



Related MLN Matters Article #: MM5527 **Revised**

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Related CR #: 5527

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

Key Words

MM5527, CR5527, R1228CP, MM5853, CR5853, CR3927, MM3927, A-C IOL, IOL, Astigmatism, Intraocular, Lens

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare Carriers, Fiscal Intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries

Note: MLN Matters article MM5527 was changed on April 10, 2008, to add a reference to MM5853 (<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5853.pdf>). MM5853 provides instructions regarding the use of Healthcare Common Procedure Coding System 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.

Key Points

- The effective date of the instruction is January 22, 2007.
- The implementation date is May 29, 2007.
- The Centers for Medicare & Medicaid Services (CMS) Administrator rulings serve as precedent final opinions and orders, and 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. 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.

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- Change Request (CR) 5527 discusses a recent CMS Administrator Ruling concerning requirements for determining payment for insertion of IOLs that replace beneficiaries' natural lenses and correct pre-existing astigmatism following cataract surgery under the Social Security Act.

Note: CR5527 restates CMS policy provided in CR3927, except that CR3927 focused on presbyopia-correcting IOLs and CR5527 (MLN Matters article MM5527) focuses on A-C IOLs. The related MLN Matters article MM3927 may be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm3927.pdf> on the CMS website.

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; and
 - 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.
- 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).
- 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 table on pages 3 and 4 of MM5527 is a summary of benefits for which Medicare makes payment, and services for which Medicare does not pay (no benefit category).
- Currently, there is one "new technology IOL" (NTIOL) class 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.
- 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

- **For an IOL** inserted following removal of a cataract in a hospital on an outpatient basis paid under the Outpatient Prospective Payment System (OPPS), or on an inpatient basis paid under the Inpatient Prospective Payment System (IPPS), 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 an outpatient basis paid under the OPPS, or on an inpatient basis paid under the IPPS, 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 Current Procedural Terminology (CPT) code that is used to report removal of a cataract with insertion of a conventional IOL (see Coding section 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 A-C-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 section," 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 A-C 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.
- 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), 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 A-C 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.
 - 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

- Physicians and facilities should be aware of the following 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; therefore, it 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 at:
 - <http://www.cms.hhs.gov/BNI/Downloads/CMS20007English.pdf> for the English language version and
 - <http://www.cms.hhs.gov/BNI/Downloads/CMS20007Spanish.pdf> for the Spanish language version on the CMS website.

Important Links

The related MLN Matters article can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5527.pdf> on the CMS website.

The official instruction (CR5527) regarding this change may be viewed at

<http://www.cms.gov/Transmittals/downloads/R1228CP.pdf> on the CMS website.