Local Coverage Determination (LCD)

LCD - Cataract Extraction (L33954)

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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

LCD Information

Document Information

LCD ID
L33954

LCD Title
Cataract Extraction

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 01/04/2024

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-no changes were made.

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 Section 410.32 indicates that diagnostic tests may only be ordered by the treating physician (or other treating practitioner acting within the scope of his or her license and Medicare requirements.

CMS Publications:

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Part 1:

> 10.1 Use of Visual Tests Prior to and General Anesthesia during Cataract Surgery 260 Ambulatory Surgical Center Services

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 80.8 Endothelial Cell Photography 80.10 Phaco-Emulsification Procedure - Cataract Extraction

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Abstract:

A cataract is an opacity or cloudiness in the lens of the eye(s), blocking the passage of light through the lens, sometimes resulting in impaired vision. Cataract development occurs in 60% of adults 65 years of age or greater. There are multiple factors associated with cataract development. Some causes of cataracts may include: ultraviolet-β radiation exposure, complications of diabetes, drug and/or alcohol use, smoking, and the natural process of aging. Medicare coverage for cataract extraction and cataract extraction with intraocular lens implant is based on services that are reasonable and medically necessary for the treatment of beneficiaries with cataract(s). This policy defines coverage and describes criteria necessary to justify the performance of cataract extraction(s) or other select lensectomies.

Indications and Limitations:

Indications:

Medicare coverage for cataract extraction and cataract extraction with intraocular lens implant is based on services that are reasonable and medically necessary for the treatment of beneficiaries who have a cataract, and who meet all of the following criteria:

The patient has impairment of visual function due to cataract(s) and the following criteria are met and clearly documented:

- Decreased ability to carry out activities of daily living including (but not limited to): reading, watching television, driving, or meeting occupational or vocational expectations; and
- The patient has a best corrected visual acuity of 20/50 or worse at distant or near; or additional testing shows one of the following:
    - Consensual light testing decreases visual acuity by two lines, or
    - Glare testing decreases visual acuity by two lines
- The patient has determined that he/she is no longer able to function adequately with the current visual function; and
- Other eye disease(s) including, but not limited to macular degeneration or diabetic retinopathy, have been ruled out as the primary cause of decreased visual function; and
- Significant improvement in visual function can be expected as a result of cataract extraction; and
- The patient has been educated about the risks and benefits of cataract surgery and the alternative(s) to surgery (e.g., avoidance of glare, optimal eyeglass prescription, etc.); and
- The patient has undergone an appropriate preoperative ophthalmologic evaluation that generally includes a comprehensive ophthalmologic exam and ophthalmic biometry.

Cataract extraction may be covered when an unimpeded view of the fundus is mandatory for proper management of patients with diseases of the posterior segment of the eye(s).

Cataract extraction may be covered during vitrectomy procedures if it is determined that the lens interferes with the performance of the surgery for far peripheral vitreoretinal dissection and excision of the vitreous base, as in cases of proliferative vitreoretinopathy, complicated retinal detachments, and severe proliferative diabetic retinopathy.

For patients with a best corrected visual acuity of 20/40 or better, cataract extraction will be considered if all other criteria have been met and there is substantial documentation of the medical necessity of the procedure for that patient.

If the decision to perform cataract extraction in both eyes is made prior to the first cataract extraction, the documentation must support the medical necessity for each procedure to be performed.

Bilateral cataract extraction performed on both eyes, on the same date of service is termed immediate sequential bilateral cataract surgery (ISBCS). ISBCS as an approach to bilateral cataract extraction may afford certain clinical benefits but carries with it, the possibility of bilateral visual loss. The decision to perform ISBCS should be an individual decision, made jointly by the patient and physician. The medical record must document the rationale for ISBCS and that the patient has been apprised of the risks and benefits of both this approach and of the available alternatives.

If the first cataract extraction is performed and a subsequent contralateral cataract extraction is considered, the criteria for coverage of the procedure in the contralateral eye are the same as the criteria for the first cataract extraction.

Complex Cataract Surgery (CPT code 66982)

The code for complex cataract surgery (CPT code 66982) is intended to differentiate the extraordinary work performed during the intraoperative or postoperative periods in a subset of cataract operations including, and not limited to, the following:

- A miotic pupil which will not dilate sufficiently to allow adequate visualization of the lens in the posterior chamber of the eye and which requires the insertion of four (4) iris retractors through four (4) additional incisions, Beechler or similar expansion device, a sector iridectomy with subsequent suture repair of iris sphincter,synechialysis tuilizing papillary stretch maneuvers or sphincterotomies created with scissors.
- The presence of a disease state that produces lens support structures that are abnormally weak or absent. This requires the need to support the lens implant with permanent intraocular sutures and/or a capsular support ring (approved by the FDA) may be necessary to allow placement of an intraocular lens.
- Pediatric cataract surgery may be more difficult intraoperatively because of an anterior capsule which is more difficult to tear, cortex which is more difficult to remove, and the need for a primary posterior capsulotomy or capsulorhexis. Furthermore, there is additional postoperative work associated with pediatric cataract surgery.
- Extraordinary work may occur during the postoperative period. This is the case with pediatric cases mentioned above and very rarely when there is extreme postoperative inflammation and pain.

The “Documentation Requirements” section of the policy provides a list of diagnosis codes to be reported with CPT code 66982 in specified circumstances.

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.

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

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.

For outpatient settings other than CORFs, references to "physicians" throughout this policy include non-physicians, such as nurse practitioners, clinical nurse specialists and physician assistants. Such non-physician practitioners, with certain exceptions, may certify, order and establish the plan of care for cataract extraction services as authorized by

State law. (See Sections 1861[s][2] and 1862[a][14] of Title XVIII of the Social Security Act; 42 CFR, Sections 410.74, 410.75, 410.76 and 419.22; 58 FR 18543, April 7, 2000.)

Summary of Evidence

N/A

Analysis of Evidence (Rationale for Determination)

N/A

General Information

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 medical record and/or test results documenting medical necessity should be maintained and made available on request.

If cataract extraction is performed due to anisometropia, the medical record must substantiate the presence of significant aniseikonia secondary to anisometropia arising from the first cataract extraction with IOL implant. The medical record must reflect that the aniseikonia is visually significant to the patient by documenting the patient's subjective complaints and must also document that anisometropia is present by determination of the refractive error in both eyes after the first cataract surgery.

If cataract extraction is performed in order to visualize the fundus, the disease being treated must appear in the medical record, and the necessity for visualization must be described in the medical record.

Sources of Information

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

American Academy of Ophthalmology. Cataract in the Adult Eye, Preferred Practice Pattern. San Francisco: American Academy of Ophthalmology, 2006. Available at: www.aao.org/ppp. Accessed 04/04/2008.

Carrier Advisory Committee

Other Medicare local coverage determinations especially Wheatlands Administrative Services, Inc. (L22215 – Complex Cataract Surgery)

Bibliography

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
01/04/2024	R20	R20 Revision Effective: 01/04/2024 Revision Explanation: Annual review, no changes were made. 12/29/2023: *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)
01/05/2023	R19	R19 Revision Effective: 01/05/2023 Revision Explanation: Annual review, no changes were made. 12/28/2022: *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)
01/06/2022	R18	R18 Revision Effective: 01/06/2022 Revision Explanation: Annual review, no changes were made. 12/28/2021: *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
12/24/2020	R17	R17 Revision Effective: 12/24/2020 Revision Explanation: Annual review, no changes were made. 12/17/2020: *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)
12/26/2019	R16	R16 Revision Effective: 12/26/2019 Revision Explanation: Annual review no changes made. 12/20/2019:*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.*	• Other (Annual Review)
09/19/2019	R15	R15 Revision Effective: 09/19/2019 Revision Explanation: Converted policy into new policy template that no longer includes coding section based on CR 10901. For Approval, no changes. 09/13/2019:*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
09/19/2019	R14	R14 Revision Effective: 09/19/2019 Revision Explanation: Converted policy into new policy template that no longer includes coding section based on CR 10901. 09/12/2019:*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

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
10/01/2016	R13	R13 Revision Effective: 05/23/2019 Revision Explanation: Removed all billing and coding details from policy into related Billing and Coding article. Coding information was removed based on CR10901. 05/15/2019:*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.*	• Other (Removed coding based on CR10901)
10/01/2016	R12	R12 Revision Effective: N/A Revision Explanation: Annual review no changes made. *12/21/2018: 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.*	• Other (Annual Review)
10/01/2016	R11	R11 Revision Effective: N/A Revision Explanation: Annual review no changes made. *12/21/2017: 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.*	• Other (annual review)
10/01/2016	R10	R10 Revision Effective: N/A Revision Explanation: H25.011-H25.013 and Q12.9 were left out of chart in associated information section in error. Needed to add	• Other (Add 21st Century Cures Act statement)

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
		statement concerning 21st Century Cures Act sections. *07/06/2017: 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.*	
10/01/2016	R9	R9 Revision Effective: N/A Revision Explanation: H25.011-H25.013 and Q12.9 were left out of chart in associated information section in error.	• Typographical Error
10/01/2016	R8	R8 Revision Effective: N/A Revision Explanation: Typo in chart in the first section E20.21-E20.23 this should be H20.21-H20.23.	• Typographical Error
10/01/2016	R7	R7 Revision Effective: N/A Revision Explanation: Annual review no changes.	• Other (Annual Review)
10/01/2016	R6	Revision#:R6 Revision Effective date: 10/01/2016 Revision Explanation: Added H25.011, H25.012, and H25.013 to group 2 ICD-10 codes for 66982.	• Request for Coverage by a Practitioner (Part B)
10/01/2016	R5	Revision#:R5 Revision Effective date: 10/01/2016 Revision Explanation: Removed the unspecified codes that were inadvertently added during annual ICD-10 review.E08.3219, E08.3299, E08.3319, E08.3399, E08.3419, E08.3499, E08.3519, E08.3519, E08.3529, E08.3539, E08.3549, E08.3559, E08.359, E08.37X9, E09.3219, E09.3299, E09.3319, E09.3399, E09.3419, E09.3499, E09.3519, E09.3519, E09.3529, E09.3539, E09.3549, E09.3559, E09.359, E09.37X9,E10.3219, E10.3299, E10.3319, E10.3399, E10.3419, E10.3499, E10.3519, E10.3519, E10.3529, E10.3539, E10.3549, E10.3559, E10.359, E10.37X9, E11.3219, E11.3299, E11.3319, E11.3399, E11.3419, E11.3499, E11.3519, E11.3519, E11.3529, E11.3539, E11.3549, E11.3559, E11.359,	• Typographical Error

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
		E11.37X9, E13.3219, E13.3299, E13.3319, E13.3399, E13.3419, E13.3499, E13.3519, E13.3519, E13.3529, E13.3539, E13.3549, E13.3559, E13.359, E13.37X9, H35.3210, H35.3220, H35.3230, H35.3290, H35.3291, H35.3292, H35.3293	
10/01/2016	R4	Revision#:R4 Revision Effective date: 10/01/2016 Revision Explanation: The following codes were added based on annual ICD-10 update:E08.3211, E08.3212, E08.3213, E08.3219, E08.3291, E08.3292, E08.3293, E08.3299, E08.3311 E08.3312, E08.3313, E08.3319, E08.3391, E08.3392, E08.3393, E08.3399, E08.3411, E08.3412, E08.3413, E08.3419, E08.3491, E08.3492, E08.3493, E08.3499, E08.3511, E08.3512 E08.3513, E08.3519, E08.3521, E08.3522, E08.3523, E08.3529, E08.3531, E08.3532, E08.3533, E08.3539, E08.3541, E08.3542, E08.3543, E08.3549, E08.3551, E08.3552, E08.3553 E08.3559, E08.3591, E08.3592, E08.3593, E08.3599, E08.37X1, E08.37X2, E08.37X3, E08.37X9, E09.3211, E09.3212, E09.3213, E09.3219, E09.3291, E09.3292, e09.3293, E09.3299 E09.3311, E09.3312, E09.3313, E09.3319, E09.3391, E09.3392, E09.3393, E09.3399, E09.3411, E09.3412, E09.3413, E09.3419, E09.3491, E09.3492, E09.3493, E09.3499, E09.3511, E09.3512, E09.3513, E09.3519, E09.3521, E09.3522, E09.3523, E09.3529, E09.3531, E09.3532, E09.3533, E09.3539, E09.3541, E09.3542, E09.3543, E09.3549, E09.3551 E09.3552, E09.3553, E09.3559, E09.3591, e09.3592, E09.3593, E09.3599, E09.37X1, E09.37X2, E09.37X3, E09.37X9, E10.3211, E10.3212, E10.3213, E10.3219, E10.3291, E10.3292 E10.3293, E10.3299, E10.3311, E10.3312, E10.3313, E10.3319, E10.3391, E10.3392, E10.3393, E10.3399, E10.3411, E10.3412, E10.3413, E10.3419, E10.3491, E10.3492, E10.3493 e10.3499, E10.3511, E10.3512, e10.3513, E10.3519, E10.3521, E10.3522, E10.3523, E10.3529, E10.3531, E10.3532, E10.3533, E10.3539, E10.3541, E10.3542, E10.3543, E10.3549 E10.3551, E10.3552, E10.3553, E10.3559, E10.3591, E10.3592, E10.3593, E10.3599, E10.37X1, E10.37X2, E10.37X3, E10.37X9, E11.3211, e11.3212, E11.3213, E11.3219, E11.3291 E11.3292, E11.3293, e11.3299, E11.3311, E11.3312, E11.3313, E11.3319, E11.3391, E11.3392, E11.3393, E11.3399, E11.3411, E11.3412, E11.3413, e11.3419, E11.3491, E11.3492 E11.3493, E11.3499, E11.3511, e11.3512, E11.3513, E11.3519, E11.3521, E11.3522, E11.3523, E11.3529, E11.3531, E11.3532, E11.3533, E11.3539, E11.3541, E11.3542, E11.3543 E11.3549, E11.3551, E11.3552, E11.3553, E11.3559, E11.3591,	• Revisions Due To ICD-10-CM Code Changes

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
		E11.3592, E11.3593, E11.3599, E11.37X1, E11.37X2, E11.37X3, E11.37X9, E13.3211, E13.3212, E13.3213, E13.3219 E13.3291, E13.3292, E13.3293, E13.3299, E13.3311, E13.3312, E13.3313, E13.3319, E13.3391, E13.3392, E13.3393, E13.3399, E13.3411, E13.3412, e13.3413, E13.3419, E13.3491 E13.3492, e13.3493, E13.3499, E13.3511, E13.3512, E13.3513, E13.3519, E13.3521, E13.3522, E13.3523, E13.3529, E13.3531, E13.3532, E13.3533, E13.3539, E13.3541, E13.3542 E13.3543, e13.3549, E13.3551, E13.3552, E13.3553, e13.3559, E13.3591, e13.3592, E13.3593, E13.3599, E13.37X1, E13.37X2, E13.37X3, E13.37X9, H35.3210, H35.3211, H35.3212, H35.3213, H35.3220, H35.3221, H35.3222, H35.3223, H35.3230, H35.3231, H35.3232, H35.3233, H35.3290, H35.3291, H35.3292, H35.3293. Codes E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, and H35.32 were deleted effective 09/30/2016.	
10/01/2015	R3	Revision#:R3 Revision Effective date: 10/01/2015 Revision Explanation: ICD-10 codes H35.041-H35.043, H35.071-H35.073, H35.21-H35.23, H35.32, H35.341-H35.343, H35.371-H35.373 were left off in error from the first paragraph listed in the group one asterisk section.	• Typographical Error
10/01/2015	R2	Revision#:R2 Revision Effective date: N/A Revision Explanation: Annual review no changes made also prior revision was #1 not 3.	• Other (Annual Review)
10/01/2015	R1	Revision#:R3 Revision Effective date: N/A Revision Explanation: Clarified coverage indications for bilateral surgery	• Creation of Uniform LCDs With Other MAC Jurisdiction

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Articles

A56453 - Billing and Coding: Cataract Extraction

Related National Coverage Documents

N/A

Public Versions

UPDATED ON	EFFECTIVE DATES	STATUS
12/29/2023	01/04/2024 - N/A	Currently in Effect (This Version)
12/28/2022	01/05/2023 - 01/03/2024	Superseded
Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.		

Keywords

N/A