LCD Reference Article	Billing and Coding Article

Article - Billing and Coding: Capsule Opacification Following Cataract Surgery: Discission and YAG Laser Capsulotomy (A56493)

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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

Article Information

General Information

Article ID
A56493

Article Title
Billing and Coding: Capsule Opacification Following Cataract Surgery: Discission and YAG Laser Capsulotomy

Article Type
Billing and Coding

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10/01/2015

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11/16/2023

Revision Ending Date
N/A

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N/A

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

CMS National Coverage Policy

N/A

Article Guidance

Article Text

This article gives guidance for billing, coding, and other guidelines in relation to local coverage policy Capsule Opacification Following Cataract Surgery: Discission and YAG Laser Capsulotomy L33946.

General Guidelines for Claims submitted to Part A or Part B MAC:

Procedure codes may be subject to National Correct Coding Initiative (NCCI) edits or OPPS packaging edits. Refer to NCCI and OPPS requirements prior to billing Medicare. For services requiring a referring/ordering physician, the name and NPI of the referring/ordering physician must be reported on the claim. A claim submitted without a valid ICD-10-CM diagnosis code will be returned to the provider as an incomplete claim under Section 1833(e) of the Social Security Act. The diagnosis code(s) must best describe the patient's condition for which the service was performed. For diagnostic tests, report the result of the test if known; otherwise the symptoms prompting the performance of the test should be reported.

Advance Beneficiary Notice of Non-coverage (ABN) Modifier Guidelines

An ABN may be used for services which are likely to be non-covered, whether for medical necessity or for other reasons. Refer to CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 30, for complete instructions.

Effective from April 1, 2010, non-covered services should be billed with modifier –GA, -GX, -GY, or –GZ, as appropriate.

The –GA modifier (“Waiver of Liability Statement Issued as Required by Payer Policy”) should be used when physicians, practitioners, or suppliers want to indicate that they anticipate that Medicare will deny a specific service as not reasonable and necessary and they do have an ABN signed by the beneficiary on file. Modifier GA applies only when services will be denied under reasonable and necessary provisions, sections 1862(a)(1), 1862(a)(9), 1879(e), or 1879(g) of the Social Security Act. Effective April 1, 2010, Part A MAC systems will automatically deny services billed with modifier GA. An ABN, Form CMS-R-131, should be signed by the beneficiary to indicate that ?he/she accepts responsibility for payment.? The -GA modifier may also be used on assigned claims when a patient refuses to sign the ABN and the latter is properly witnessed. For claims submitted to the Part A MAC, occurrence code 32 and the date of the ABN is required.

Modifier GX (“Notice of Liability Issued, Voluntary Under Payer Policy”) should be used when the beneficiary has signed an ABN, and a denial is anticipated based on provisions other than medical necessity, such as statutory

exclusions of coverage or technical issues. An ABN is not required for these denials, but if non-covered services are reported with modifier GX, will automatically be denied services.

The –GZ modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an ABN signed by the beneficiary. ?If the service is statutorily non-covered, or without a benefit category, submit the ?appropriate CPT/HCPCS code with the -GY modifier. An ABN is not required for these denials, and the limitation of liability does not apply for beneficiaries. Services with modifier GY will automatically deny.

Documentation Requirements

The patient's medical record should include but is not limited to:

- The assessment of the patient by the ordering provider as it relates to the complaint of the patient for that visit,
- Relevant medical history
- Results of pertinent tests/procedures
- Signed and dated office visit record/operative report (Please note that all services ordered or rendered to Medicare beneficiaries must be signed.)

Other Comments:

For claims submitted to the Part A MAC: this coverage determination also applies within states outside the primary geographic jurisdiction with facilities that have nominated CGS to process their claims.

Limitation of liability and refund requirements apply when denials are likely, whether based on medical necessity or other coverage reasons. The provider/supplier must notify the beneficiary in writing, prior to rendering the service, if the provider/supplier is aware that the test, item or procedure may not be covered by Medicare. The limitation of liability and refund requirements do not apply when the test, item or procedure is statutorily excluded, has no Medicare benefit category or is rendered for screening purposes.

Associated Information:

The patient's medical record must contain documentation that fully supports the medical necessity for services included within this LCD. (See "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

The indications for a capsulotomy procedure performed less than three months after cataract surgery should be clearly documented in the medical record (e.g., significant visual debility as defined in the policy, preoperative uveitis, chronic glaucoma, diabetes mellitus, prolonged use of pilocarpine hydrochloride, etc.).

Similarly, if a capsulotomy is performed more than once on the same eye during the same, or a separate, episode of care, the rationale and indications should be clearly documented in the medical record.

Not applicable

Surgical intervention for ACO/PCO is not often indicated less than three months after cataract surgery. If a claim is submitted for capsulotomy surgery within three months of cataract surgery, documentation justifying the need for the procedure would be required to support medical necessity. Payment will only be allowed for a physician or group once per eye per patient per global period (90 days), no matter how many YAG treatment sessions occur.

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

N/A

Group 1 Codes: (2 Codes)

CODE	DESCRIPTION
66820	DISCISSION OF SECONDARY MEMBRANOUS CATARACT (OPACIFIED POSTERIOR LENS CAPSULE AND/OR ANTERIOR HYALOID); STAB INCISION TECHNIQUE (ZIEGLER OR WHEELER KNIFE)
66821	DISCISSION OF SECONDARY MEMBRANOUS CATARACT (OPACIFIED POSTERIOR LENS CAPSULE AND/OR ANTERIOR HYALOID); LASER SURGERY (EG, YAG LASER) (1 OR MORE STAGES)

CPT/HCPCS Modifiers

N/A

ICD-10-CM Codes that Support Medical Necessity

Group 1 Paragraph:

It is the responsibility of the provider to code to the highest level specified in the ICD-10-CM. The correct use of an ICD-10-CM code listed below does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination.

Group 1 Codes: (10 Codes)

CODE	DESCRIPTION
H26.40	Unspecified secondary cataract
H26.411 - H26.413	Soemmering's ring, right eye - Soemmering's ring, bilateral
H26.491 - H26.493	Other secondary cataract, right eye - Other secondary cataract, bilateral
T85.21XA	Breakdown (mechanical) of intraocular lens, initial encounter
T85.22XA	Displacement of intraocular lens, initial encounter
T85.29XA	Other mechanical complication of intraocular lens, initial encounter

ICD-10-CM Codes that DO NOT Support Medical Necessity

N/A

ICD-10-PCS Codes

N/A

Additional ICD-10 Information

N/A

Bill Type Codes

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 article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

CODE	DESCRIPTION
011x	Hospital Inpatient (Including Medicare Part A)
012x	Hospital Inpatient (Medicare Part B only)
013x	Hospital Outpatient
018x	Hospital - Swing Beds
085x	Critical Access Hospital

Revenue Codes

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

Revenue codes only apply to providers who bill these services to the Part A MAC. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or Part B MAC.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

All revenue codes billed on the inpatient claim for the dates of service in question may be subject to review.

CODE	DESCRIPTION
0360	Operating Room Services - General Classification
0370	Anesthesia - General Classification
0490	Ambulatory Surgical Care - General Classification
0710	Recovery Room - General Classification
0760	Specialty Services - General Classification
0960	Professional Fees - General Classification

Other Coding Information

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
11/16/2023	R7	Revision Effective: 11/16/2023 Revision Explanation: Updated LCD Reference Article section.
11/03/2023	R6	Revision Effective: 11/03/2023 Revision Explanation: Annual review, no changes.
10/27/2022	R5	Revision Effective: 10/27/2022 Revision Explanation: Annual review, no changes.
10/21/2021	R4	Revision Effective: 10/21/2021 Revision Explanation: Annual review, no changes.
11/07/2019	R3	Revision Effective: N/A Revision Explanation: Annual review, no changes.

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
11/07/2019	R2	Revision Effective: 11/07/2019 Revision Explanation:Updated article text with other comments from Coverage Indications, Limitations and/or Medical Necessity and Associated Information based on TDL 190550. Added details from LCD L33946.
09/19/2019	R1	R1 Revision Effective: 09/19/2019 Revision Explanation: Converted article into new Billing and Coding template no other changes made.

Associated Documents

Related Local Coverage Documents

LCDs

L33946 - Capsule Opacification Following Cataract Surgery: Discission and YAG Laser Capsulotomy

Related National Coverage Documents

N/A

Statutory Requirements URLs

N/A

Rules and Regulations URLs

N/A

CMS Manual Explanations URLs

N/A

Other URLs

N/A

Public Versions

UPDATED ON	EFFECTIVE DATES	STATUS
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11/07/2023	11/16/2023 - N/A	Currently in Effect (This Version)
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Keywords

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