Local Coverage Article:
Response to Comments: Cataract Extraction (including Complex Cataract Surgery) (A58765)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
First Coast Service Options, Inc.	A and B MAC	09101 - MAC A	J - N	Florida
First Coast Service Options, Inc.	A and B MAC	09102 - MAC B	J - N	Florida
First Coast Service Options, Inc.	A and B MAC	09201 - MAC A	J - N	Puerto Rico Virgin Islands
First Coast Service Options, Inc.	A and B MAC	09202 - MAC B	J - N	Puerto Rico
First Coast Service Options, Inc.	A and B MAC	09302 - MAC B	J - N	Virgin Islands

Article Information

General Information

Article ID
A58765

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Article Title
Response to Comments: Cataract Extraction (including Complex Cataract Surgery)

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N/A

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Response to Comments

Article Guidance

Article Text:

The following are the comment summaries and contractor responses for First Coast Service Options Proposed Local Coverage Determination (LCD) DL38926 Cataract Extraction (including Complex Cataract Surgery) which was posted for comment on January 14, 2021, and presented at the January 2021 Open Meeting. All comments were reviewed and incorporated into the final LCD where applicable.

Response to Comments

Response to Comments

NUMBER	COMMENT	RESPONSE
1	Letters with multiple comments were received from professional societies. Several comments were received regarding the Covered Indications section of the proposed	Thank you for your comments. In the History/Background and/or General Information section of the LCD it is stated:

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	LCD where it indicates: Cataract Surgery will be considered medically reasonable and necessary when: and then lists 8 conditions. There are several covered indications that seem reasonable although the presentation or listing is ambiguous and not clear whether one, or all, of these criteria are required. A slight rearrangement and perhaps considering the use of "and" and "or" connectors to improve usability. The commenters contend that one of the criteria as written in the modified listing (provided) should be sufficient. Additionally, the commenters recommended changing the word "formal" to "complete" in criteria #3 under the Covered Indication section to reduce ambiguity of recording the symptoms and findings.	Coverage will be based upon documentation that supports medical necessity and therefore covered by Medicare when one or more of the covered indications are present. The Covered Indication section of the LCD will be clarified and the word "formal" will be deleted to avoid ambiguity.
2	A comment was submitted stating that there is not a good mechanism and much confusion about proper coding for billing a cataract extraction requiring anterior vitrectomy or posterior vitrectomy due to lens dropping or ruptured capsule. At present, there is no unique coding system for this complication of cataract surgery that requires additional instrumentation. The commenter is proposing to create a separate code for anterior vitrectomy that will also serve to keep a real-time data about this complication. The commenter further states that the fee for this code could be the same as complex cataract.	Thank you for your comment. It is outside of the Medicare Administrative Contractors (MACs) work to establish coding. Current Procedural Terminology (CPT) codes are copyright of the American Medical Association (AMA). Providers must bill the procedure code that best describes the service provided, per the AMA CPT book. The medical record documentation must support the threshold of medically reasonable and necessary and the medical management of the given Medicare beneficiary for the specific episode of care. Services performed for cataract extraction requiring anterior or posterior vitrectomy procedures must meet all the indications and limitations stated in the LCD, and should be consistent with National Correct Coding Initiative (NCCI), the general requirements for medical necessity as stated in CMS payment policy manuals, any and all existing CMS national coverage determinations, and all Medicare payment rules.
3	A comment was received regarding using CPT code 66982 and billing for complex cataract surgeries. Comment was made that the use of dye in and of itself does not constitute sufficient extra work or intensity or time to qualify the case as being coded complex. Also, regarding pupillary enlargement procedures, the use of a Malyugin Ring may qualify as a complex case when there is a miotic pupil; however, simply its use cannot be considered valid and the commenter suggests that pupillary measurements before	Thank you for your comments. The MAC agrees that the additional work of instilling and removing Trypan Blue dye from the anterior segment, though an additional surgical step, does not reach the threshold of physician time, work, or intensity necessary to report the complex cataract code. Thus, the use of dye in and of itself does not constitute sufficient extra work or

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	and after dilation that show insufficient dilation are mandatory chart documentation in both the office and Operating Room charts. The commenter also indicated that intraoperative complications, such as vitreous loss, iris prolapse, and dropped nucleus or IOL, does not qualify the case as complex. "The original intent was that, for the most part, the complex cataract code 66982 should be used when the physician plans prospectively and documents that a complex cataract procedure is to be performed in the preoperative plan." In conclusion, "More often than not, the surgeon is aware that the case qualifies as complex in advance—and that should be documented in the office visit when the surgery is scheduled. Some physicians, by the nature of their practices, will have a higher percentage of these cases than others. In all instances, it is wise to have complete and precise chart documentation preoperatively and include documentation in the operative note itself." Another comment was received regarding the "Complex cataract surgery:" section, in the proposed LCD, Indication #3. "Mature cataract requiring dye for visualization of capsulorrhexis." The commenter explains, since it is important to visualize the capsulorrhexis to decrease intraoperative complications, limiting the use of Trypan Blue dye to "mature" cataract ignores the risk of poor visualization of capsulorrhexis due to other indications such as dense vitreous hemorrhage obscuring red reflex, uncontrolled COPD with breathing that interferes with focus and visualization of the capsule, corneal scarring that obscures visualization of the capsule, and 4+ posterior capsular cataract without red reflex, etc. The use of Trypan Blue dye decreases the risk of complications in cases as mentioned above with poor visualization of the capsule. Aversion of complications decreases cost of care and most importantly improves patient outcomes. The commenter is requesting expansion of indications that would clarify reasonable usage of Trypan Blue for visualization of capsulorrhexis.	intensity to qualify the case to be coded as complex. The statement "Mature cataract requiring dye for visualization of capsulorrhexis" will be deleted as an indication supporting medical necessity of complex cataract surgery. Regarding management of cataract extraction complications, please see response to comment # 2.
4	A comment was received from a professional society indicating that they agree with the addition of the Provider Qualification section content in the proposed LCD.	Thank you for your comments. Regarding Provider qualifications see response to comment #6.

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	Additionally, the commenter indicated that a miotic pupil that will not dilate sufficiently should not be listed independently as an indication for complex cataract surgery. If the miotic pupil needs to be managed with one of the techniques described in item (1) this becomes redundant. On the other hand, if the mitotic pupil is managed with means such as manual stretching, scissor sphincterotomies, intracameral mydriatics, or synechiolysis, this does create additional work, which may or may not rise to the level of complex surgery. If the intention is to include one or more of these maneuvers as an inclusion criterion for complex cataract, they should be specifically listed in item (2). Finally, the commenter felt that the omission of pediatric cataract surgery from this list of criteria is also concerning as the rationale for its previous inclusion is well justified in the existing LCD and no rationale is given for its exclusion in the proposed LCD.	The Contractor agrees that a miotic pupil that will not dilate sufficiently should not be listed independently as an indication for complex cataract surgery. Indications 1 and 2 will be consolidated as: 1) A miotic pupil that will not dilate sufficiently requiring the use of a mechanical iris expansion device, (Iris retractors through four additional incisions, Beehler expansion device, or Malyugin ring) to adequately visualize the lens in the posterior chamber of the eye. Also, language will be added to the covered indication section of the LCD to address pediatric cataract surgery.
5	A comment was received stating that there is a bullet point in the proposed LCD under the Limitations section #4 that says, "There are contraindications for visually impairing cataract" and one is surgery will not improve visual function. The commenter explained that there are times when cataracts have to be removed for reasons other than for visual improvement. Typically, this might involve a need to visualize structures behind the cataract or if the cataract is creating some type of a problem, such as an elevation in the intraocular pressure inside the eye. Not all of those patients have a potential for improved visual function, but none the less, there is a medical need to perform the surgery for those indications. So, no visual benefit to be obtained should not necessarily contraindicate the surgery since there are several situations in which a medically indicated cataract extraction can and often should be performed, even in poorly seeing eyes that don't have any hope for visual improvement.	Thank you for your comment. The Contractor agrees with the commenter. The LCD limitation does include the language "no other indication for lens removal exists." The word "and" will be changed to "or" to clarify that there could be other indications for cataract surgery such as the examples provided in the comment.
6	A comment was submitted supporting the modifications that address the patient's clinical conditions for cataract extraction to be medically necessary. Several comments were received about the statements, in the proposed LCD regarding or limiting coverage based on the graduate school attended by or licensure of the physician providing the service. The comments suggest that the language is more restrictive than state and Medicare law and regulations and is unnecessary verbiage for a coverage determination. Most LCDs do not and should not	Thank you for your comment. Societies such as the American Academy of Ophthalmology (AAO), Ophthalmology Variation Analysis Committee: Optimum Physician Alliance (OPA), American Society of Cataract and Refractive Surgery, and the European Society of Cataract & Refractive Surgeons are all in support of Cataract Surgery (Including Complex Cataract Surgery) for its safe and effective methods of treatment for cataract and other ocular

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	have such language. As written, the LCD language in question, straight from the AAO, suggests, contrary to state and Medicare law and regulations, that only an ophthalmologist can diagnose or manage cataracts. Medicare beneficiaries can and do choose a Doctor of Optometry – not just ophthalmologists – to diagnose and manage lenticular opacities before the surgical procedure, and/or manage the condition following the procedure. Medicare beneficiaries frequently choose a Doctor of Optometry for their medical eye care. The American Optometric Association's (AOA) Health Policy Institute (HPI) June 2020, reviewed utilization data and found that from 2013 to 2018, the number of Medicare patients for a Doctor of Optometry increased more than 740,000 (12.3% increase), while patients for ophthalmology decreased 450,000 (4.2%). We assume that the "provider qualifications" language in question was included in the LCD to solve some problem, not merely to favor ophthalmologists while economically disadvantaging doctors of optometry by discouraging (through coverage denials) Medicare beneficiaries from receiving covered care legally from a doctor of optometry. If the LCD is not intended to restrict the role of non-ophthalmologists in the diagnosis and management of cataract patients, then the proscriptive provider qualifications verbiage should be removed from all sections where it appears.	diseases. The LCD is not intended to restrict the role of non-ophthalmologists in the diagnosis and management of cataract patients. The scope of practice is established by State laws and is not within the scope of this LCD. However, we understand that both routine and complex cataract surgery may carry risk and appropriate training is necessary. To ensure the safety of the Medicare beneficiaries, we will require all providers to have documentation of training as outlined in the LCD. The Provider Qualifications section of the LCD will be clarified, and the proscriptive provider qualifications verbiage will be removed.

Associated Documents

Related Local Coverage Document(s)

Article(s)

A58592 - Billing and Coding: Cataract Extraction (including Complex Cataract Surgery)

LCD(s)

L38926 - Cataract Extraction (including Complex Cataract Surgery)

Related National Coverage Document(s)

N/A

Public Version(s)

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