Program Memorandum
Carriers

Department of Health and Human Services (DHHS)

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal B-00-29 **Date: JUNE 2000**

CHANGE REQUEST 1202

SUBJECT: Correct Effective Date for Adjustment in Payment Amounts for New Technology Intraocular Lenses (NTIOLs) Furnished by Medicare Approved Ambulatory Surgical Centers (ASCs)

The purpose of this Program Memorandum (PM) is to announce the effective date for payment of NTIOLs. A notice was published in the May 3, 2000, ***Federal Register***. The effective date for payment for NTIOLs is for services on or after May 18, 2000.

Background on NTIOLs was provided in PM B-99-18, published in April 1999. Only two temporary procedure codes are effective for dates of service on or after May 18, 2000.

- Q1001 -- New Technology Intraocular Lens Category 1 as defined in ***Federal Register*** Notice, VOL 65, dated May 3, 2000.

- Q1002 -- New Technology Intraocular Lens Category 2 as defined in ***Federal Register*** Notice, VOL 65, dated May 3, 2000.

The above lenses are eligible for an additional payment of $50 when furnished by an ASC. The model for Q1001 is AMO Array Multifocal Model SA4ON, which is manufactured by Allergan. Q1002 lenses are manufactured by STAAR Surgical Company, and their characteristic is reduction in preexisting astigmatism. The model is an Elastic Ultraviolet-Absorbing Silcone Posterior Chamber. These are the only two NTIOLs that have been approved by HCFA for payment. As other manufacturers and models are approved, they will be announced in a ***Federal Register*** notice, and HCFA will then issue a PM. The above two Q codes are effective for 5 years (May 18, 2000 through May 18, 2005).

Carrier Billing Instructions and Provider Education

Instruct ASC facilities that in order to be paid the additional $50, they must bill using 2 line items on Form HCFA-1500. One line item must be for one of the following procedures: **66983, 66984, 66985, or 66986**, whichever appropriately describes the surgical insertion procedure that was performed. In addition, a second line item must show whichever Medicare approved NTIOL was furnished, either Q1001 or Q1002. The $50 payment is per lense. If a patient had the procedure in June on his/her left eye and then in November had the procedure done on the right eye, the ASC where the service was furnished would receive another $50 payment.

For the short period of time from May 18 until July 1, if you receive a claim for NTIOL that is not billed on the same claim as the surgery, check history for evidence of the surgery before paying the NTIOL. Until sufficient provider education is done on the correct billing for NTIOLs, separate claims for the surgery and lenses could possibly be submitted. If any carrier would need more time for provider education, you can request an extension beyond July 1 for enforcing the same claim billing requirement.

Coverage and payment is limited to Medicare approved NTIOLs (Q1001 or Q1002) furnished by a Medicare approved ASC. Therefore, claims for an NTIOL must indicate place of service (24) ASC as well as provider speciality (49).

Medicare Summary Notices (MSN)/Explanation of Your Medicare Benefits (EOMB)/Remittance Advice Messages.

If a claim is received by other than a Medicare approved ASC for an NTIOL, deny payment for the NTIOL.

- Use MSN 33.1, "The ambulatory surgical center must bill for this service." For those carriers still using EOMB, use 33.1, "The claim for Medicare benefits must be filed by the ambulatory surgical center."

- For the remittance advice, use existing American National Standard Institute (ANSI) X12-835 claim adjustment reason code B6, "This service/procedure is denied/reduced when performed/billed by this type of provider or by a provider of this speciality."

If a claim for an NTIOL lists a place of service other then ASC, deny payment for the NTIOL.

- Use MSN 16.2, "This service cannot be paid when provided in this location/facility." or EOMB 16.4, "Medicare does not pay for this in the place or facility where you received it."

- For remittance advice, use existing ANSI X12-835 claim adjustment reason code 58, "Claim/service denied/reduced because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service."

If a claim for an NTIOL is billed for a date of service past the discontinued date (after the 5-year period), deny payment for the NTIOL.

- Use MSN 21.11, "This service was not covered by Medicare at the time you received it." or EOMB 21.31, "This service was not covered by Medicare at the time you received it."

- For the remittance advice, use existing ANSI X12-835 claim adjustment reason code 27, "Expenses incurred after coverage terminated."

If a claim is submitted containing only Q1001 or Q1002, the claim is incomplete and must be returned as unprocessable. Use the appropriate MIA/MOA codes. For example, M67 along with MA130.

The *effective date* for this PM is May 18, 2000.

The *implementation date* for this PM is July 1, 2000.

Contractors must be able to process these claims by no later then July 1, 2000. Claims for dates of service on or after May 18 may be held until your system is ready to accept these services.

These instructions should be implemented within your current operating budget.

This PM may be discarded after August 31, 2001.

If you have any questions, contact your regional office. Regional office staff can direct their questions to Patricia Gill on 410-786-1297.