LCD - Cataract Surgery in Adults (L34203)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
Noridian Healthcare Solutions, LLC	A and B MAC	01111 - MAC A	J - E	California - Entire State
Noridian Healthcare Solutions, LLC	A and B MAC	01112 - MAC B	J - E	California - Northern
Noridian Healthcare Solutions, LLC	A and B MAC	01182 - MAC B	J - E	California - Southern
Noridian Healthcare Solutions, LLC	A and B MAC	01211 - MAC A	J - E	American Samoa Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	A and B MAC	01212 - MAC B	J - E	American Samoa Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	A and B MAC	01311 - MAC A	J - E	Nevada
Noridian Healthcare Solutions, LLC	A and B MAC	01312 - MAC B	J - E	Nevada
Noridian Healthcare Solutions, LLC	A and B MAC	01911 - MAC A	J - E	American Samoa California - Entire State Guam Hawaii Nevada Northern Mariana Islands

LCD Information

Document Information

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L34203

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

LCD Title
Cataract Surgery in Adults

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N/A

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N/A

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07/29/2023

Issue

Issue Description

Updated information.

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, 40.7, Claims for Multiple Surgeries, Claims for Bilateral Surgeries

Coverage Guidance

Coverage Indications, Limitations, 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 (i.e., non-surgical) treatment for cataracts.

In general, cataract surgery is performed to alleviate compromise of visual function 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.

MEDICAL NECESSITY
Lens extraction is considered medically necessary and therefore covered by Medicare when one (or more) of the following conditions or circumstances are documented in the medical record (see Documentation Requirements in Article A57195):

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 the patient's inability to function satisfactorily while performing Activities of Daily Life 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 that exists as a result of lens extraction in the first eye (despite satisfactorily corrected monocular visual acuity.

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

Surgery is not deemed to be medically necessary purely on the basis of lens opacity in the absence of one or more of the aforementioned justifications.

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. Visual acuity should be considered in the context of the patient's visual impairment and other ocular findings.

Specialized Ophthalmic Testing

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 would be anticipated to be performed.

Additional ancillary testing as appropriate in the establishment or exclusion of medical necessity. This should be directed by specific patient complaint or symptom where possible.

Certain testing would **not** be anticipated to be required in a pre-operative workup when performing routine cataract surgery. These include, but are not limited to:

a. B-Scan/Ultrasound of the Posterior Segment
b. Glare Testing
c. Brightness Acuity Testing
d. Low-contrast visual acuity testing
e. Contrast sensitivity testing
f. Potential vision testing
g. Formal visual fields
h. Fluorescein angiography
i. External photography
j. Corneal pachymetry/specular microscopy
k. Specialized color vision tests
l. Electrophysiological tests

However, there may be legitimate reasons to perform these tests. For example (other reasonable examples are possible):

a. B-scan ultrasound testing would be medically necessary to assess such structures for the purpose of surgical decision-making in circumstances where an adequate view of the intraocular structures cannot be obtained because of dense cataract,

b. Glare testing/brightness acuity testing would be medically necessary in a patient with a complaint of difficulty driving at night, and

c. Corrected Snellen visual acuity testing under low-contrast conditions or formal contrast sensitivity testing would be medically necessary to uncover or demonstrate functional impairments correlated with the patient's symptoms.

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.), and must have results and indications of medical necessity properly documented. Ancillary tests that are **not** routinely indicated in the preoperative workup for cataract surgery will not be considered a covered benefit unless medical necessity for the particular patient's circumstances is clearly documented in the patient's record. (see Documentation Requirements in Local Coverage Article).

Second Eye Surgery

Should a significant cataract also be present in the second eye, as supported by *Cataract in the Adult Eye,* a "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. Allow an adequate interval of time to 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.

Complex Cataract Surgery

Note that a procedure coded as "Complex Cataract Surgery" must meet all other requirements for Cataract Surgery as outlined above and in the associated Billing and Coding Article A57195.

Summary of Evidence

N/A

Analysis of Evidence (Rationale for Determination)

N/A

General Information

Associated Information

N/A

Sources of Information

1. American Academy of Ophthalmology. Cataract and Anterior Segment Panel. Cataract in the Adult Eye Preferred Practice Pattern®. San Francisco, CA. 2016.
2. Gayer S, Zuleta J. Perioperative Management of the Elderly Undergoing Eye Surgery. *Clinics in Geriatric Medicine.* 2008;24(4):687-700.
3. Yanoff M, Duker JS. *Yanoff & Duker:Ophthalmology.* 3rd ed. Mosby, An Imprint of Elsevier. 2008.
4. 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):1878-82.

Bibliography

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
07/30/2023	R4	The proposed LCD was taken to an Open Meeting on 03/09/2023 due to editorial changes throughout the policy.	• Provider Education/Guidance
10/01/2019	R3	Updated #1 under **Sources of Information** to remove broken link.	• Typographical Error
10/01/2019	R2	10/01/2019: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which	• Revisions Due To Code Removal

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
		requires comment and notice. This revision is not a restriction to the coverage. LCD was converted to the "no-codes" format.	
10/10/2017	R1	08/07/2017: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.	• Creation of Uniform LCDs Within a MAC Jurisdiction

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Articles

A57195 - Billing and Coding: Cataract Surgery in Adults

DA57195 - Billing and Coding: Cataract Surgery in Adults

A59413 - Response to Comments: Cataract Surgery In Adults

Related National Coverage Documents

N/A

Public Versions

UPDATED ON	EFFECTIVE DATES	STATUS
06/09/2023	07/30/2023 - N/A	Currently in Effect (This Version)
09/23/2022	10/01/2019 - 07/29/2023	Superseded
09/20/2019	10/01/2019 - N/A	Superseded
Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.		

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- Surgery
- Adults