

Contractor's Policy Number

03-07

Contractor's Name

CareFirst of Maryland Inc., Medicare Part A

Contractor Number

00190

Contractor Type

Fiscal Intermediary

LMRP Title

Cataract Extraction

AMA CPT Copyright Statement

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CMS National Coverage Policy

- Establishment of national policy supersedes all previous contractor policy statements, including Local Medical Policy coverage guidelines
- Title XVIII of the Social Security Act, section 1862 (a) (7). This section excludes routine physical examinations.
- Title XVIII of the Social Security Act, section 1862 (a) (1) (A). This section allows coverage and payment for only those services that are considered to be medically 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, Section 1833(e). This section prohibits Medicare payment for any claim that lacks the necessary information to process the claim.
- Coverage Issues Manual CMS Pub 6. §35-9, Phaco-emulsification Procedure-Cataract Extraction
- Coverage Issues Manual CMS Pub 6. §50-38, Endothelial Cell Photography.

Primary Geographic Jurisdiction

Maryland

Washington, DC

Secondary Geographic Jurisdiction

Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, Washington state, and Wyoming

CMS Region

Region III

CMS Consortium

Northeast

Original Policy Effective Date

09/29/2003

Original Policy Ending Date

Revision Effective Date

Revision Ending Date

LMRP Description

This policy defines the medical necessity for cataract extraction and describes the preoperative evaluation of a patient necessary to justify the performance of cataract extraction for Medicare coverage. It addresses the following four components:

- determination of visual functional status,
- visual impairment,
- patient informed consent, and;
- preoperative ophthalmologic testing and medical assessment.

This policy also includes the code for complex cataract surgery, which is intended to differentiate the extraordinary work performed during the intraoperative or postoperative periods in a subset of cataract operations.

Indications and Limitations of Coverage and/or Medical Necessity

Medicare coverage for cataract extraction with intraocular lens implant is based on services that are reasonable and medically necessary for the treatment of beneficiaries who have a cataract, and who **meet all of the following criteria:**

- The patient has undergone a standardized formal measure of his/her visual functional status, the results of which suggest that the patient's visual functional status can be improved commensurate with the risk of surgery by undergoing cataract extraction with intraocular lens implant. Such testing can be performed with standardized measurement tools, such as the Activities of Daily Vision Scale or the VF 14,
- The patient has impairment of visual function due to cataract(s) resulting in:
 - decreased ability to carry out activities of daily living such as reading, viewing television, driving, or meeting occupational or avocational expectations,
 - Snellen visual acuity testing of 20/50 or worse. Not all patients with visual acuity of 20/50 or worse require cataract surgery because:
 - they are able to satisfactorily carry out their activities of daily living with changes in eyeglasses, lighting, or other non-operative means,
 - the operative risk is not commensurate with the potential benefit to the patient, and;
 - other eye disease such as macular degeneration or diabetic retinopathy rather than cataract is the limiting factor of visual function.

Generally, patients with visual acuity 20/40 or better do not require cataract surgery to improve their ability to carry out activities of daily living. However, glare or other environmental factors may adversely affect some patients' activities of daily living because a cataract is present and significantly diminishes function, even with Snellen acuity of 20/40 or better.

- The patient has been educated about the risks and benefits of cataract surgery and the alternative to surgery, and has provided informed consent,
- The patient has undergone an appropriate preoperative ophthalmologic evaluation, which generally includes a comprehensive ophthalmologic exam and an A-scan ultrasound. Other ophthalmologic studies should be reserved for special situations, such as:

- glare testing for patient with cataracts who complain of glare, yet measure good Snellen acuity in testing circumstances of an office, and;
- B-scan for patients with dense cataracts which preclude visualization of the posterior segment of the eye including the vitreous and/or retina, but not limited to these.

Note: Routine preoperative screening without substantiated signs or symptoms of disease is not a covered service under Medicare. When the only diagnosis is a cataract (s), Medicare does not cover testing other than one comprehensive eye examination (or a combination of brief/intermediate examinations not to exceed the charge of a comprehensive examination) plus an appropriate ultrasound scan.

The goals of the physical exam of a patient whose chief complaint might be related to a cataract are:

- to diagnose or confirm the presence of a cataract,
- to confirm that the cataract is a significant factor related to the visual impairment and symptoms described by the patient, and;
- to exclude or identify other ocular or systemic conditions that might contribute to the patient's visual impairment or affect the surgical plan or ultimate outcome.

The ophthalmic examination should include the following components:

- patient history (including patient's assessment of functional status),
- Snellen acuity and refraction,
- measurement of intraocular pressure,
- assessment of pupillary function,
- examination of ocular motility,
- external examination,

- undilated and dilated slit-lamp examination (unless dilation is contraindicated by the anatomy of the eye), and;
- dilated examination of the fundus (unless contraindicated by the anatomy of the eye).

The maximum appropriate interval between the preoperative examination and the date of surgery is three months, in case there are significant changes in the patient's health or vision. Patients should be educated to contact the ophthalmologist if they have a change in visual symptoms during the interval between the examination and surgery.

The following tests are generally not indicated in the preoperative workup for cataract surgery. If performed, the indications for their use must be documented in the patient's medical record:

- contrast sensitivity testing,
- potential vision testing,
- formal visual fields,
- fluorescein angiography,
- external photography,
- corneal pachymetry/specular microscopy,
- specialized color vision tests, and;
- electrophysiologic tests.

It is not medically necessary to perform bilateral cataract extractions the same day.

The following are contraindications to surgery for visually impairing cataract:

- Glasses or visual aids provide satisfactory functional vision,
- The patient's lifestyle is not compromised by the cataract,
- The patient is unable to undergo surgery because of coexisting medical or ocular conditions,
- The patient does not desire surgery,

- Surgery will not improve visual function, or;
- A legal consent cannot be obtained.

There are several indications and limitations for the use of the 66982 for complex cataract surgery.

- A miotic pupil that will not dilate sufficiently to allow adequate visualization of the lens in the posterior chamber of the eye and that requires the insertion of four iris retractors through four additional incisions, the use of the Beehler expansion device, a sector iridectomy with subsequent suture repair of iris sphincter, or sphincterotomies created with scissors.
- The presence of a disease state that produces lens support structures that are abnormally weak or absent. This requires the need to support the lens implant with permanent intraocular sutures, or alternatively, a capsular support ring may be necessary to allow placement of an intraocular lens. At this time, the FDA has not approved the use of capsular support rings.
- Pediatric cataract surgery, which may be more difficult intraoperatively because of an anterior capsule that is more difficult to tear, a cortex that is more difficult to remove, and the need for a primary posterior capsulotomy or capsulorhexis. Also, there is additional postoperative work associated with pediatric cataract surgery.
- Extraordinary work that may occur during the postoperative period. This is the case with pediatric cases mentioned above and very rarely, when there is extreme postoperative inflammation and pain.
- Mature cataract requiring dye for visualization of capsulorhexis

CPT/HCPCS Section & Benefit Category

Surgery/Ophthalmology

Type of Bill Code

13X, 83X

Revenue Codes

036X, 049X

CPT/HCPCS Codes

The AMA and CMS require the use of short descriptors for policies published on the Web. Refer to the CPT book for the long description of the following codes:

- 66840© Removal of lens material
- 66850© Removal of lens material
- 66852© Removal of lens material
- 66920© Extraction of lens
- 66940© Extraction of lens
- 66982© Cataract surgery, complex
- 66983© Cataract surg with iol, 1 stage
- 66984© Cataract surg with iol, 1 stage

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Not Otherwise Classified (NOC)

ICD-9 Codes that Support Medical Necessity

ICD-9-CM code listings may cover a range and include truncated codes. It is the provider's responsibility to avoid truncated codes by selecting a code(s) carried out to the highest level of specificity and selected from the ICD-9-CM book appropriate to the year in which the claim is submitted.

It is not enough to link the procedure code to a correct, payable ICD-9-CM code. The diagnosis or clinical suspicion must be present for the procedure to be paid.

Medicare is establishing the following limited coverage for **66840, 66850, 66852, 66920, 66940, 66983, and 66984**:

Covered for:

365.51	Phacolytic glaucoma
366.00	Nonsenile cataract, unspecified
366.01	Anterior subcapsular polar cataract
366.02	Posterior subcapsular polar
366.03	Cortical, lamellar, or zonular cataract
366.04	Nuclear cataract
366.09	Other and combined forms of non-senile cataract
366.10	Senile cataract, unspecified
366.11	Pseudoexfoliation of lens capsule
366.12	Incipient cataract
366.13	Anterior subcapsular polar senile cataract
366.14	Posterior subcapsular polar senile cataract
366.15	Cortical senile cataract
366.16	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	Cataracts complicata, unspecified
366.31	Glaucomatous flecks (subcapsular)
366.32	Cataract in inflammatory disorders
366.33	Cataract with neovascularization
366.34	Cataract secondary to ocular disorders

- 366.41 Cataract associated with other disorders, 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 other disorders
- 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
- 998.82 Cataract fragments in eye following cataract surgery

Medicare is establishing the following limited coverage for **66982**:

- 364.23 Lens induced iridocyclitis
- 364.51 Essential or progressive iris atrophy
- 364.55 Miotic cysts of the pupillary margin
- 364.57 Degenerative changes of the ciliary body
- 364.59 Other iris atrophy
- 364.75 Pupillary abnormalities
- 364.76 Iridodialysis
- 364.8 Other disorders of iris and ciliary body
- 364.9 Unspecified disorder of iris and ciliary body
- 366.00 Non-senile cataract, unspecified
- 366.01 Anterior subcapsular polar cataract
- 366.02 Posterior subcapsular polar cataract
- 366.03 Cortical, lamellar, or zonular cataract
- 366.04 Nuclear cataract
- 366.09 Other and combined forms of nonsenile cataract

- 366.10 Senile cataract, unspecified
- 366.11 Senile cataract, pseudoexfoliation of lens capsule
- 366.13 Anterior subcapsular polar senile cataract
- 366.14 Posterior subcapsular polar senile cataract
- 366.16 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
- 366.32 Cataract inflammatory conditions
- 366.33 Cataract with neovascularization
- 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
- 379.32 Subluxation of the lens
- 379.33 Anterior dislocation of lens
- 379.34 Posterior dislocation of lens
- 379.40 Abnormal pupillary function, unspecified
- 379.41 Anisocoria
- 379.42 Miosis (persistent), not due to miotics
- 379.43 Mydriasis (persistent), not due to mydriatics
- 379.45 Argyll Robertson pupil, atypical
- 379.46 Tonic pupillary reaction

379.49	Other anomalies of pupillary function
743.36	Anomalies of lens shape spherophakia
743.37	Congenital ectopic lens
743.45	Aniridia
743.46	Other specified anomalies of the iris and ciliary body

Diagnoses that Support Medical Necessity

As listed in the "ICD-9 Codes that Support Medical Necessity" section of this policy.

ICD-9 Codes that DO NOT Support Medical Necessity

Any diagnosis codes not listed in the "ICD-9 Codes that Support Medical Necessity" section of this policy.

Diagnoses that DO NOT Support Medical Necessity

Conditions not listed in the "ICD-9 Codes that Support Medical Necessity" section of this policy.

Reasons for Denial

- All other indications not listed in the "Indications and Limitations of Coverage" section of this policy,
- The service is for screening purposes,
- The service is not medically necessary,
- The medical record does not verify that the service described by the HCPCS code was provided, and;
- The service does not follow the guidelines of this policy.

Non-covered ICD-9 Codes

Any diagnosis codes not listed in the "ICD-9 Codes that Support Medical

Necessity" section of this policy.

Non-covered Diagnoses

Conditions not listed in the "ICD-9 Codes that Support Medical Necessity" section of this policy.

Coding Guidelines

- The primary diagnosis submitted by the physician performing the preoperative ophthalmic evaluation must be cataract (ICD-9 codes listed in the "ICD-9 Codes that Support Medical Necessity" section of this policy),
- The diagnoses submitted by the physician performing the evaluation and management component of the preoperative workup, when it is medically necessary, should indicate cataract (ICD-9 codes listed in the "ICD-9 Codes that Support Medical Necessity" section of this policy) as the primary or secondary diagnosis,
- Codes 92002-92014 may not be billed the same day as evaluation and management codes 99201-99333.
- To report this service, use the appropriate HCPCS code,
- All of the coverage criteria must be met before this service can be reimbursed by Medicare,
- Diagnosis (es) must be present on any claim submitted, and be coded to the highest level of specificity, and;
- The diagnosis codes(s) must be representative of the patient's condition.

Documentation Requirements

- Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and available to Medicare upon request.
- Medical records must document the four elements of the preoperative workup described in the "Indications and Limitations of Coverage" section of this policy. If records to support claims for cataract surgery with IOL

implant do not substantiate the medical necessity for the procedure based on these elements, claims may be reopened and denied and reimbursement to Medicare requested.

Utilization Guidelines

Medicare will monitor the utilization of this procedure through the Medical Review process.

Other Comments

Medicare will reimburse an evaluation and management (E/M) **or** an ophthalmology service (92002-92014), for the evaluation of a patient's need for cataract surgery, **but not both**.

Financial Responsibility:

Provider Liable

The provider of the service or the ordering physician must have notified the patient in writing, prior to the service, and obtained a signature verifying Advance Beneficiary Notice. Without prior notice, services denied as not medically necessary cannot be billed to the beneficiary. The provider is liable.

Beneficiary Liable

If there is clear evidence that the beneficiary was issued and signed an Advanced Beneficiary Notice (ABN) prior to the service, the liability rests with the beneficiary. Claims for dates of service prior to January 1, 2003 should contain the condition code 20 and occurrence code 32, with date to signify that an ABN was issued to the beneficiary. Absence of these codes will result in a provider liable determination

Claims for dates of service beginning January 1, 2003 should contain the occurrence code 32 with date to signify that an ABN was issued to the

beneficiary. Absence of this code will result in a provider liable determination.

Reference: PM AB-02-168, CR 2415

Sources of Information and Basis for Decision

- TrailBlazer LMRP
- Carrier Medical Director's CMD Ophthalmology Clinical Workgroup

Advisory Committee 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 includes representatives from the appropriate specialty (ies).

Advisory Committee Meeting Date:

Start Date of Comment Period

06/17/2003

End Date of Comment Period

08/01/2003

Start Date of Notice Period

08/13/2003

Revision History

Number	Date	Change
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THIS BULLETIN SHOULD BE SHARED WITH ALL HEALTH CARE PRACTITIONERS AND MANAGERIAL MEMBERS OF THE PROVIDER/SUPPLIER STAFF. BULLETINS ISSUED AFTER OCTOBER 1, 1999 ARE AVAILABLE FROM OUR WEBSITE AT www.marylandmedicare.com

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