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Additional \$50 Payment for New Technology Intraocular Lenses (NTIOLs) Furnished in Ambulatory Surgical Centers (ASCs)

Note: This article was revised on May 4, 2006, to correct the citation to the SSA law applicable to this change. Also, language was added to show that any subsequent IOLs recognized by CMS as being a member of the reduced spherical aberration subset will receive the same payment adjustment effective upon CMS recognition and continuing for the balance of the 5-year period.

Provider Types Affected

Approved Ambulatory Surgery Centers (ASC) that bill Medicare for the insertion of new technology intraocular lenses (NTIOLs)

Provider Action Needed



STOP – Impact to You

Effective for dates of service on and after February 27, 2006, through February 26, 2011, Medicare will pay you an additional \$50 for NTIOLs that the Centers for Medicare & Medicaid Services (CMS) recognizes as Category 3 (Reduced Spherical Aberration).



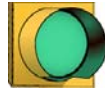
CAUTION – What You Need to Know

Your carrier will pay you an additional \$50 for the insertion of NTIOL Category 3; Advanced Medical Optics (AMO) Tecnis® IOL, model numbers Z9000, Z9001, and ZA9003 (characteristic: improved contrast sensitivity). In addition, any subsequent IOLs recognized by CMS as being a member of the reduced spherical aberration subset will receive the same payment adjustment effective upon CMS recognition and continuing for the balance of the 5-year period. Effective for all NTIOL Category 3 claims with dates of service on and after February 27, 2006, through

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February 26, 2011, Medicare-approved ASCs are eligible for the additional \$50 when billed using HCPCS code Q1003 along with procedure codes 66982, 66983, 66984, 66985, or 66986.



GO – What You Need to Do

Make sure that your billing staffs are aware of this additional NTIOL payment and the required HCPCS code Q1003.

Background

Section 141(b) of the Social Security Act Amendments of 1994 (SSAA 1994) requires that CMS establish a process for designating particular IOLs as “new technology,” and therefore eligible for additional payment. A final rule, published in the Federal Register (FR) on June 16, 1999 (64 FR 32198), established: (1) the process for adjusting payment amounts for NTIOLs that ASCs furnish; (2) an initial flat rate payment adjustment of \$50; and, (3) a 5-year payment adjustment period beginning when CMS recognizes the first of a new IOL subset or class.

CR4361, from which this article is taken, announces the approval of NTIOL Category 3 (as defined in the FR at 71 FR 4586, dated January 27, 2006) which applies to Advanced Medical Optics (AMO); Tecnis® IOL model numbers Z9000, Z9001, and ZA9003 (characteristic: improved contrast sensitivity). Additionally, any subsequent IOLs having the same characteristics as the first IOL recognized for payment will receive the same adjustment for the remainder of the 5-year period. This category and the associated \$50 NTIOL Medicare payment adjustment will expire on February 26, 2011.

The payment adjustment is allowed when Medicare-approved ASCs (place of service 24) insert a Category 3 NTIOLs and submit HCPCS code Q1003 (created for this purpose) on the same claim as the surgical insertion procedure (66982, 66983, 66984, 66985, or 66986). HCPCS code Q1003 is already established and listed in the HCPCS file, and the Medicare Claims Processing Manual, chapter 14, Sections 10.2 & 40.3, have been updated to reflect this change.

Additional Information

Please be aware that carriers will deny payment for Q1003 when submitted by ASCs not approved by Medicare. If denied, the carrier will use MSN 16.2 (This service cannot be paid when provided in this location/facility) and Claims Adjustment Reason Code 58 (Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service).

Carriers will return as unprocessable claims for NTIOLs with Q1003 alone or with a procedure code other than 66982, 66983, 66984, 66985, or 66986. When such

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claims are returned, use claim adjustment reason code 16 (Claim/service lacks information needed for adjudication. Additional information is supplied using remittance advice codes whenever appropriate), remittance advice remark code M67 (Missing/Incomplete/Invalid other procedure codes) and remark code MA130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information).

Further, they will deny payment if submitted for services rendered after the discontinued date (February 26, 2011). If denied, they will use MSN 21.11 (This service was not covered by Medicare at the time you received it) and Claims Adjustment Reason Code 27 (Expenses incurred after coverage terminated).

Lastly, contractors need not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors shall adjust claims brought to their attention with dates of service on and after February 27, 2006.

You can find more information about approval of the \$50 additional payment for NTIOL Category 3 by reviewing CR4361, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R914CP.pdf> on the CMS website. The revised Medicare Claims Processing Manual, Chapter 14 (Ambulatory Surgical Centers), Sections 10.2 (10.2 - Ambulatory Surgical Center Services on ASC List) and 40.3 (Payment for Intraocular Lens (IOL)) are attached to CR4361.

If you have any questions, please contact your carrier at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>

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