenses and correct pre-existing astigmatism following cataract surgery under the following sections of the Social Security Act (the Act):

- Section 1832(a)(2)(F) for services furnished in connection with surgical procedures performed in an Ambulatory Surgical Center (ASC).
- Section 1833(t)(1)(B)(iii) for implantable items described in paragraphs (3), (6), or (8) of section 1861(s) that are covered hospital outpatient department services.
- Section 1861(s)(1) for physicians' services.
- Section 1861(s)(2)(A) for services and supplies furnished incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either furnished without charge or included in the physicians' bills.
- Section 1861(s)(2)(B) for hospital services incident to physicians' services furnished to outpatients.
- Section 1861(s)(8) for one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens.
- Section 1862(a)(7) where notwithstanding any other provision of this title, no payment may be made under Medicare Part A or Part B for any expenses incurred for items or services

where such expenses are for …eyeglasses (other than eyewear described in section 1861(s)(8)) or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes.

- A cataract is an opacity or cloudiness in the crystalline lens of the eye, blocking the passage of light through the lens, sometimes resulting in blurred or impaired vision. Surgical extraction of the clouded lens and insertion of an artificial intraocular lens is the conventional treatment for cataracts.

- Regular astigmatism is a visual condition where part of an image is blurred due to uneven corneal curvature. A normal cornea has the same curvature at all axes, whereas the curvature of an astigmatic cornea differs in two primary axes, resulting in vision that is distorted at all distances.

An astigmatism-correcting IOL is indicated for primary implantation in the capsular bag of the eye for the visual correction of aphakia (absence of the lens of the eye) in patients with pre-existing astigmatism, and is intended to provide improved near, intermediate, and distance vision.

B. Policy:

Coverage Policy

1. In general, an item or service covered by Medicare must satisfy three basic requirements:

   a. Fall within a statutorily-defined benefit category;

   b. Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part;

   c. Not be excluded from coverage.

2. The Act specifically excludes eyeglasses and contact lenses from coverage, with an exception for one pair of eyeglasses or contact lenses covered as a prosthetic device furnished after each cataract surgery with insertion of an IOL.

3. There is no Medicare benefit category to allow payment for the surgical correction of cylindrical lenses of eyeglasses or contact lenses that may be required to compensate for the imperfect curvature of the cornea (astigmatism).

4. The astigmatism-correcting IOL is intended to provide what is otherwise achieved by two separate items: an implantable conventional IOL (one that is not astigmatism -correcting) that is covered by Medicare , and the surgical correction, eyeglasses, or contact lenses that are not covered by Medicare.

5. Although astigmatism-correcting IOLs may serve the same function as eyeglasses or contact lenses furnished following removal of a cataract, astigmatism-correcting IOLs are neither eyeglasses nor contact lenses.

BENEFIT SUMMARY

Benefits for Which Medicare Makes Payment	Services for Which Medicare Does NOT Pay – No Benefit Category
A conventional intraocular lens (IOL) implanted following cataract surgery.	The astigmatism-correcting functionality of an IOL implanted following cataract surgery.
Facility or physician services and supplies required to insert a conventional IOL following cataract surgery.	Facility or physician services and resources required to insert and adjust an astigmatism-correcting IOL following cataract surgery that exceed the services and resources furnished for insertion of a conventional IOL.
One pair of eyeglasses or contact lenses as a prosthetic device furnished after each cataract surgery with insertion of an IOL.	The surgical correction of cylindrical lenses of eyeglasses or contact lenses that may be required to compensate for imperfect curvature of the cornea (astigmatism)
	Eye examinations performed to determine the refractive state of the eyes specifically associated with insertion of an astigmatism-correcting IOL (including subsequent monitoring services), that exceed the one-time eye examination following cataract surgery with insertion of a conventional IOL.

Definition of IOLs

1. A "conventional IOL" means a small, lightweight, clear disk that replaces the distance focusing power of the eye's natural crystalline lens. When a conventional IOL is inserted subsequent to removal of a cataract, eyeglasses or contact lenses are usually required to provide near or intermediate vision.

2. A "new technology IOL" (NTIOL) means an IOL that is furnished by an ambulatory surgery center (ASC) and that CMS determines has been approved by the FDA for use in labeling and advertising the IOL's claims of specific clinical advantages and superiority over existing IOLs with regard to reduced risk of intraoperative or post-operative complication or trauma, accelerated postoperative recovery, reduced induced astigmatism, improved postoperative visual acuity, more stable postoperative vision, or other comparable clinical advantages. Currently there is one NTIOL class that is approved for special payment when furnished by an ASC. This currently active NTIOL category for "Reduced Spherical Aberration" was established on February 27, 2006, and expires on February 26, 2011.

3. An IOL that also corrects for pre-existing astigmatism is indicated for primary implantation in the capsular bag of the eye for the visual correction of aphakia (absence of the lens of the eye) in patients with pre-existing astigmatism, and is also intended to provide improved near, intermediate, and distance vision. For some patients, the astigmatism-correcting IOL may improve vision, especially distance vision, so much that no other vision enhancing intervention or support is required to provide adequate vision at certain distances. In some cases, a single IOL that also corrects pre-existing astigmatism may provide what is otherwise achieved by two separate items: the implantable conventional IOL that is covered by Medicare and the surgical correction, eyeglasses, or contact lenses for treatment of pre-existing astigmatism that are not covered by Medicare. Effective for services furnished on or after January 22, 2007, CMS now recognizes the following as astigmatism-correcting IOLs:

- Acrysof® Toric IOL (models: SN60T3, SN60T4, and SN60T5), manufactured by Alcon Laboratories, Inc.

- Silicon 1P Toric IOL (models: AA4203TF and AA4203TL), manufactured by STAAR Surgical.

Payment Policy for Facility Services and Supplies

1. 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:

    a. Medicare does not make separate payment to the hospital or the 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.

    b. 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.

2. For an astigmatism-correcting 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:

    a. The facility shall bill for removal of a cataract with insertion of a conventional IOL, regardless of whether a conventional or astigmatism-correcting IOL is inserted. When a beneficiary receives an astigmatism-correcting 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 (see “Coding” below).

    b. There is no Medicare benefit category that allows payment of facility charges for services and supplies required to insert and adjust an astigmatism-correcting 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.

    c. 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 an astigmatism-correcting IOL following removal of a cataract that exceed 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.

Payment Policy for Physician Services and Supplies

1. For an IOL inserted following removal of a cataract in a physician’s office:

    Medicare makes separate payment, based on reasonable charges, for an IOL inserted subsequent to extraction of a cataract that is performed at a physician’s office.

2. For an astigmatism-correcting IOL inserted following removal of a cataract in a physician’s office:

a. A physician shall bill for a conventional IOL, regardless of whether a conventional or astigmatism-correcting IOL is inserted (see "Coding," below).

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

c. There is no Medicare benefit category that allows payment of physician charges for subsequent treatments, services, and supplies required to examine and monitor a beneficiary following removal of a cataract with insertion of an astigmatism-correcting IOL that exceed the physician charges for services and supplies to examine and monitor a beneficiary following removal of a cataract with insertion of a conventional IOL.

3. For an astigmatism-correcting IOL inserted following removal of a cataract in a hospital or ASC:

a. A physician may not bill Medicare for an astigmatism-correcting IOL inserted during a cataract procedure performed in those settings because payment for the lens is included in the payment made to the facility for the entire procedure.

b. There is no Medicare benefit category that allows payment of physician charges for services and supplies required to insert and adjust an astigmatism-correcting IOL following removal of a cataract that exceed physician charges for services and supplies required for the insertion of a conventional IOL.

c. There is no Medicare benefit category that allows payment of physician charges for subsequent treatments, services, and supplies required to examine and monitor a beneficiary following removal of a cataract with insertion of an astigmatism-correcting IOL that exceed the physician charges for services and supplies required to examine and monitor a beneficiary following cataract surgery with insertion of a conventional IOL.

Coding

1. No new codes are being established at this time to identify an astigmatism-correcting IOL or procedures and services related to an astigmatism-correcting IOL.

2. Hospitals, ASCs, and physicians report one of the following CPT codes to bill Medicare for removal of a cataract with IOL insertion:

a. 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 developmental stage

b. 66983 Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)

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

3. Physicians inserting an IOL or an astigmatism-correcting IOL in an office setting may bill code V2632 (posterior chamber intraocular lens) for the IOL or the astigmatism-correcting IOL, which is paid on a reasonable charge basis.

4. 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.

Beneficiary Liability

When the beneficiary requests insertion of an astigmatism-correcting IOL instead of a conventional IOL following removal of a cataract and that procedure is performed, the beneficiary is responsible for payment of facility charges for services and supplies attributable to the astigmatism-correcting functionality of the astigmatism-correcting IOL:

1. In determining the beneficiary's liability, the facility and physician may take into account any additional work and resources required for insertion, fitting, vision acuity testing, and monitoring of the astigmatism-correcting IOL that exceeds the work and resources attributable to insertion of a conventional IOL.

2. The physician and the facility may not charge for cataract extraction with insertion of an astigmatism-correcting IOL unless the beneficiary requests this service.

3. The physician and the facility may not require the beneficiary to request an astigmatism-correcting IOL as a condition of performing a cataract extraction with IOL insertion.

Provider Notification Requirements

When a beneficiary requests insertion of an astigmatism-correcting IOL instead of a conventional IOL following removal of a cataract:

1. Prior to the procedure to remove a cataractous lens and insert an astigmatism-correcting lens, the facility and the physician must inform the beneficiary that Medicare will not make payment for services that are specific to the insertion, adjustment, or other subsequent treatments related to the astigmatism-correcting functionality of the IOL.

2. The correcting functionality of an astigmatism-correcting IOL does not fall into a Medicare benefit category, and, therefore, is not covered. Therefore, the facility and physician are not required to provide an Advanced Beneficiary Notice to beneficiaries who request an astigmatism-correcting IOL.

3. Although not required, CMS strongly encourages facilities and physicians to issue a **Notice of Exclusion from Medicare Benefits** to beneficiaries in order to clearly identify the non-payable aspects of an astigmatism-correcting IOL insertion. This notice may be found: English language at: http://www.cms.hhs.gov/BNI/Downloads/CMS20007English.pdf
   Spanish language at: http://www.cms.hhs.gov/BNI/Downloads/CMS20007Spanish.pdf

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	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5527.1	Contractors shall continue to accept and pay the ASC facility rate for claims from ASC facilities for the following procedures: 66982, 66983, or 66984. **NOTE:** These procedure codes shall continue to be used by ASCs when either a conventional IOL or an astigmatism-correcting IOL (A-C IOL) is furnished to replace the organic lens following removal of a cataract performed in an ASC.	X			X							
5527.1.2	Contractors shall continue to accept and pay claims from physicians who perform the following procedures in an ASC (POS = 24) whether a conventional or an astigmatism-correcting IOL is inserted following cataract extraction surgery: CPT codes 66982, 66983, or 66984. **NOTE:** These physician services continue to be paid under the Medicare Physician Fee Schedule.	X			X							
5527.2	Contractors shall continue to accept and pay claims for removal of a cataract performed in a physician's office (POS = 11) for CPT codes 66982, 66983 or 66984.	X			X							
5527.2.1	In addition to the above procedure codes when performed in a physician's office, contractors shall continue to accept claims that also contain the following HCPCS code when either an A-C IOL or conventional IOL is implanted: V2632 - Posterior chamber intraocular lens **NOTE:** The code for the lens shall continue to be paid at reasonable charge. Only physicians can bill V2632 when cataract extraction with IOL insertion is performed in a physician's office, which is indicated by POS = 11 on the claim.	X			X							

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5527.3	Contractors shall continue to accept and pay hospital outpatient claims (12X, 13X, 83X, 85X TOB) for insertion of conventional or astigmatism-correcting IOLs following cataract extraction.	X		X								
5527.4	Contractors shall continue to pay claims that contain CPT procedure codes 66982, 66983, 66984 under current payment methodologies.	X		X								
5527.5	Contractors shall educate the provider community via the MLN Matters article that effective for dates of service on or after January 22, 2007, Medicare will pay the same amount for cataract extraction with A-C IOL insertion that it pays for cataract extraction with conventional IOL insertion. The beneficiary is responsible for payment of that portion of the hospital or ASC charge for the procedure that exceeds the facility's usual charge for cataract extraction and insertion of a conventional IOL following cataract surgery, as well as any fees that exceed the physician's usual charge to perform a cataract extraction with insertion of a conventional IOL.	X		X	X							
5527.6	Contractors shall remind physicians via the MLN Matters article that they can be reimbursed for the conventional or A-C IOL (V2632) only when the service is performed in a physician's office (POS = 11). When performing cataract surgery in an ASC or hospital outpatient setting, the physician shall only bill for the professional service because payment for the lens is bundled into the facility payment for the cataract extraction.	X			X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5527.7	A provider education article related to this instruction 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 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. 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. In addition, the entire instruction must be included in your next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X							

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):): Gift Tee at gift.tee@cms.hhs.gov , 410-786-0378;

Chuck Braver (payment policy) at chuck.braver@cms.hhs.gov , 410-786-6719;

Pat Gill (Part B Claims Processing) at patricia.gill@cms.hhs.gov , (410) 786-1297

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 (FIs) and Carriers:***

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. ***For Medicare Administrative Contractors (MAC):***

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). 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.

Medicare Claims Processing Manual

Chapter 32 – Billing Requirements for Special Services

Table of Contents

(Rev. 1228, 04-27-07)

120 - Presbyopia-Correcting (P-C IOLS) *and Astigmatism-Correcting Intraocular Lenses (A-C IOLs)* (General Policy Information)

120 - Presbyopia-Correcting (P-C IOLS) and *Astigmatism-Correcting Intraocular Lenses (A-C IOLs)* (General Policy Information)

(Rev. 1228; Issued: 04-27-07; Effective: 01-22-07; Implementation: 05-29-07)

Per CMS Ruling 05-01, issued May 3, 2005, Medicare will allow beneficiaries to pay additional charges associated with insertion of a P-C IOL following *cataract surgery.*

- Presbyopia is a type of age-associated refractive error that results in progressive loss of the focusing power of the lens of the eye, causing difficulty seeing objects at near distance, or close-up. Presbyopia occurs as the natural lens of the eye becomes thicker and less flexible with age.

- A presbyopia-correcting IOL is indicated for primary implantation in the capsular bag of the eye for the visual correction of aphakia (absence of the lens of the eye) following cataract extraction that is intended to provide near, intermediate and distance vision without the need for eyeglasses or contact lenses.

Per CMS-1536-Ruling, effective for services on and after January 22, 2007, Medicare will allow beneficiaries to pay additional charges (which are non-covered by Medicare as these additional charges are not part of a Medicare benefit category) for insertion of an A-C IOL.

- *Regular astigmatism is a visual condition where part of an image is blurred due to uneven corneal curvature. A normal cornea has the same curvature at all axes, whereas the curvature of an astigmatic cornea differs in two primary axes, resulting in vision that is distorted at all distances.*

- *The A-C IOL is intended to provide what is otherwise achieved by two separate items; an implantable conventional IOL (one that is not astigmatism-correcting) that is covered by Medicare, and the surgical correction, eyeglasses or contact lenses that are not covered by Medicare.*

A list of A-C IOLs and P-C IOLs can be accessed online at http://www.cms.hhs.gov/HospitalOutpatientPPS/01_overview.asp

120.1 - Payment for Services and Supplies

(Rev. 1228; Issued: 04-27-07; Effective: 01-22-07; Implementation: 05-29-07)

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. 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. 1228; Issued: 04-27-07; Effective: 01-22-07; Implementation: 05-29-07)

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, 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.)

When denying the non-payable charges submitted with 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.

120.3 - Provider Notification Requirements

(Rev. 1228; Issued: 04-27-07; Effective: 01-22-07; Implementation: 05-29-07)

When a beneficiary requests insertion of a *P-C or A-C IOL* instead of a conventional IOL following removal of a cataract:

- Prior to the procedure to remove a cataractous lens and insert a *P-C or A-C* lens, the facility and the physician must inform the beneficiary that Medicare will not make payment for services that are specific to the insertion, adjustment or other subsequent treatments related to the *P-C or A-C* functionality of the IOL.

- The *P-C or A-C* functionality of a *P-C or A-C* IOL does not fall into a Medicare benefit category, and, therefore, is not covered. Therefore, the facility and physician are not required to provide an Advanced Beneficiary Notice to beneficiaries who request a *P-C or A-C* IOL.

- Although not required, CMS strongly encourages facilities and physicians to issue a Notice of Exclusion from Medicare Benefits to beneficiaries in order to clearly identify the non-payable aspects of a *P-C or A-C* IOL insertion. This notice may be found in English at http:\\cms.hhs.gov/medicare/bni/20007_English.pdf

Spanish language at: http://cms.hhs.gov/medicare/bni/20007_Spanish.pdf.

120.4 - Beneficiary Liability

(Rev. 1228; Issued: 04-27-07; Effective: 01-22-07; Implementation: 05-29-07)

When a beneficiary requests insertion of a *P-C or A-C IOL* instead of a conventional IOL following removal of a cataract and that procedure is performed, the beneficiary is responsible for payment of facility and physician charges for services and supplies attributable to the *P-C or A-C* functionality of the *P-C or A-C* IOL:

- In determining the beneficiary's liability, the facility and physician may take into account any additional work and resources required for insertion, fitting, vision acuity testing, and monitoring of the *P-C or A-C* IOL that exceed the work and resources attributable to insertion of a conventional IOL.

- The physician and the facility may not charge for cataract extraction with insertion of a *P-C or A-C* IOL unless the beneficiary requests this service.

- The physician and the facility may not require the beneficiary to request a *P-C or A-C* IOL as a condition of performing a cataract extraction with IOL insertion.