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Note: This article was updated on August 27, 2012, to reflect current Web addresses. This article was also revised on April 10, 2008, to add a reference to MLN Matters article MM5853 (http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM5853.pdf), which provides instructions regarding the use of HCPCS Code V2787 when billing for intraocular lens procedures and services involving recognized A-C IOLs that take place in Ambulatory Surgery Centers (ASCs), Physician Offices, or Hospital Outpatient Departments (HOPDs). All other information is the same.

Instructions for Implementing the Centers for Medicare & Medicaid (CMS) Ruling CMS 1536-R; Astigmatism-Correcting Intraocular Lens (A-C IOLs)

Provider Types Affected

This article affects physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 5527 which discusses a recent Administrator Ruling from the Centers for Medicare & Medicaid Services (CMS) regarding astigmatism-correcting intraocular lenses (A-C IOLs) following cataract surgery (CMS-1536-R). The new policy is effective for dates of service on and after January 22, 2007. Physicians and providers need to be aware that effective 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 ambulatory surgery center (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.

In addition, CMS reminds physicians that they can be reimbursed for the conventional or A-C IOL (V2632) only when the service is performed in a physician's office. Also, when physicians perform cataract surgery in an ASC or hospital outpatient setting, the physician may only bill for the professional service because payment for the lens is bundled into the facility payment for the cataract extraction.

Background

The Centers for Medicare & Medicaid Services (CMS) Administrator rulings serve as 1) precedent final opinions and orders and 2) statements of policy and interpretation. The Administrator rulings 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. These rulings also promote consistency in interpretation of policy and adjudication of disputes, and they 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.

CR5527 discusses a recent CMS Administrator Ruling concerning requirements for determining payment for insertion of intraocular lenses (IOLs) that replace beneficiaries' natural lenses and correct pre-existing astigmatism following cataract surgery under the Social Security Act:

Note: CR5527 basically restates CMS policy provided in CR3927 (*MLN Matters* article MM3927), except that CR3927 focused on presbyopia-correcting IOLs and this article focuses on A-C IOLs.

Coverage Policy

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

- Fall within a statutorily-defined benefit category;
- Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part;
- Not be excluded from coverage.

The Social Security 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. In addition, there is no Medicare benefit category to allow payment for the surgical correction or cylindrical lenses of eyeglasses or contact lenses that may be required to compensate for the imperfect curvature of the cornea (astigmatism).

An 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.

Although A-C IOLs may serve the same function as eyeglasses or contact lenses furnished following removal of a cataract, A-C IOLs are neither eyeglasses nor contact lenses. The following table is a summary of benefits for which Medicare makes payment, and services for which Medicare does not pay (no benefit category):

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.

Benefits for Which Medicare Makes Payment	Services for Which Medicare Does NOT Pay – No Benefit Category
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 AC-IOL following cataract surgery that exceeds 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 AC-IOL (including subsequent monitoring services), that exceed the one-time eye examination following cataract surgery with insertion of a conventional IOL.

Currently, there is one NTIOL class approved for special payment when furnished by an ASC, and this currently active NTIOL category for "Reduced Spherical Aberration" was established on February 27, 2006 and expires on February 26, 2011.

Effective for services furnished on or after January 22, 2007, CMS now recognizes the following as A-C IOLs:

- Acrysof® Toric IOL (models: SN60T3, SN60T4, and SN60T5), manufactured by Alcon Laboratories, Inc; and
- Silicon 1P Toric IOL (models: AA4203TF and AA4203TL), manufactured by STAAR Surgical.

Payment Policy for Facility Services and Supplies

The following applies to an IOL inserted following removal of a cataract in a hospital (on either an outpatient or inpatient basis) that is paid under 1) the hospital Outpatient Prospective Payment System (OPPS) or 2) the Inpatient Prospective Payment System (IPPS), respectively (or in a Medicare-approved ASC that is paid under the ASC fee schedule):

- 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; and
- 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 an 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 should bill for removal of a cataract with insertion of a conventional IOL, regardless of whether a conventional or A-C IOL is inserted. When a beneficiary receives an A-C IOL following removal of a cataract, hospitals and ASCs should report the same CPT code that is used to report removal of a cataract with insertion of a conventional IOL (see "Coding" below);
- There is no Medicare benefit category that allows payment of facility charges for services and supplies required to insert and adjust an 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; and
- 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 AC-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

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.

For an A-C IOL inserted following removal of a cataract in a physician's office:

- A physician should bill for a conventional IOL, regardless of whether a conventional or A-C IOL is inserted (see "Coding," below);
- There is no Medicare benefit category that allows payment of physician charges for services and supplies required to insert and adjust an 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; and

- 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 AC-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.

For an A-C IOL inserted following removal of a cataract in a hospital or ASC:

- A physician may not bill Medicare for the A-C 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;
- There is no Medicare benefit category that allows payment of physician charges for services and supplies required to insert and adjust an A-C IOL following removal of a cataract that exceed physician charges for services and supplies required for the insertion of a conventional IOL; and
- 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 A-C 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

No new codes are being established at this time to identify an A-C IOL or procedures and services related to an A-C IOL, and hospitals, ASCs, and physicians should report one of the following CPT codes to bill Medicare for removal of a cataract with IOL insertion:

- CPT Code 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,
- CPT Code 66983 - Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure), or
- CPT Code 66984 - Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), ma manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification).

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

If appropriate, 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 a beneficiary requests insertion of an 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 charges for services and supplies attributable to the astigmatism-correcting functionality of the 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 AC-IOL that exceeds 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 an A-C IOL unless the beneficiary requests this service; and
- The physician and the facility may not require the beneficiary to request an A-C IOL as a condition of performing a cataract extraction with IOL insertion.

Provider Notification Requirements

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

- Prior to the procedure to remove a cataractous lens and insert an A-C IOL, 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.
- The correcting functionality of an 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 an 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 identify clearly the non-payable aspects of an A-C IOL insertion. This notice may be found on the CMS website at:

- http://www.cms.gov/Medicare/Medicare-General-Information/BNI/downloads/CMS20007English.pdf for the English language version and
- http://www.cms.gov/Medicare/Medicare-General-Information/BNI/downloads/CMS20007Spanish.pdf for the Spanish language version.

Additional Information

The official instruction, CR5527, issued to your Medicare Carrier, intermediary, and A/B MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1228CP.pdf on the CMS website.

If you have any questions, please contact your Medicare Carrier, intermediary, or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.