LCD - Ophthalmic Biometry for Intraocular Lens Power Calculation (L34181)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
CGS Administrators, LLC	MAC - Part A	15101 - MAC A	J - 15	Kentucky
CGS Administrators, LLC	MAC - Part B	15102 - MAC B	J - 15	Kentucky
CGS Administrators, LLC	MAC - Part A	15201 - MAC A	J - 15	Ohio
CGS Administrators, LLC	MAC - Part B	15202 - MAC B	J - 15	Ohio

LCD Information

Document Information

LCD ID
L34181

LCD Title
Ophthalmic Biometry for Intraocular Lens Power Calculation

Proposed LCD in Comment Period
N/A

Source Proposed LCD
N/A

Original Effective Date
For services performed on or after 10/01/2015

Revision Effective Date
For services performed on or after 05/25/2023

Revision Ending Date
N/A

Retirement Date
N/A

Notice Period Start Date
N/A

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

Notice Period End Date
N/A

Issue

Issue Description

Annual review

CMS National Coverage Policy

Language quoted from Centers for Medicare and Medicaid Services (CMS), National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See §1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, italicized text represents quotation from one or more of the following CMS sources:

Title XVIII of the Social Security Act (SSA):

Section 1862(a)(1)(A) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Section 1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Code of Federal Regulations:

42 CFR §410.32 indicates that diagnostic tests may only be ordered by a treating physician (or other treating practitioner acting within the scope of his/her license and Medicare requirements) who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Tests not ordered by the physician (or other qualified non-physician provider) who is treating the beneficiary are not reasonable and necessary (see Sec. 411.15(k)(1) of this chapter).

CMS Publications:

CMS Publication 100-02, *Medicare National Coverage Determinations Manual,* Chapter 1, Part 1:

10.1 Use of Visual Tests Prior to and General Anesthesia during Cataract Surgery,

CMS Publication 100-03, *Medicare National Coverage Determinations Manual,* Chapter 1, Part 1:

10.1 Use of Visual Tests Prior to and General Anesthesia during Cataract Surgery

CMS Publication 100-03, *Medicare National Coverage Determinations Manual,* Chapter 30:
220.5 Ultrasound Diagnostic Procedures

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Abstract:

There are two methods used for intraocular lens power calculation:

- A-Scan Ultrasound Ophthalmic Biometry
  Ophthalmic A-scan biometry by ultrasound echography is performed through the optical axis of the eye to determine the power of an intraocular (IOL) lens implant. The technical portion of ophthalmic biometry is usually performed in both eyes at the same setting.
- Non-Ultrasound Ophthalmic Biometry
  Optical coherence biometry (OCB) utilizes partial coherence interferometry for measuring axial length (biometry) and for intraocular lens power calculation when planning for cataract surgery. OCB also measures the corneal curvature and anterior chamber depth. The technical portion is usually performed in both eyes at the same visit.

Indications:

Cataract surgery with an intraocular lens (IOL) implant is a high volume Medicare procedure. Along with the surgery, a substantial number of preoperative tests are available to the surgeon. In most cases, a comprehensive eye examination (ocular history and ocular examination) and a single scan to determine the appropriate pseudophakic power of the IOL are sufficient. In most cases involving a simple cataract, a diagnostic ultrasound A-scan is used. For patients with a dense cataract, an ultrasound B-scan may be used. (CMS Publication 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Part 1, Section 10.1)

Accordingly, where the only diagnosis is cataract(s), Medicare does not routinely cover testing other than one comprehensive eye examination (or a combination of a brief/intermediate examination not to exceed the charge of a comprehensive examination) and an A-scan or, if medically justified, a B-scan. Claims for additional tests are denied as not reasonable and necessary unless there is an additional diagnosis and the medical need for the additional tests is fully documented. (CMS Publication 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Part 1, Section 10.1?)

Because cataract surgery is an elective procedure, the patient may decide not to have the surgery until later, or to have the surgery performed by a physician other than the diagnosing physician. In these situations, it may be medically appropriate for the operating physician to conduct another examination. To the extent the additional tests are considered reasonable and necessary by the carrier's medical staff, they are covered. (CMS Publication 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Part 1, Section 10.1)

A second complete A scan/OCB will be covered if a different surgeon, unaffiliated with the surgeon who performed the first cataract extraction, performed the extraction on the second eye. We would not anticipate a high frequency of these instances.

Limitations:

Currently, the relative value units (RVUs) for the global and technical components of each method of ophthalmic biometry for intraocular lens power calculation are based on the procedure being bilaterally performed. If unilateral cataract extraction with an IOL implant is planned, a bilateral technical component of the A-scan or OCB is typically performed, while the professional component of the power calculation is performed unilaterally (on the operative eye only). Thus, the technical components are considered bilateral and the professional component is considered unilateral.

Prior to cataract surgery on the second, contralateral eye, allowance for the power calculation can be made. However, allowance for the technical component of the A-scan or OCB CPT code cannot be made since this bilateral procedure was performed and reimbursed at the time of the first surgery.

The technical component of the scan will generally provide valid information for twelve months. A repeat scan in less than twelve months would not be covered without documentation of significant change in vision (unless required because a second unaffiliated surgeon performed the second cataract extraction.) Generally, when bilateral cataracts are noted at examination, extraction of the second cataract is only performed after results of the first cataract extraction are known and symptoms or findings support the medical necessity for removal of the cataract in the other eye. If ophthalmic biometry is performed and later the surgery is canceled, it is reasonable to allow a repeat scan if significant time, e.g., greater than one (1) year, has elapsed when surgery is rescheduled.

Ophthalmic biometry for lens power calculation should not be performed unless a decision to remove the cataract has been made by the patient and 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 the biometry is repeated by the operating surgeon due to inadequacy of the study, the original eye care physician/provider should anticipate not being reimbursed for the study.

Summary of Evidence

N/A

Analysis of Evidence (Rationale for Determination)

N/A

General Information

Associated Information

N/A

Sources of Information

This bibliography presents those sources that were obtained during the development of this policy. CGS Administrators, LLC. is not responsible for the continuing viability of Web site addresses listed below.

CMS National Coverage Policies

Carrier Advisory Committee

Other Medicare Contractor Local Coverage Determinations/Local Medical Review Policies, particularly Wheatlands Administrative Services, Inc., Contractor Number 00650.

Medicare Physician Fee Schedule Relative Value File/Database

Bibliography

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
05/25/2023	R15	R16 Revision Effective: 05/25/2023 Revision Explanation: Annual review, no changes were made. *05/19/2023 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.*	• Other (Annual Review)
06/02/2022	R14	R15 Revision Effective: 06/02/2022 Revision Explanation: Annual review, no changes were made. *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.*	• Other (Annual Review)
05/27/2021	R13	R14 Revision Effective: 05/27/2021 Revision Explanation: Annual review, no changes were made. 5/17/2021: *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.*	• Other (Annual Review)

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
12/05/2019	R12	R13 Revision Effective: n/a Revision Explanation: Annual review, no changes made. 5/27/2020:*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.*	• Other (Annual Review, no changes)
12/05/2019	R11	R12 Revision Effective: 12/05/2019 Revision Explanation: Removed the other comments section and associated documents section and placed into the billing and coding article. 11/26/2019:*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.*	• Provider Education/Guidance
09/26/2019	R10	R11 Revision Effective: 09/26/2019 Revision Explanation: Converted new policy template that no longer includes coding section based on CR 10901. No changes, approval only. 09/20/2019:*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.*	• Revisions Due To Code Removal
06/06/2019	R9	R10 Revision Effective: 6-6-19 Revision Explanation: Annual review,	• Other

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
		typographical error. Previous update did not process. 5-29-19 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.	
10/01/2016	R8	R9 Revision Effective:N/A Revision Explanation: Annual review, typographical error. 5-6-19 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.	• Other (Annual Review, typographical errors updated)
10/01/2016	R7	R8 Revision Effective:N/A Revision Explanation: Annual review no changes made.	• Other (Annual Review)

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
		DATE (05/31/2018): 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. R7 Revision Effective: N/A Revision Explanation: Annual revision no changes made	
10/01/2016	R6	R Revision Effective: 10/01/2016 Revision Explanation: During annual ICd-10 update the following codes were deleted, H40.11X0-H40.11X4 and replaced with the following codes:H40.1110, H40.1111, H40.1112, H40.1113, H40.1114, H40.1120, H40.1121, H40.1122, H40.1123, H40.1124, H40.1130, H40.1131, H40.1132, H40.1133, H40.1134.	• Revisions Due To ICD-10-CM Code Changes
01/01/2016	R5	R5 Revision Effective: N/A Revision Explanation: Annual revision no changes made	• Other (Annual review)
01/01/2016	R4	R4 Revision Effective: 01/01/2016 Revision Explanation: POS 19 added to supplemental article. POS 19 effective 01/01/2016 for any DOS when the claim is processed on or after 01/01/2016.	• Provider Education/Guidance

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
10/01/2015	R3	R3 Revision Effective: 10/01/2015 Revision Explanation: Added the following ICD-10 codes that were left off inadvertently: H25.11-H25.13, H25.091-H25.093, H40.2210-h40.2214, H40.2220-H40.2224, H40.2230-h40.2234, H40.31X0-H40.31X4, H40.32X0-H40.32X4, H40.33X0-H40.33X4, H40.41X0-H40.41X4, h40.42X0-H40.42X4, H40.43X0-H40.43X4, H40.51X0-H40.51X4 H40.52X0-H40.52X4,and H40.53X0-h40.53X4.	• Provider Education/Guidance
10/01/2015	R2	R2 Revision Effective: 10/01/2015 Revision Explanation: Added back bill type codes that were removed in error.	• Typographical Error
10/01/2015	R1	R1 Revision Effective: 10/01/2015 Revision Explanation: Accepted revenue code description changes.	• Other (revenue code description)

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Articles

A57070 - Billing and Coding: Ophthalmic Biometry for Intraocular Lens Power Calculation

Related National Coverage Documents

N/A

Public Versions

UPDATED ON	EFFECTIVE DATES	STATUS
05/19/2023	05/25/2023 - N/A	Currently in Effect (This Version)
05/26/2022	06/02/2022 - 05/24/2023	Superseded
Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.		

Keywords

N/A