Medicare Learning Network
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Information for Medicare Fee-For-Service Health Care Professionals

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Instructions for Reporting New HCPCS Code V2788 for Presbyopia-Correcting Intraocular Lenses (PC-IOLs)

Note: This article was updated on February 25, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Physicians, providers, and suppliers billing Medicare carriers or fiscal intermediaries (FIs) for Intraocular Lenses (IOLs)

Provider Action Needed

This instruction provides guidance regarding the new Healthcare Common Procedure Coding System (HCPCS) code, V2788 (Presbyopia-correcting function of an intraocular lens). It is being established as a code for reporting non-covered charges associated with the insertion of a presbyopia-correcting lens.

Providers may report this code on claims to reflect the PC-IOL when inserted in lieu of the conventional IOL in conjunction with correcting cataract surgery. The new HCPCS code will be part of the annual HCPCs update and is not a payable service for Medicare on the HCPCS file for 2006.

Background

The Centers for Medicare & Medicaid Services (CMS) announce that Section 120 has been added to Publication 100-04, Chapter 32, which outlines general policy, payment, and billing procedures for PC-IOLs. Much of this information was previously released in Change Request 3927 in August, 2005.

A *MLN Matters* article (MM3927) on the subject can be viewed at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3927.pdf on the CMS website. As

stated in CR3927, the new coverage policy was effective for dates of service on and after May 3, 2005.

CR4184 provides a new HCPCS code, effective January 1, 2006, for reporting non-covered charges associated with the insertion of a presbyopia-correcting lens. That code is V2788. Medicare carriers and intermediaries will use an appropriate claim adjustment reason code such as 96 (non-covered charges) when denying non-covered PC-IOL charges. The carrier or intermediary will also send an appropriate message to the beneficiary via a Medicare Summary Notice to inform the beneficiary of the denial.

CPT Codes

Physicians and hospitals are to report one of the following Current Procedure Terminology (CPT) codes on these claims:

- 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.

Additional Information

For complete details, please see CR4184, the official instruction issued to your carrier or intermediary regarding this change, which may be found at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R801CP.pdf on the CMS website.

If you have any questions, please contact your Medicare carrier or intermediary 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.