Medicare C/D Medical Coverage Policy

Extracapsular Cataract Extraction with Intraocular Lens Implantation

Origination: July 1, 1999
Review Date: November 16, 2009
Next Review: November 2011

DESCRIPTION OF PROCEDURE OR SERVICE
Extracapsular cataract extraction with intraocular lens implantation (ECCE with IOL) is a procedure performed to remove a cloudy lens (cataract) from an eye. The technique can be either phacoemulsification of the lens, using ultrasound, or an extracapsular technique where the entire lens nucleus is removed intact. Following cataract extraction, a plastic or silicone intraocular lens is inserted into the eye.

Patients seeking this procedure are generally in their mid-50’s or older, although younger individuals may also have significant cataracts. Aging is the most common etiology, but certain medications, ocular and systemic diseases, and trauma may cause cataract formation.

POLICY STATEMENT
Coverage will be provided for cataract extraction when it is determined to be medically necessary, as outlined in the below guidelines and medical criteria.

BENEFIT APPLICATION
Please refer to the member's individual Evidence of Coverage (E.O.C.) for benefit determination. Coverage will be approved according to the E.O.C. limitations if the criteria are met.

Coverage decisions will be made in accordance with:
- The Centers for Medicare & Medicaid Services (CMS) national coverage decisions;
- General coverage guidelines included in original Medicare manuals unless superseded by operational policy letters or regulations; and
- Written coverage decisions of local Medicare carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered.

Benefit payments are subject to contractual obligations of the Plan. If there is a conflict between the general policy guidelines contained in the Medical Coverage Policy Manual and the terms of the member's particular Evidence of Coverage (E.O.C.), the E.O.C. always governs the determination of benefits.
CRITERIA REQUIRED FOR COVERAGE APPROVAL

1. Preauthorization by the Plan is required;

2. The patient must meet criteria A, B, or C:
   
   A. Patient complains of visual impairment that interferes with activities or alters quality of life, such as difficulty reading, viewing television, driving or meeting occupational or vocational expectations
      
      AND
      
      Post-operative results are expected to improve patient’s visual function
      
      AND
      
      Absence of other ocular disease that is contributing to a reduction in visual acuity
      
      AND
      
      Best-corrected visual acuity, based on the results of a careful manifest refraction, is 20/40 or worse in the proposed operative eye. (The 20/40 threshold applies to standard testing conditions or to glare testing with a low or medium setting.)

   B. Documentation that lens removal will improve visualization of the fundus and thus allow essential monitoring of other ocular disease.

   C. Documentation of lens-induced inflammation and/or glaucoma (e.g., phacoanaphylaxis, phacolytic glaucoma, phacomorphic glaucoma).

WHEN COVERAGE WILL NOT BE APPROVED

1. Level of vision is not interfering with activities or quality of life
2. Associated ocular disease that may be contributing to a reduction in visual acuity is present
3. Best-corrected visual acuity is better than 20/40.

BILLING/ CODING/PHYSICIAN DOCUMENTATION INFORMATION

This policy may apply to the following codes. Inclusion of a code in the section does not guarantee reimbursement.

Applicable Codes: 66984, 66982

The Plan may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.
SPECIAL NOTES
Special situations might arise where a patient would need better than 20/40 vision to function (pilots, professional drivers, etc.). In these instances, additional documentation should be available in the patient’s medical record describing these circumstances.

GLOSSARY OF MEDICAL TERMS
N/A

References:
1. Medicare Local Coverage Determination for Cataract Surgery (ID# L2514); Effective date: 11/5/07; Accessed via Internet site www.cms.hhs.gov/mcd/viewncd on 10/14/09.
3. Medicare Local Coverage Determination for Cataract Extraction Surgery (ID# L13600); Effective date: 7/16/09; Accessed via Internet site www.cms.hhs.gov/mcd/viewlcd on 9/17/09.

Policy Implementation/Update Information:
Revision Date: Revised 4-24-00, Revised 3-12-01, Reviewed 3-25-03, Language modified for clarity 8-1-03: Medical Director Review section; numbers 2 and 3, Reviewed 4-11-04, Reviewed 4-29-05, Reviewed 4-3-06, Reviewed 3-14-07, Language modified for clarity 3-26-07: Approval Criteria section; criterion 1 divided into criteria 1 and 2, Reviewed 3-16-08, Reviewed 3-23-09
Last reviewed 9-17-09: Clinical Data, Approval Criteria, and Medical Director Review criteria modified on 9-17-09 to reflect L30205, the Medicare Part B guideline for cataract surgery (eff. 9-15-09).

Approval Dates:
Medical Coverage Policy Committee: November 3, 2009
Physician Advisory Group (PAG) Committee: November 16, 2009
Quality Improvement Committee (QIC): November 18, 2009

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