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REIMBURSEMENT FOR ADVANCED TECHNOLOGY IOLS

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1

QUESTION: What are advanced technology IOLs?

ANSWER: Following removal of a cataract, a surgeon implants an intraocular lens to replace the human crystalline lens. A conventional IOL is a monofocal lens designed to focus at just one of the following points: distance, midrange, or near. An advanced technology IOL (AT-IOL) has additional capabilities that correct astigmatism and/or presbyopia. CMS maintains a list of AT-IOLs[1] subject to Ruling 05-01 for presbyopia-correcting IOLs[2] and Ruling 1536-R for astigmatism-correcting IOLs.[3,4]

2

QUESTION: Who provides the AT-IOL?

ANSWER: For cataract surgery performed in a facility, either ambulatory surgery center or hospital outpatient department, the AT-IOL is purchased and provided by the facility. In the rare case when cataract surgery is performed in an office setting, the surgeon purchases and provides the AT-IOL.

3

QUESTION: Does CMS instruct providers how to charge for an AT-IOL or set limiting charges?

ANSWER: No. Recognizing that an AT-IOL has two ingredients, a covered portion to treat cataract and a noncovered portion to treat astigmatism and/or presbyopia, it is common practice to calculate the second portion as follows:

1. Average net purchase price of AT-IOL after discounts and rebates
   a. For astigmatism-correcting IOL
   b. For presbyopia-correcting IOL
   c. For combined AC/PC IOL
2. Plus (+) facility handling fee and taxes
3. Minus (-) average acquisition price of a conventional monofocal IOL

4

QUESTION: How is the upgrade lens charge for an AT-IOL reported on a claim?

ANSWER: On a CMS-1500 or CMS-1450 (UB-04) claim, use HCPCS code V2787, *astigmatism-correcting function of an IOL*, to report the noncovered charges for a toric IOL.[5] Use HCPCS code V2788, *presbyopia-correcting function of IOL,* to report the noncovered charges for an accommodating or multifocal IOL.[6] Also, use V2788 when the IOL has both functionalities because the astigmatism-correcting functionality is not reported separately on the claim but is treated as secondary to the presbyopia-correcting functionality.

On a CMS-1450 (UB-04) claim, use revenue code 276 on the line with V2787 or V2788, and also report V2632 for the conventional posterior chamber IOL with revenue code 276.[7]

For office-based surgery, report V2632 along with 6698X and V2787 or V2788.[8]

5

QUESTION: Is it necessary to segregate the facility charges from the surgeon's charges?

ANSWER: Where the facility and the surgeon belong to separate enterprises with separate provider numbers and tax identification numbers, funds should not be commingled. Each entity (*i.e.,* clinic and facility) should separate covered and noncovered charges for the patient and file its own claim. Typically, there are separate agreements with payors in these cases.

In the opposite case where there is a solitary provider number and tax identification number, review your contract terms with the payor since the same CPT code (*i.e.,* 66982 or 66984) is used by the facility and the surgeon.

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6 ***QUESTION:*** How should we tell beneficiaries about the noncovered charges associated with an AT-IOL?

ANSWER: Because noncovered items are the financial responsibility of the beneficiary, it is appropriate to notify the patient prior to surgery about the anticipated out-of-pocket expense and to collect payment in advance. A financial waiver can take several forms, depending on insurance.

- An Advance Beneficiary Notice of Non-coverage (ABN) is required for services where Part B Medicare coverage is ambiguous or doubtful, and may be useful where a service is never covered. You may collect your fee from the patient at the time of service or wait for a Medicare denial. If both the patient and Medicare pay, promptly refund the patient or show why Medicare paid in error.
- For Part C Medicare (Medicare Advantage), determination of benefits is required to identify beneficiary financial responsibility prior to performing noncovered services; MA Plans may have their own waiver forms.
- For non-Medicare insurance beneficiaries, a Notice of Exclusion from Health Plan Benefits (NEHB) is an alternative to an ABN.

This helps prevent misunderstandings and "buyer's remorse" afterwards. Separate financial waivers are used by the surgeon and the facility.

7 ***QUESTION:*** Which modifiers are used with claims for AT-IOLs?

ANSWER: Several modifiers apply depending on the payor and the circumstances: GA, GX, GY.[8] Use modifier -GX (*Notice of liability issued, voluntary under payer policy)* where there is a clear policy of noncoverage, as exists for Part B Medicare, and a voluntary financial waiver, such as an ABN, has been issued and the beneficiary requests that you submit a claim.

Use modifier -GY (*Item or service statutorily excluded or does not meet the definition of any Medicare benefit or, for non Medicare insurers, is not a contract benefit*) where there is a clear policy of noncoverage, as exists for Part B Medicare, and the beneficiary requests that you submit a claim.

Use modifier -GA (*Waiver of liability statement issued as required by payer policy*) where a financial waiver, such as an ABN, has been issued because you suspect that the item or service is not covered but need to file a claim to find out for sure.

8 ***QUESTION:*** Do all payers follow CMS' rulings for AT-IOLs?

ANSWER: No. While many do, some do not. Some payors cover the entire AT-IOL charge and the beneficiary has no financial responsibility. Check with the payor prior to providing any item or service.

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1 CMS website. AT-IOLs. Link here.
2 CMS Ruling 05-01. Link here.
3 CMS Ruling 1536-R. Link here.
4 MCPM Transmittal 1228. Link here.
5 V2787. Link here.
6 V2788. Link here.
7 MCPM Chapter 32, §120.2. Link here.
8 MCPM Transmittal 2148. Link here.

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