

# LCD - Cataract Surgery (L34413)

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## Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
<a href="#">Palmetto GBA</a>	A and B MAC	10111 - MAC A	J - J	Alabama
<a href="#">Palmetto GBA</a>	A and B MAC	10112 - MAC B	J - J	Alabama
<a href="#">Palmetto GBA</a>	A and B MAC	10211 - MAC A	J - J	Georgia
<a href="#">Palmetto GBA</a>	A and B MAC	10212 - MAC B	J - J	Georgia
<a href="#">Palmetto GBA</a>	A and B MAC	10311 - MAC A	J - J	Tennessee
<a href="#">Palmetto GBA</a>	A and B MAC	10312 - MAC B	J - J	Tennessee
<a href="#">Palmetto GBA</a>	A and B and HHH MAC	11201 - MAC A	J - M	South Carolina
<a href="#">Palmetto GBA</a>	A and B and HHH MAC	11202 - MAC B	J - M	South Carolina
<a href="#">Palmetto GBA</a>	A and B and HHH MAC	11301 - MAC A	J - M	Virginia
<a href="#">Palmetto GBA</a>	A and B and HHH MAC	11302 - MAC B	J - M	Virginia
<a href="#">Palmetto GBA</a>	A and B and HHH MAC	11401 - MAC A	J - M	West Virginia
<a href="#">Palmetto GBA</a>	A and B and HHH MAC	11402 - MAC B	J - M	West Virginia
<a href="#">Palmetto GBA</a>	A and B and HHH MAC	11501 - MAC A	J - M	North Carolina
<a href="#">Palmetto GBA</a>	A and B and HHH MAC	11502 - MAC B	J - M	North Carolina

## LCD Information

### Document Information

**LCD ID**

L34413

**LCD Title**

Cataract Surgery

**Proposed LCD in Comment Period**

N/A

**Source Proposed LCD**

[DL34413](#)

**Original Effective Date****AMA CPT / ADA CDT / AHA NUBC Copyright Statement**

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For services performed on or after 10/01/2015

**Revision Effective Date**

For services performed on or after 05/26/2022

**Revision Ending Date**

N/A

**Retirement Date**

N/A

**Notice Period Start Date**

01/28/2016

**Notice Period End Date**

03/13/2016

**Issue**

**Issue Description**

This LCD outlines coverage for this service with specific details under **Coverage Indications, Limitations and/or Medical Necessity**.

**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.

42 CFR §411.15 (b)(2) and (o)(1)&(2) Particular services excluded from coverage.

42 CFR §416.65 Covered surgical procedures.

CMS Internet-Only Manual, Pub. 100-03, Medicare National Coverage Determinations (NCD) Manual, Chapter 1, Part 1, §80.10, Phaco-Emulsification Procedure-Cataract Extraction.

**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.

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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 treatment for cataracts.

In general, cataract surgery is performed to alleviate visual impairments 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. This A/B Medicare Administrative Contractor (MAC) encourages but does not require providers to use the framework of the International Classification of Functioning, Disability, and Health (ICF) to organize the information related to relevant structural/functional impairments, activity limitations and/or participation restrictions, and any environmental factors influencing the decision to recommend cataract surgery.

### **Medical Necessity**

Medical necessity for cataract surgery is not based solely on the presence of opacity in the lens(es). Lens extraction is considered medically necessary and therefore covered by Medicare when 1 (or more) of the following conditions or circumstances exists:

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, lighting, or non-operative means resulting in specific activity limitations and/or participation restrictions 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 exists as a result of lens extraction in the first eye (despite satisfactorily corrected monocular visual acuity).

Medicare will consider coverage of cataract surgery for circumstances not listed above. Coverage will be based on documentation that supports medical necessity and is compatible with the accepted standards of medical care. Medicare coverage extends only to standard non-correcting prosthetic lenses. Advanced technology prosthetic lenses

are not covered.

## Visual Acuity

The Snellen chart is frequently used as a screening tool to measure visual acuity. However, testing using high contrast letters viewed in dark room conditions, can underestimate the functional impairments caused by some cataracts in common real-life situations (e.g., glare conditions, poor contrast environments, reading, halos and starbursts at night, and impaired optical quality causing monocular diplopia and ghosting). An evaluation of visual acuity alone can neither rule in nor rule out the need for surgery. Visual acuity should be recorded and considered in the context of the patient's visual impairment and other ocular findings.

## Second Eye Surgery

Surgery is generally not performed in both eyes during the same surgical session because of the potential for bilateral visual loss. The publication, *Cataract in the Adult Eye, Preferred Practice Pattern*<sup>®</sup>, by the American Academy of Ophthalmology<sup>®</sup>, describes circumstances under which bilateral cataract surgery might be an option (e.g., a significant cataract in the second eye).

In the more common situation, where surgery is performed sequentially 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. An adequate interval of time has elapsed to evaluate and treat early postoperative complications in first eye, such as endophthalmitis; and/or
7. Logistical and travel considerations of the patient.

## Summary of Evidence

N/A

## Analysis of Evidence (Rationale for Determination)

N/A

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# General Information

## Associated Information

## Documentation Requirements

The following documentation must be present in the medical chart:

### For Visually-Symptomatic Cataract:

- A statement indicating specific symptomatic (i.e., causing the patient to seek medical attention) impairment of visual function resulting in specific activity limitations and/or participation restrictions. Such activities would typically include, but are not limited to, reading, viewing television, driving, or meeting vocational or recreational expectations. The patient's words should be included in the statement where possible.
- A statement or measurements indicating that the patient's impairment of visual function is believed not to be correctable with a tolerable change in glasses or contact lenses.
- A current best-corrected Snellen visual acuity must be recorded at a distance or near, if the primary visual impairment is near. Acuity is determined by a careful refraction under standard testing conditions. Neither uncorrected visual acuity nor corrected acuity with the patient's current prescription will satisfy this requirement. The refraction may be performed by the surgeon or by suitably trained staff in the surgeon's practice as permitted by law.

As indicated above, a Snellen visual acuity alone can neither rule in nor rule out the need for surgery, but should be considered in the context of the patient's visual impairment and other ocular findings.

The degree of lens opacity should correlate with the impairment of corrected visual acuity when cataract is the primary cause of visual compromise.

- When 1 or more concomitant ocular diseases are present that potentially affect visual function (e.g., macular degeneration or diabetic retinopathy), the medical record should indicate that cataract is believed to be significantly contributing to the patient's visual impairment.
- A statement that the patient desires surgical correction, that the risks, benefits, and alternatives have been explained, and that a reasonable expectation exists that lens surgery will significantly improve both the visual and functional status of the patient.

## **Second Eye Surgery**

The patient and the ophthalmologist should discuss the benefits, risks, need, and timing of second-eye surgery evaluating and taking into account the above factors.

Whether at the time of assessment for surgery on the patient's first eye, or thereafter, the patient must sign a consent for surgery on the second eye.

If assessment for surgery on the second eye is performed after assessment for surgery on the first eye, this may be a compensable service even if performed in the global period of the first eye since it is separate and additional work to post-operative evaluation of the operated eye. However, this A/B MAC would consider the need for a separate service to be rare and must be justified with documentation.

- 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.

## **Other types of Cataract:**

- A statement indicating that the appropriate medical condition or circumstance exists and the specific reason for surgical intervention (e.g., "Cataract surgery is being performed to establish clear media for the treatment [or monitoring] of diabetic retinopathy").
- A statement that the patient desires surgical correction, that the risks, benefits, and alternatives have been explained, and that the patient understands that the surgery is being done to address the medical condition or circumstance. If vision is specifically not expected to improve, the statement should include the patient's understanding of that fact.

### **All types of Cataract:**

An appropriate preoperative ophthalmologic evaluation should be documented, which generally includes a comprehensive ophthalmologic exam (or its equivalent components occurring over a series of visits). Preoperative testing for elective cases should be performed and completed in a location other than the Operating Room (OR) suite, ideally prior to the surgical date to allow the following:

- Consideration of all surgical options by the surgeon
- Patient time in a non-surgical environment to make an unbiased decision to undergo the proposed surgery and to select the performing surgeon

**NOTE:** Certain examination components may be appropriately excluded based on the specific condition and/or urgency of surgical intervention.

Ancillary testing should occur (as appropriate) in the establishment or exclusion of medical necessity. This should be directed by specific patient complaint or symptom where possible.

For example (other reasonable examples are possible):

1. Glare testing/brightness acuity testing reducing corrected visual acuity combined with a complaint of difficulty driving at night might support medical necessity.
2. Corrected Snellen visual acuity testing under low-contrast conditions or formal contrast sensitivity testing that uncover or demonstrate functional impairments correlated with the patient's symptoms might support medical necessity.
3. A B-scan ultrasound test that demonstrates a total retinal detachment in the presence of "no light perception" vision and a cataract that obscures the view of the inside of the eye would likely not support medical necessity in the circumstance of "visually symptomatic" cataract.

### **Anticipated Placement of an intraocular lens (IOL)**

Since the patient and surgeon determine the medical necessity for cataract surgery, only the surgeon may order and receive reimbursement for the professional component of an A-scan or partial coherence interferometry service.

For circumstances where an adequate view of the intraocular structures cannot be obtained because of dense cataract, B-scan ultrasound testing should be considered to assess such structures and determine the need for surgery. B-scans performed without documented evidence of a dense cataract or evidence that the cataract precluded visualization of the posterior segment of the eye including the vitreous and/or retina will be considered not medically necessary.

The following ancillary tests are not routinely indicated in the preoperative workup for cataract surgery, and if performed, will not be considered a covered benefit unless medical necessity is defended by a statement in the patient's record:

- Potential vision testing,
- Corneal Topography,
- Anterior or Posterior Segment Ocular Coherence Tomography,
- Formal visual fields,
- Fluorescein angiography,
- External photography,
- Corneal pachymetry/Specular microscopy,
- Specialized color vision testing,
- Electrophysiologic testing,
- Fundus photography,
- Extended ophthalmoscopy, and;
- Ophthalmic ultrasound B scan.

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.).

Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available to the A/B MAC upon request.

### **Sources of Information**

N/A

### **Bibliography**

1. American Academy of Ophthalmology. Cataract and Anterior Segment Panel. Cataract in the Adult Eye Preferred Practice Pattern<sup>®</sup>. San Francisco, CA. 2016.
2. Centers for Disease Control and Prevention (CDC). Vision Health Initiative (VHI). [Common Eye Disorders and Diseases](#). Accessed 4/13/22.
3. Gayer S, Zuleta J. Perioperative management of the elderly undergoing eye surgery. *Clin Geriatr Med*. 2008;24(4):687-700.
4. U.S. National Library of Medicine. Medical Encyclopedia. [Cataract removal](#). Accessed 4/13/22.
5. National Eye Institute (NIH). [Cataracts](#). Accessed 4/13/22.
6. Obstbaum SA, American Academy of Ophthalmology, American Society of Cataract and Refractive Surgery, European Society of Cataract and Refractive Surgeons. Utilization, appropriate care, and quality of life for patients with cataracts. *Ophthalm*. 2006;113(10):1878-1882.
7. World Health Organization. [Blindness and vision impairment](#). Accessed 4/13/22.
8. Yanoff M, Duker JS. *Yanoff & Duker:Ophthalmology*. 3rd ed. Mosby, An Imprint of Elsevier. 2008.

# Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
05/26/2022	R16	<p>Under <b>CMS National Coverage Policy</b> updated descriptions. Under <b>Bibliography</b> repaired the broken hyperlink for the seventh reference. Changes were made to citations to reflect AMA citation guidelines. Formatting, punctuation and typographical errors were corrected throughout the LCD.</p>	<ul style="list-style-type: none"> <li>Provider Education/Guidance</li> </ul>
10/10/2019	R15	<p>This LCD is being revised in order to adhere to CMS requirements per Chapter 13, Section 13.5.1 of the Program Integrity Manual, to remove all coding from LCDs. There has been no change in coverage with this LCD revision. Regulations regarding billing and coding were removed from the <b>CMS National Coverage Policy</b> section of this LCD and placed in the related Billing and Coding: Cataract Surgery A56613 article.</p> <p><i>At this time 21<sup>st</sup> 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.</i></p>	<ul style="list-style-type: none"> <li>Provider Education/Guidance</li> </ul>
06/13/2019	R14	<p>All coding located in the <b>Coding Information</b> section has been moved into the related Billing and Coding: Cataract Surgery A56613 article and removed from the LCD. Under <b>Bibliography</b> changes were made to citations to reflect AMA citation guidelines. Formatting, punctuation and typographical errors were corrected throughout the LCD.</p> <p><i>At this time 21<sup>st</sup> 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.</i></p>	<ul style="list-style-type: none"> <li>Provider Education/Guidance</li> </ul>
02/26/2018	R13	<p>The Jurisdiction "J" Part B Contracts for Alabama (10112), Georgia (10212) and Tennessee (10312) are now being serviced by Palmetto GBA. The notice period for this LCD begins on 12/14/17 and ends on 02/25/18. Effective 02/26/18, these three contract numbers are being added to this LCD. No coverage, coding or other substantive changes</p>	<ul style="list-style-type: none"> <li>Change in Affiliated Contract Numbers</li> </ul>



REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
		(beyond the addition of the 3 Part B contract numbers) have been completed in this revision.	
01/29/2018	R12	The Jurisdiction "J" Part A Contracts for Alabama (10111), Georgia (10211) and Tennessee (10311) are now being serviced by Palmetto GBA. The notice period for this LCD begins on 12/14/17 and ends on 01/28/18. Effective 01/29/18, these three contract numbers are being added to this LCD. No coverage, coding or other substantive changes (beyond the addition of the 3 Part A contract numbers) have been completed in this revision.	<ul style="list-style-type: none"> <li>Change in Affiliated Contract Numbers</li> </ul>
07/10/2017	R11	Under <b>ICD-10 Codes That Support Medical Necessity- Group 2: Paragraph</b> deleted the following verbiage from the second paragraph, "For example, H34, E10.39, E11.39, H25, H26, H27, H28."	<ul style="list-style-type: none"> <li>Provider Education/Guidance</li> <li>Other</li> </ul>
06/11/2017	R10	Under <b>ICD-10 Codes that Support Medical Necessity</b> – added to <b>Group 1: Codes:</b> H20.21, H20.22, H20.23. Moved codes from <b>Group 1 to Group 2: Codes:</b> H40.10X2, H40.10X3, H40.89. Revised verbiage under <b>Group 2: Paragraph</b> to read "The following codes may be used as codes to justify a cataract lens removal when the cataract density does not appear to justify the extraction. Appropriate documentation is expected to be maintained in the medical record". Added verbiage to <b>Group 2: Paragraph</b> "ICD-10 codes H40.51X1, H40.51X2, H40.51X3, H40.51X4, H40.52X1, H40.52X2, H40.52X3, H40.52X4, H40.53X1, H40.53X2, H40.53X3 and H40.53X4 require a secondary diagnosis. For example, H34, E10.39, E11.39, H25, H26, H27, H28." Added codes to <b>Group 2: Codes:</b> H40.031, H40.032, H40.033, H40.061, H40.062, H40.063, H40.2211, H40.2212, H40.2213, H40.2214, H40.2221, H40.2222, H40.2223, H40.2224, H40.2231, H40.2232, H40.2233, H40.2234, H40.231, H40.232, H40.233, H40.241, H40.242, H40.243, H40.51X1, H40.51X2, H40.51X3, H40.51X4, H40.52X1, H40.52X2, H40.52X3, H40.52X4, H40.53X1, H40.53X2, H40.53X3, H40.53X4, H53.2 and H52.31.	<ul style="list-style-type: none"> <li>Provider Education/Guidance</li> <li>Revisions Due To ICD-10-CM Code Changes</li> </ul>
05/11/2017	R9	Under <b>Sources of Information and Basis for Decision-</b> updated version to 2016 for AAO Preferred Practice Pattern Guidelines.	<ul style="list-style-type: none"> <li>Provider Education/Guidance</li> </ul>
10/01/2016	R8	Under <b>ICD-10 Codes that Support Medical Necessity Group 1: Codes</b> deleted ICD-10 codes H40.11X2 and	<ul style="list-style-type: none"> <li>Provider</li> </ul>

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
		H40.11X3. Under <b>ICD-10 Codes that Support Medical Necessity</b> added <b>Group 2</b> with ICD-10 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 and H40.1134.	<ul style="list-style-type: none"> <li>Education/Guidance</li> <li>Revisions Due To ICD-10-CM Code Changes</li> </ul>
05/19/2016	R7	The revision effective date for revision 6 should be May 19, 2016.	<ul style="list-style-type: none"> <li>Other (Correction to revision effective date for revision 6. )</li> </ul>
03/14/2016	R6	Under <b>CMS National Coverage Policy</b> corrected the citation format for 42 CFR §§411.15(b)(2)&(3) and (o)(1)&(2); 42 CFR §416.65. Under <b>Medical Necessity</b> deleted the paragraph pertaining to symptomatic cataracts and clarified the coverage for symptoms related to lens opacity. Under <b>Visual Acuity</b> clarified the role of the Snellen chart in determining the need for cataract surgery. Under <b>Second Eye Surgery</b> clarified the circumstances under which bilateral cataract surgery could be considered. Deleted "be consented" and replaced with "sign a consent". Under <b>Visually-Symptomatic Cataract</b> the information in the third bullet point was reworded. The word "specific" was removed from the first paragraph. Under <b>Anticipated Placement of an intraocular lens (IOL)</b> "etc" was removed. Under <b>Utilization Guidelines</b> deleted codes H26.22I and H26.222 that were repeated in the code list. Under <b>Sources of Information and Basis for Decision</b> deleted "in" from the third cited journal title journal title and added the place of publication for the last cited reference.	<ul style="list-style-type: none"> <li>Provider Education/Guidance</li> </ul>
03/14/2016	R5	Under <b>Sources of Information and Basis for Decision</b> updated the URL for the CDC Vision Health Initiative reference.	<ul style="list-style-type: none"> <li>Other</li> </ul>
03/14/2016	R4	Under <b>Coverage Indications, Limitations, and/or Medical Necessity</b> removed the prior section #2 on Snellen visual acuity, removed the reference to "open angle glaucoma" and removed the section stating "the need to visualize the fundus..." and reduced the section. Added lighting, or non-operative means under #1 for medical necessity. Under <b>Associated Information</b> removed "when they have had the opportunity to evaluate the results of surgery on the first eye" and added "Whether at the time of assessment for surgery on the patient's first eye, or thereafter" and "If assessment for surgery on the second eye	<ul style="list-style-type: none"> <li>Provider Education/Guidance</li> <li>Public Education/Guidance</li> <li>Typographical Error</li> </ul>

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
		is performed after assessment for surgery on the first eye". Under <b>Sources of Information and Basis for Decisions</b> Added references for CDC,WHO, NIH, and National Library of Medicine Medline Plus.	
10/01/2015	R3	Per CMS Internet-Only Manual, Pub 100-08, Medicare Program Integrity Manual, Chapter 13, §13.1.3 LCDs consist of only "reasonable and necessary" information. All bill type and revenue codes have been removed.	<ul style="list-style-type: none"> <li>• Other (Bill type and/or revenue code removal)</li> </ul>
10/01/2015	R2	Under <b>CMS National Coverage Policy</b> added "(NCD)" to title of Medicare National Coverage Determinations Manual. Under <b>Sources of Information and Basis for Decision</b> revised first reference to AMA format. Revised last reference to add author's name "Obstbaum, SA" and "European Society of Cataract and Refractive Surgeons".	<ul style="list-style-type: none"> <li>• Provider Education/Guidance</li> <li>• Other (Maintenance Annual Review)</li> </ul>
10/01/2015	R1	Under <b>General Information</b> subheading <i>Documentation Requirements</i> , corrected formatting and removed the numerical number 2. <i>Utilization Guidelines</i> removed ICD-10 codes H26.239, H26.229, and H26.30 as these codes were not specific diagnoses.	<ul style="list-style-type: none"> <li>• Provider Education/Guidance</li> <li>• Automated Edits to Enforce Reasonable &amp; Necessary Requirements</li> <li>• Typographical Error</li> </ul>

## Associated Documents

### Attachments

N/A

### Related Local Coverage Documents

### Articles

[A54828 - \(MCD Archive Site\)](#)

[A56613 - Billing and Coding: Cataract Surgery](#)

[A53047 - Billing and Coding: Complex Cataract Surgery: Appropriate Use and Documentation](#)

### LCDs

[DL34413 - \(MCD Archive Site\)](#)

### Related National Coverage Documents

N/A

### Public Versions

UPDATED ON	EFFECTIVE DATES	STATUS
05/16/2022	05/26/2022 - N/A	Currently in Effect (This Version)

UPDATED ON	EFFECTIVE DATES	STATUS
10/04/2019	10/10/2019 - 05/25/2022	Superseded
Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.		

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## Keywords

- Cataract