

FUTURE DRAFT Local Coverage Determination (LCD) for Cataract Surgery (DL32379)

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Please note: This is a Future Draft LCD.

Contractor Information

Contractor Name

Palmetto GBA

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Contractor Number

11202

Contractor Type

MAC - Part B

LCD Information

Document Information

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LCD ID Number

DL32379

LCD Title

Cataract Surgery

Contractor's Determination Number

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Primary Geographic Jurisdiction

South Carolina

Oversight Region

Region IV

Original Determination Effective Date

For services performed on or after 03/05/2012

Original Determination Ending Date

Revision Effective Date

For services performed on or after 03/05/2012

Revision Ending Date

CMS National Coverage Policy

Title XVIII of the Social Security Act §1862(a)(7) excludes routine physical examinations.

Title XVIII of the Social Security Act, §1862 (a)(1)(A) allows coverage and payment for only those services that are considered to be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Title XVIII of the Social Security Act, §1833(e) prohibits Medicare Payment for any claim which lacks the necessary information to process the claim.

Code of Federal Regulations 42 CFR CH IV [411.15(b)(2)&(3)and(o)(1)&(2)] Services excluded from coverage

Code of Federal Regulations 42 CFR CH IV [416.65] Covered surgical procedures

CMS Manual System, Pub 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Part 1, §80.10, Phaco-Emulsification Procedure-Cataract Extraction

CMS Manual System, Pub 100-04, Medicare Claims Processing Manual, Chapter 12, §40.6 Claims for Multiple Surgeries and §40.7 Claims for Bilateral Surgeries

Indications and Limitations of Coverage and/or Medical Necessity

Cataract is defined as an opacity or loss of optical clarity of the crystalline lens. Cataract development follows a continuum extending from minimal changes in the crystalline lens to the extreme stage of total opacity. Cataracts may be due to a variety of causes. Age-related cataract (senile cataract) is the most common type found in adults. Other types are pediatric (both congenital and acquired), traumatic, toxic and secondary (meaning the result of another disease process) cataract.

Most cataracts are not visible to the naked eye until they become dense enough (mature or hypermature) to cause blindness. However, a cataract at any stage of development can be observed through a sufficiently dilated pupil using a slit lamp biomicroscope. In settings where this instrument is unavailable (e.g. skilled nursing facility), a direct ophthalmoscope can be used to assess the degree to which the fundus reflectivity (red reflex) is impaired by the ocular media. There is no scientifically proven medical treatment for cataracts.

In general, cataract surgery is performed to alleviate visual impairments attributable to lens opacity. There are uncommon situations when lens extraction becomes medically necessary for anatomic rather than optical reasons. These include lens induced angle closure (e.g., microspherophakia) and lens subluxation (e.g. Marfan syndrome). In other situations, cataract extraction might be medically indicated with relatively less opacity because of intolerable optical imbalance. Most commonly, this would be due to surgically induced anisometropia (a significant difference in refractive errors between the eyes) or aniseikonia (a difference in magnification as a result of prior lens extraction in the one eye). Some patients may elect lens removal and replacement primarily for refractive benefits to reduce their dependence on spectacles. Such elective procedures are not medically necessary and are called "refractive lens exchanges" to distinguish them from medically indicated cataract surgery. Finally, advanced cataracts may need to be removed to properly visualize, treat, and monitor retinal disease, apart from the patient's visual symptoms and potential.

This policy statement defines the medical necessity for cataract and other lens extraction in adults, and specifies the required documentation of the preoperative evaluation necessary to justify the procedure. Palmetto GBA encourages but does not require providers to use the framework of the International Classification of Functioning, Disability, and Health (ICF) to organize the information related to relevant structural/functional impairments, activity limitations and/or participation restrictions, and any environmental factors influencing the decision to recommend cataract surgery.

MEDICAL NECESSITY

Lens extraction is considered medically necessary and therefore covered by Medicare when one (or more) of the following conditions or circumstances exists:

1. Cataract causing symptomatic (i.e., causing the patient to seek medical attention) impairment of visual function not correctable with a tolerable change in glasses or contact lenses resulting in specific activity limitations and/or participation restrictions including, but not limited to reading, viewing television, driving, or meeting vocational or recreational needs
2. Concomitant intraocular disease (e.g., diabetic retinopathy or intraocular tumor) requiring monitoring or treatment that is prevented by the presence of cataract
3. Lens-induced disease threatening vision or ocular health (including, but not limited to, phacomorphic or phacolytic glaucoma)
4. High probability of accelerating cataract development as a result of a concomitant or subsequent procedure (e.g., pars plana vitrectomy, iridocyclectomy, procedure for ocular trauma) and treatments such as external beam irradiation
5. Cataract interfering with the performance of vitreoretinal surgery
6. Intolerable anisometropia or aniseikonia uncorrectable with glasses or contact lenses exists as a result of lens extraction in the first eye (despite satisfactorily corrected monocular visual acuity)

Any circumstances not listed will be considered based on the standard of care and other factors related to medical necessity.

Surgery is not deemed to be medically necessary purely on the basis of lens opacity in the absence of symptoms.

Visual Acuity

The Snellen visual acuity chart is an excellent way of measuring distance refractive error (e.g. myopia, hyperopia, astigmatism) in healthy eyes, and is in wide clinical use. However, testing only with high contrast letters viewed in dark room conditions will underestimate the functional impairments caused by some cataracts in common real-life situations such as day or nighttime glare conditions, poor contrast environments or reading, halos and starbursts at night, and impaired optical quality causing monocular diplopia and ghosting.

While a single arbitrary objective measure might be desirable a specific Snellen visual acuity alone can neither rule in nor rule out the need for surgery. It should be recorded and considered in the context of the patient's visual impairment and other ocular findings.

Second Eye Surgery

Should a significant cataract also be present in the second eye, as supported by *Cataract in the Adult Eye, Preferred Practice Pattern* by the American Academy of Ophthalmology, except in special circumstances, surgery is generally not performed in both eyes at the same time because of the potential for bilateral visual loss.

In the more common situation where surgery is performed sequentially in the other eye on separate days for bilateral visually symptomatic cataracts the appropriate interval between the first-eye surgery and second-eye surgery is influenced by several factors:

1. The patient's visual needs
2. The patient's preferences
3. Visual function in the second eye
4. The medical and refractive stability of the first eye
5. The need to restore binocular vision and resolve anisometropia
6. An adequate interval of time has elapsed to evaluate and treat early postoperative complications in first eye, such as endophthalmitis; and/or
7. Logistical and travel considerations of the patient.

The patient and the ophthalmologist should discuss the benefits, risks, need, and timing of second-eye surgery when they have had the opportunity to evaluate the results of surgery on the first eye, taking into account the above factors.

If the decision to perform cataract extraction in both eyes is made prior to the first (sequential) cataract extraction, the documentation must support the medical necessity for each procedure to be performed.

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Coding Information

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Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

012x	Hospital Inpatient (Medicare Part B only)
013x	Hospital Outpatient
085x	Critical Access Hospital

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

0360	Operating Room Services - General Classification
0361	Operating Room Services - Minor Surgery
0490	Ambulatory Surgical Care - General Classification

**CPT/HCPCS Codes
GroupName**

66830	REMOVAL OF SECONDARY MEMBRANOUS CATARACT (OPACIFIED POSTERIOR LENS CAPSULE AND/OR ANTERIOR HYALOID) WITH CORNEO-SCLERAL SECTION, WITH OR WITHOUT IRIDECTOMY (IRIDOCAPSULOTOMY, IRIDOCAPSULECTOMY)
66840	REMOVAL OF LENS MATERIAL; ASPIRATION TECHNIQUE, 1 OR MORE STAGES
66850	REMOVAL OF LENS MATERIAL; PHACOFRAGMENTATION TECHNIQUE (MECHANICAL OR ULTRASONIC) (EG, PHACOEMULSIFICATION), WITH ASPIRATION
66852	REMOVAL OF LENS MATERIAL; PARS PLANA APPROACH, WITH OR WITHOUT VITRECTOMY
66920	REMOVAL OF LENS MATERIAL; INTRACAPSULAR
66940	REMOVAL OF LENS MATERIAL; EXTRACAPSULAR (OTHER THAN 66840, 66850, 66852)
66982	EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF INTRAOCULAR LENS PROSTHESIS (1-STAGE PROCEDURE), MANUAL OR MECHANICAL TECHNIQUE (EG, IRRIGATION AND ASPIRATION OR PHACOEMULSIFICATION), COMPLEX, REQUIRING DEVICES OR TECHNIQUES NOT GENERALLY USED IN ROUTINE CATARACT SURGERY (EG, IRIS EXPANSION DEVICE, SUTURE SUPPORT FOR INTRAOCULAR LENS, OR PRIMARY POSTERIOR CAPSULORRHESIS) OR PERFORMED ON PATIENTS IN THE AMBLYOGENIC DEVELOPMENTAL STAGE
66983	INTRACAPSULAR CATARACT EXTRACTION WITH INSERTION OF INTRAOCULAR LENS PROSTHESIS (1 STAGE PROCEDURE)
66984	EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF INTRAOCULAR LENS PROSTHESIS (1 STAGE PROCEDURE), MANUAL OR MECHANICAL TECHNIQUE (EG, IRRIGATION AND ASPIRATION OR PHACOEMULSIFICATION)

ICD-9 Codes that Support Medical Necessity

365.51	PHACOLYTIC GLAUCOMA
366.00	NONSENILE CATARACT UNSPECIFIED
366.01	ANTERIOR SUBCAPSULAR POLAR NONSENILE CATARACT
366.02	POSTERIOR SUBCAPSULAR POLAR NONSENILE CATARACT

366.03	CORTICAL LAMELLAR OR ZONULAR NONSENILE CATARACT
366.04	NUCLEAR NONSENILE CATARACT
366.09	OTHER AND COMBINED FORMS OF NONSENILE CATARACT
366.10	SENILE CATARACT UNSPECIFIED
366.11	PSEUDOEXFOLIATION OF LENS CAPSULE
366.12	INCIPIENT SENILE CATARACT
366.13	ANTERIOR SUBCAPSULAR POLAR SENILE CATARACT
366.14	POSTERIOR SUBCAPSULAR POLAR SENILE CATARACT
366.15	CORTICAL SENILE CATARACT
366.16	SENILE NUCLEAR SCLEROSIS
366.17	TOTAL OR MATURE CATARACT
366.18	HYPERMATURE CATARACT
366.19	OTHER AND COMBINED FORMS OF SENILE CATARACT
366.20	TRAUMATIC CATARACT UNSPECIFIED
366.21	LOCALIZED TRAUMATIC OPACITIES
366.22	TOTAL TRAUMATIC CATARACT
366.23	PARTIALLY RESOLVED TRAUMATIC CATARACT
366.30	CATARACTA COMPLICATA UNSPECIFIED
366.31	CATARACT SECONDARY TO GLAUCOMATOUS FLECKS (SUBCAPSULAR)
366.32	CATARACT IN INFLAMMATORY OCULAR DISORDERS
366.33	CATARACT WITH OCULAR NEOVASCULARIZATION
366.34	CATARACT IN DEGENERATIVE OCULAR DISORDERS
366.41	DIABETIC CATARACT
366.42	TETANIC CATARACT
366.43	MYOTONIC CATARACT
366.44	CATARACT ASSOCIATED WITH OTHER SYNDROMES
366.45	TOXIC CATARACT
366.46	CATARACT ASSOCIATED WITH RADIATION AND OTHER PHYSICAL INFLUENCES
366.50	AFTER-CATARACT UNSPECIFIED
366.51	SOEMMERING'S RING
366.52	OTHER AFTER-CATARACT NOT OBSCURING VISION
366.53	AFTER-CATARACT OBSCURING VISION
366.8	OTHER CATARACT
366.9	UNSPECIFIED CATARACT
379.32	SUBLUXATION OF LENS
379.33	ANTERIOR DISLOCATION OF LENS
379.34	POSTERIOR DISLOCATION OF LENS
743.30	CONGENITAL CATARACT UNSPECIFIED
743.31	CONGENITAL CAPSULAR AND SUBCAPSULAR CATARACT
743.32	CONGENITAL CORTICAL AND ZONULAR CATARACT
743.33	CONGENITAL NUCLEAR CATARACT
743.34	CONGENITAL TOTAL AND SUBTOTAL CATARACT
743.36	CONGENITAL ANOMALIES OF LENS SHAPE
743.37	CONGENITAL ECTOPIC LENS
743.39	OTHER CONGENITAL CATARACT AND LENS ANOMALIES
998.82	CATARACT FRAGMENTS IN EYE FOLLOWING CATARACT SURGERY

Diagnoses that Support Medical Necessity

N/A

ICD-9 Codes that DO NOT Support Medical Necessity

N/A

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

N/A

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General Information

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Documentations Requirements

The following documentation must be present in the medical chart:

For Visually-Symptomatic Cataract:

- A statement indicating that specific symptomatic (i.e., causing the patient to seek medical attention) impairment of visual function resulting in specific activity limitations and/or participation restrictions. Such activities would typically include, but are not limited to, reading, viewing television, driving, or meeting vocational or recreational expectations. The patient's own words should be included in the statement where possible.
- A statement or measurements indicating that the patient's impairment of visual function is believed not to be correctable with a tolerable change in glasses or contact lenses.

A best-corrected Snellen visual acuity at distance (and near if the primary visual impairment is at near) as determined by a careful refraction under standard testing conditions as appropriate must be recorded to establish this fact. Neither uncorrected visual acuity nor corrected acuity with the patient's current prescription will satisfy this requirement. The refraction may be performed by the surgeon or by suitably trained staff in the surgeon's practice as permitted by law.

As indicated above, a specific Snellen visual acuity alone can neither rule in nor rule out the need for surgery, but should be considered in the context of the patient's visual impairment and other ocular findings.

The degree of lens opacity should correlate with the impairment of corrected visual acuity when cataract is the primary cause of visual compromise.

- When one or more concomitant ocular diseases are present that potentially affect visual function (e.g., macular degeneration or diabetic retinopathy), the medical record should indicate that cataract is believed to be significantly contributing to the patient's visual impairment.
- A statement that the patient desires surgical correction, that the risks, benefits, and alternatives have been explained, and that a reasonable expectation exists that lens surgery will significantly improve both the visual and functional status of the patient.

Other types of Cataract:

- A statement indicating that the appropriate medical condition or circumstance exists and the specific reason for surgical intervention (e.g., "Cataract surgery is being performed to establish clear media for the treatment [or monitoring] of diabetic retinopathy").
- A statement that the patient desires surgical correction, that the risks, benefits, and alternatives have been explained, and that the patient understands that the surgery is being done to address the medical condition or circumstance. If vision is specifically not expected to improve, the statement should include the patient's understanding of that fact.

All types of Cataract:

- An appropriate preoperative ophthalmologic evaluation, which generally includes a comprehensive ophthalmologic exam (or its equivalent components occurring over a series of visits). Certain examination components may be appropriately excluded based on the specific condition and/or urgency of surgical intervention.
- Ancillary testing as appropriate in the establishment or exclusion of medical necessity. This should be directed by specific patient complaint or symptom where possible.

For example (other reasonable examples are possible):

1. Glare testing/brightness acuity testing reducing corrected visual acuity combined with a complaint of difficulty driving at night might support medical necessity.
2. Corrected Snellen visual acuity testing under low-contrast conditions or formal contrast sensitivity testing that uncover or demonstrate functional impairments correlated with the patient's symptoms might support medical necessity.
3. B-scan ultrasound testing demonstrating a total retinal detachment in the presence of "no light perception" vision and a cataract obscuring the view of the inside of the eye would likely not support medical necessity in the circumstance of "visually symptomatic" cataract.

For circumstances where the placement of an intraocular lens (IOL) is anticipated, A-scan ultrasound testing or partial coherence interferometry, keratometry (may be from corneal topography), and IOL calculations and selection should be recorded. Ophthalmic biometry for lens power calculation should not be performed unless a decision to remove the cataract has been made by the patient and the surgeon. If an optometrist or an ophthalmologist who is not the surgeon performs the biometry, he/she should do so in coordination with the operating surgeon so that only one procedure is necessary. If biometry is repeated by the operating surgeon due to inadequacy of the first study, the original eye care physician/provider should anticipate not being reimbursed for the study.

For circumstances where an adequate view of the intraocular structures cannot be obtained because of dense cataract, B-scan ultrasound testing should be considered to assess such structures for the purpose of surgical decision-making. B-scans performed without documented evidence of a dense cataract or evidence that the cataract precluded visualization of the posterior segment of the eye including the vitreous and/or retina will be considered not medically necessary.

The following ancillary tests are not routinely indicated in the preoperative workup for cataract surgery, and if performed, will not be considered a covered benefit unless medical necessity is defended by a statement in the patient's record:

- Potential vision testing
- Corneal Topography
- Anterior or Posterior Segment Ocular Coherence Tomography
- Formal visual fields
- Fluorescein angiography
- External photography
- Corneal pachymetry/Specular microscopy
- Specialized color vision testing
- Electrophysiologic testing

In general, any performed ancillary testing must be conducted so as not to deliberately bias the decision toward the performance of surgery (e.g., glare testing done on abnormally high settings inconsistent with the instructions of the testing device's manufacturer, etc.).

Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available to the A/B MAC upon request.

Appendices N/A

Utilization Guidelines N/A

Sources of Information and Basis for Decision

American Academy of Ophthalmology. *Cataract in the Adult Eye. Preferred Practice Pattern*. San Francisco. American Academy of Ophthalmology, 2006. Available at: http://one.aao.org/CE/PracticeGuidelines/PPP_Content.aspx. Accessed June 30, 2011.

Gayer S, Zuleta J. Perioperative Management of the Elderly Undergoing Eye Surgery. *Clinics in Geriatric Medicine*. 2008;24(4):687-700.

Yanoff M, Duker JS. *Yanoff & Duker:Ophthalmology*. 3rd ed. Mosby, An Imprint of Elsevier. 2008.

American Academy of Ophthalmology, American Society of Cataract and Refractive Surgery, et al. Utilization, Appropriate Care, and Quality of Life for Patients with Cataracts. *Ophthalmology*. 2006;113(10):1878-1882. **Advisory Committee Meeting Notes** This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which include representatives from the affected provider community.

Contractor Advisory Committee meeting dates:

South Carolina -11/28/2011
North Carolina -11/29/2011
Virginia -11/30/2011

Start Date of Comment Period 11/28/2011

End Date of Comment Period

Start Date of Notice Period

Revision History Number Draft

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Reason for Change

Related Documents

This LCD has no Related Documents.

LCD Attachments

There are no attachments for this LCD.

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All Versions

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