Coding for Cataract Surgery with Vision Correcting Intraocular Lenses

Question: The ophthalmologist performing cataract surgery at our OPPS facility uses special vision-correcting intraocular lenses (IOLs) and performs a Refractive analysis during the surgery to guide the adjustment of the new vision-correcting lens. Neither the vision-correcting lens nor the refraction are covered by insurance.

We have rolled the charges for both the refraction and the vision-correcting lens into the operating room revenue code 360 so the insurance can't identify these specifically to deny them. Is it appropriate to break these charges out and bill the patients separately, or should these special lens charges roll up into the surgical procedure charge to be billed to insurance?

Answer: The hospital should break out the non-covered charges on its claim. Furthermore, if the hospital reports a vision-correcting lens charge properly, Medicare and many insurers will cover a portion of the vision correcting lens charge. The refraction, however, is non-covered by Medicare and most medical insurers.

Here's an image of a correctly prepared outpatient hospital claim for a vision-correcting lens and a refraction. Note there are two charges for the IOL under revenue code 0276:

Claim Details

	PARA ID	Rev Code	HCPCS	HCPCS Desc	Mod 1	Mod 2	Units	Payment	Charges
1	29521422	0250					5		$466.62
2	29521422	0276	V2632	POSTERIOR CHAMBER INTRAOCULAR LENS			1		$466.90
3	29521422	0276	V2787	ASTIGMATISM CORRECTING FUNCTION OF INTRAOCULAR LENS	GY		1		$1,050.00
4	29521422	0360	66984	EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF INTRAOCULAR LENS P...	LT		1	$1,775.58	$6,954.00
5	29521422	0370					42		$840.00
6	29521422	0636	J2250	INJECTION, MIDAZOLAM HYDROCHLORIDE, PER 1 MG			1		$48.76
7	29521422	0636	J2405	INJECTION, ONDANSETRON HYDROCHLORIDE, PER 1 MG			4		$51.42
8	29521422	0636	J3010	INJECTION, FENTANYL CITRATE, 0.1 MG			1		$49.33
9	29521422	0710					12		$156.00
10	29521422	0920	92015	DETERMINATION OF REFRACTIVE STATE	GY		1		$200.00

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In this example, both lines under revenue code 0276 represent just one lens. The total charge for a vision correcting IOL is $1,516.90. The hospital broke that charge into two components -- the conventional IOL charge at $466.90, and the vision-correcting function at $1,050.00, for a total charge of $1,516.90. The covered and non-covered portions are reported separately.

Medicare covers a conventional IOL when it is medically necessary to restore the patients vision due to cataracts. However, Medicare does not cover the *function* of an IOL that corrects for presbyopia or astigmatism. Here's an excerpt from an MLN from page 5 February 2023 on "Medicare Vision Services":

> https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/visionservices_factsheet_icn907165.pdf
>
> "Cataract Removal & IOLs Billing Table 2 lists approved cataract removal and IOL insertion CPT and HCPCS codes. You must report the appropriate P-C or A-C IOLs code even though we don't cover that service part."

Note that last word in the excerpt: "part." The MLN isn't particularly clear, but Medicare will cover a portion of the vision correcting IOL that serves the same clinical rose of a conventional IOL without the vision correcting properties. The vision-correcting *function* of an IOL may be offered at the patient's option and at patient cost – but the patient should not have to pay the full cost of the vision-correcting IOL, because the basic conventional implant is covered by Medicare. If the patient opts to have the surgeon implant a vision-correcting IOL, the patient must pay for the incremental cost of the vision-correcting feature – but the cost of the basic IOL is covered and should be billed to insurance.

For the conventional IOL charge, most hospitals report V2632 for a posterior chamber intraocular lens:

> V2632 POSTERIOR CHAMBER INTRAOCULAR LENS

If the lens has vision-correcting properties, report V2787 or V2788 with the incremental additional charge for the vision-correcting function. Append modifier GY to the non-covered charge:

> V2787 ASTIGMATISM CORRECTING FUNCTION OF INTRAOCULAR LENS
>
> V2788 PRESBYOPIA CORRECTING FUNCTION OF INTRAOCULAR LENS
>
> GY- Item or service statutorily excluded or does not meet the definition of any Medicare benefit.

Since V2787 and V2788 are statutorily non-covered, Medicare will adjudicate the charge for those HCPCS to patient liability. The hospital should append a modifier GY to V2787 or V2788 to ensure that portion of the lens charge drops to patient liability.

Medicare adjudicated the example claim shown above as follows – note the "Non-Covered" column, which will drop to patient liability:

Line No	Rev Code	HCPCS	Mod	Units	Charge	M-care Pmt	Patient Coins	Patient Deductible	NONCVRD CHGS
1	0250			5	450.80	0.00	0.00	0.00	0.00
2	0276	V2632		1	466.90	0.00	0.00	0.00	0.00
3	0276	V2787	GY	1	1,050.00	0.00	0.00	0.00	1,050.00
4	0360	66984	RT	1	6,842.00	1,775.58	443.90	0.00	0.00
10	0920	92015	GY	1	200.00	0.00	0.00	0.00	200.00

Many hospitals bill vision correcting IOLs incorrectly. Some hospitals bill the entire charge for a vision correcting IOLs on one line with V2787 or V2788, and the entire charge is assigned to patient liability. That practice is non-compliant – and unfairly shifts a greater portion of the charge to the patient.

OPPS hospitals should always report the conventional IOL when billing for cataract surgery with a vision correcting lens. When Medicare undertakes rate-setting for total APC reimbursement, a portion of the reimbursement is attributed to the cost of the covered implant. By failing to report the conventional lens cost, Medicare's OPPS rate-setting data from claims will have less cost attributed to the covered IOL.

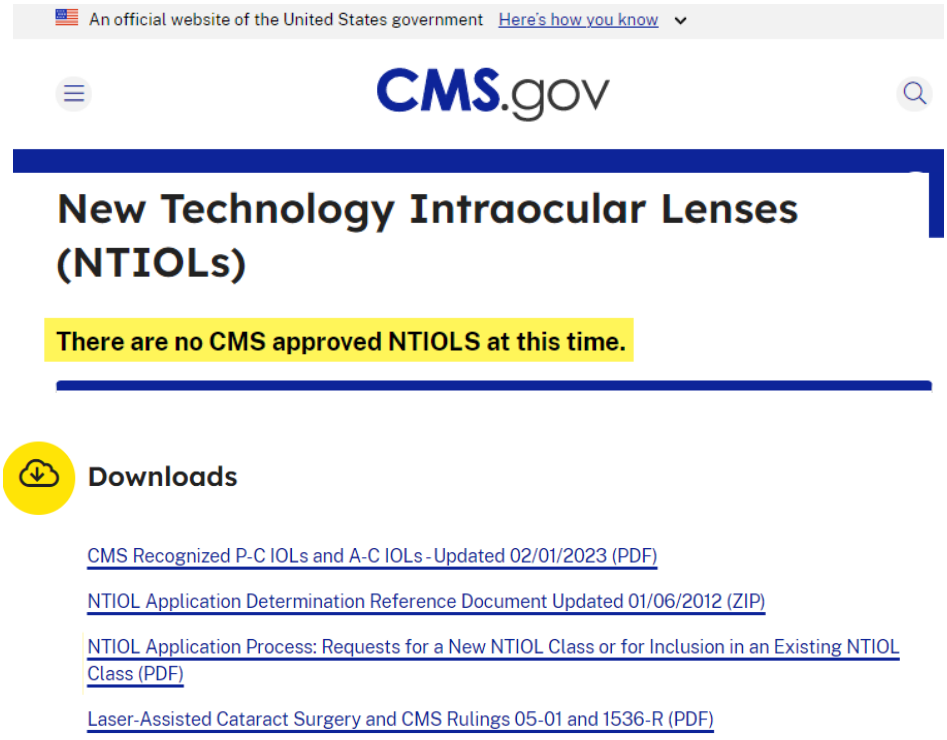
In 2023, Medicare OPPS files indicate that only 67.5% of all claims for CPT® 66984 also reported the conventional lens charge V2632 on the same claim. Since not all claims for 66984 reported a covered lens charge, we might surmise that the APC rate understated the implant cost by as much as 32.5%. Here's an excerpt from the 2023 OPPS Addendum P showing the portion of the total APC payment that is attributed, through rate-setting analysis, to the IOL:

HCPCS	Short Descriptor	SI	APC	Final CY 2023 APC Payment Rate	Device Offset Percentage	Device Offset Amount
66984	Xcapsl ctrc rmvl w/o ecp	J1	5491	$2,159.44	12.01%	$259.35

If all hospitals had reported the conventional IOL as appropriate, the total APC reimbursement might have been higher. The cost of a non-covered vision-correcting lens is not included in the APC rate-setting process.

Incidentally, some hospitals confuse a vision-correcting IOL with a "New Technology IOL" (NTIOL) – these are two different things. HCPCS C1780 – LENS, INTRAOCULAR (NEW TECHNOLOGY) is covered, but it is inaccurate. *There are **no** Medicare-approved NTIOLs*. Here's the CMS website that makes this clear, and also provides a download of the approved vision-correcting IOLs:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/NTIOLs



Finally, most hospitals have a policy that the incremental cost of a vision-correcting lens must be paid by the patient/guarantor in full prior to the eye surgery.

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