Indications and Limitations of Coverage and/or Medical Necessity

Indications

Medicare coverage for cataract extraction and 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 the following criteria:

1. The patient has undergone a standardized formal measure of his 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.

2. 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 vocational expectations.
   - Snellen visual acuity of 20/40 or worse.
   - If there is a glare component, glare testing which reduces visual acuity to worse than 20/40. Special situations might arise where a patient would need
better than 20/40 vision to function (pilots, professional drivers, etc.). In these instances additional documentation should be available in the patient's medical record describing these circumstances. (See below under Documentation)

3. Other medical indications exist for cataract removal such as:
   - Clinically significant anisometropia in the presence of a cataract.
   - The lens opacity interferes with optimal diagnosis or management of posterior segment conditions.
   - The lens causes inflammation (phacolysis, phacoanaphylaxis).
   - The lens induces angle closure (phacomorphic, phacotopic).

4. The patient has undergone an appropriate preoperative ophthalmologic evaluation, which generally includes a comprehensive ophthalmologic exam and either: an A-scan ultrasound, or partial coherence interferometry with either keratometry or corneal topography. Other ophthalmologic studies should be reserved for special situations, such as:
   - 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.

**Preoperative Ophthalmologic Evaluation and Testing**

Routine pre-operative ophthalmologic screening without substantiated signs or symptoms of disease is not medically necessary. Where the only diagnosis is cataract(s), Medicare does not cover testing other than one preoperative ophthalmologic evaluation, which generally includes a comprehensive ophthalmologic examination and an A-scan ultrasound or OCB.
The goals of the physical examination of a patient whose chief complaint may 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
- 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:

1. Patient history (including patient’s assessment of functional status
2. Snellen acuity and refraction
3. Measurement of intraocular pressure
4. Assessment of pupillary function
5. Examination of ocular motility
6. External examination
7. Slit-lamp examination
8. Dilated examination of the fundus (unless contraindicated by the anatomy of the eye)

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.
- Electrophysiologic tests.

The maximum interval between the preoperative examination and the date of surgery should be no greater than 3 months. Patients should be educated to contact the ophthalmologist if they have a
change in visual symptoms during the interval between the preoperative examination and the surgery.

**Contraindications**

The following are contraindications to surgery for visually impairing cataract except as noted above:

- 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.
- A legal consent cannot be obtained.

**Limitations**

All of the patient selection criteria outlined in the “Indications and Limitations of Coverage and/or Medical Necessity” section of this policy have not been met (e.g., best corrected visual acuity of less than 20/40).

Preoperative testing performed in excess of the guidelines outlined in the “Indications and Limitations Coverage and/or Medical Necessity” section of this policy will be considered not medically necessary.

It is expected that more than one A-scan or OCB per year would generally not be medically necessary.

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 the biometry is performed by an optometrist, 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 the inadequacy of the study, the original eye care physician/provider should anticipate not being reimbursed for the study.

B-scans performed without documented evidence of a dense
cataract or that the cataract precluded visualization of the posterior segment of the eye including the vitreous and/or retina will be considered not medically necessary.

Second-eye Surgery:

The following is taken from Cataract in the Adult Eye published as a Preferred Practice Pattern by the American Academy of Ophthalmology:

· Surgery should not be performed in both eyes at the same time because of the potential for bilateral visual loss.

· Consideration of the appropriate interval between the first-eye surgery and second-eye surgery is influenced by several factors: the patient's visual needs, the patient's preferences, visual acuity or function in the second eye, the medical and refractive stability of the first eye, the need to develop binocular vision and symptomatic anisometropia as well as logistical concerns of the patient in traveling back and forth to the physician's office.

· The patient and the ophthalmologist should discuss the benefit, risk and timing of second-eye surgery when they have had the opportunity to evaluate the results of surgery on the first eye.

· Prior to performing surgery on the second eye, the patient's first eye should have a stable postoperative refraction and the patient should perceive improved function, and sufficient time should have elapsed to evaluate and treat early postoperative complications, such as endophthalmitis.

· The patient needs sufficient time to assess the results of his or her first-eye surgery to determine the need and appropriate timing for surgery in the second eye.

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Diagnostic Tests and X-Rays
Doctor Office Visits
Outpatient Hospital Services
Surgical Services
Coding Information

Bill Type Codes:  back to top

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.

| 999x | Not Applicable |

Revenue Codes:  back to top

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
### Coding Information

Code and the policy should be assumed to apply equally to all Revenue Codes.

#### CPT/HCPCS Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>66830</td>
<td>REMOVAL OF SECONDARY MEMBRANOUS CATARACT (OPACIFIED POSTERIOR LENS CAPSULE AND/OR ANTERIOR HYALOID) WITH CORNEO-SCLERAL SECTION, WITH OR WITHOUT IRIDECTOMY (IRIDOCAPSULOTOMY, IRIDOCAPSULECTOMY)</td>
</tr>
<tr>
<td>66840</td>
<td>REMOVAL OF LENS MATERIAL; ASPIRATION TECHNIQUE, 1 OR MORE STAGES</td>
</tr>
<tr>
<td>66850</td>
<td>REMOVAL OF LENS MATERIAL; PHACOFRAGMENTATION TECHNIQUE (MECHANICAL OR ULTRASONIC) (EG, PHACOEMULSIFICATION), WITH ASPIRATION</td>
</tr>
<tr>
<td>66852</td>
<td>REMOVAL OF LENS MATERIAL; PARS PLANA APPROACH, WITH OR WITHOUT VITRECTOMY</td>
</tr>
<tr>
<td>66920</td>
<td>REMOVAL OF LENS MATERIAL; INTRACAPSULAR</td>
</tr>
<tr>
<td>66930</td>
<td>REMOVAL OF LENS MATERIAL; INTRACAPSULAR, FOR DISLOCATED LENS</td>
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<tr>
<td>66940</td>
<td>REMOVAL OF LENS MATERIAL; EXTRACAPSULAR (OTHER THAN 66840, 66850, 66852)</td>
</tr>
<tr>
<td>66982</td>
<td>EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF INTRAOCULAR LENS PROSTHESIS (ONE 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 CAPSULORRHEXIS) OR PERFORMED ON PATIENTS IN THE AMBLYOGENIC DEVELOPMENTAL STAGE</td>
</tr>
<tr>
<td>66983</td>
<td>INTRACAPSULAR CATARACT EXTRACTION WITH</td>
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</tbody>
</table>
## Coding Information

**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

It is the provider’s responsibility to select codes carried out to the highest level of specificity and selected from the ICD-9-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>366.00</td>
<td>NONSENILE CATARACT UNSPECIFIED</td>
</tr>
<tr>
<td>366.9</td>
<td>UNSPECIFIED CATARACT</td>
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</tbody>
</table>

### Diagnoses that Support Medical Necessity

N/A

### ICD-9 Codes that DO NOT Support Medical Necessity

All those not listed under the “ICD-9 Codes that Support Medical Necessity” section of this policy.

### ICD-9 Codes that DO NOT Support Medical Necessity

Asterisk Explanation

### Diagnoses that DO NOT Support Medical Necessity

Conditions that are not listed in the "ICD-9-CM Codes that Support Medical Necessity" section of this policy.
1. All documentation must be maintained in the patient’s medical record and available to the contractor upon request.

2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name dates of service(s)). The record must include the physician or non-physician practitioner responsible for and providing the care of the patient.

Documentation supporting medical necessity (e.g., office/progress notes) of the cataract surgery must contain:

- Visual acuity (best corrected Snellen chart);
- Symptomatology;
- The use of conservative treatment including current refraction is no longer satisfactory;
- Degree of functional impairment (This can be in any form; e.g., narrative or assessment tool as long as it supports how the cataract affects the patient’s ADLs.)
<table>
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<tr>
<th>General Information</th>
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<td>3. The submitted medical record should support the use of the selected ICD-9-CM code(s). The submitted CPT/HCPCS code should describe the service performed.</td>
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