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

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Please note: This is not an active version.

Contractor Information

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<th>Contract Number</th>
<th>Jurisdiction</th>
<th>State(s)</th>
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LCD Information

LCD ID
L34181

LCD Title
Ophthalmic Biometry for Intraocular Lens Power Calculation

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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

Date Information

Original Effective Date

For services performed on or after 10/01/2015

Revision Effective Date
Abstract:

There are two methods used for intraocular lens power calculation:

1. **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.

2. **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.

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 Administrators, LLC. 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.

For dates of service on or after April 1, 2010, bill type 77X should be used to report FQHC services.
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.

Coding Information

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

013x Hospital Outpatient
071x Clinic - Rural Health
073x Clinic - Freestanding
077x Clinic - Federally Qualified Health Center (FQHC)
085x Critical Access Hospital
999x Not Applicable

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 policy 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 policy 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.

032X Radiology - Diagnostic - General Classification
033X
CPT/HCPCS Codes

Group 1: Paragraph

Group 1: Codes

76519 OPHTHALMIC BIOMETRY BY ULTRASOUND
ECHOGRAPHY, A-SCAN; WITH INTRAOCULAR
LENS POWER CALCULATION

92136 OPHTHALMIC BIOMETRY BY PARTIAL
COHERENCE INTERFEROMETRY WITH
INTRAOCULAR LENS POWER CALCULATION

ICD-10 Codes that Support Medical Necessity

Note: Performance is optimized by using code ranges.

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

Group 1: Codes

E08.36 Diabetes mellitus due to underlying condition with
diabetic cataract

E09.36 Drug or chemical induced diabetes mellitus with
diabetic cataract

E10.36 Type 1 diabetes mellitus with diabetic cataract

E11.36 Type 2 diabetes mellitus with diabetic cataract

E13.36 Other specified diabetes mellitus with diabetic cataract

H25.011 - H25.013
<table>
<thead>
<tr>
<th>Code Range</th>
<th>Description</th>
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<tbody>
<tr>
<td>H25.031 - H25.033</td>
<td>Cortical age-related cataract, right eye - Cortical age-related cataract, bilateral</td>
</tr>
<tr>
<td>H25.041 - H25.043</td>
<td>Anterior subcapsular polar age-related cataract, right eye - Anterior subcapsular polar age-related cataract, bilateral</td>
</tr>
<tr>
<td>H25.21 - H25.23</td>
<td>Posterior subcapsular polar age-related cataract, right eye - Posterior subcapsular polar age-related cataract, bilateral</td>
</tr>
<tr>
<td>H25.811 - H25.813</td>
<td>Age-related cataract, morgagnian type, right eye - Age-related cataract, morgagnian type, bilateral</td>
</tr>
<tr>
<td>H25.89</td>
<td>Combined forms of age-related cataract, right eye - Combined forms of age-related cataract, bilateral</td>
</tr>
<tr>
<td>H25.9</td>
<td>Other age-related cataract</td>
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<tr>
<td>H26.001 - H26.003</td>
<td>Unspecified infantile and juvenile cataract, right eye - Unspecified infantile and juvenile cataract, bilateral</td>
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<tr>
<td>H26.011 - H26.013</td>
<td>Infantile and juvenile cortical, lamellar, or zonular cataract, right eye - Infantile and juvenile cortical, lamellar, or zonular cataract, bilateral</td>
</tr>
<tr>
<td>H26.031 - H26.033</td>
<td>Infantile and juvenile nuclear cataract, right eye - Infantile and juvenile nuclear cataract, bilateral</td>
</tr>
<tr>
<td>H26.041 - H26.043</td>
<td>Anterior subcapsular polar infantile and juvenile cataract, right eye - Anterior subcapsular polar infantile and juvenile cataract, bilateral</td>
</tr>
<tr>
<td>H26.051 - H26.053</td>
<td>Posterior subcapsular polar infantile and juvenile cataract, right eye - Posterior subcapsular polar infantile and juvenile cataract, bilateral</td>
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<tr>
<td>H26.061 - H26.063</td>
<td>Combined forms of infantile and juvenile cataract, right eye - Combined forms of infantile and juvenile cataract, bilateral</td>
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<tr>
<td>H26.09</td>
<td>Other infantile and juvenile cataract</td>
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<tr>
<td>H26.101 - H26.103</td>
<td>Unspecified traumatic cataract, right eye - Unspecified traumatic cataract, bilateral</td>
</tr>
<tr>
<td>H26.111 - H26.113</td>
<td>Localized traumatic opacities, right eye - Localized traumatic opacities, bilateral</td>
</tr>
<tr>
<td>H26.121 - H26.123</td>
<td>Partially resolved traumatic cataract, right eye - Partially resolved traumatic cataract, bilateral</td>
</tr>
<tr>
<td>H26.131 - H26.133</td>
<td>Total traumatic cataract, right eye - Total traumatic cataract, bilateral</td>
</tr>
<tr>
<td>H26.20</td>
<td>Unspecified complicated cataract</td>
</tr>
<tr>
<td>H26.211 - H26.213</td>
<td>Cataract with neovascularization, right eye - Cataract with neovascularization, bilateral</td>
</tr>
<tr>
<td>H26.221 - H26.223</td>
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</table>
Cataract secondary to ocular disorders (degenerative) (inflammatory), right eye - Cataract secondary to ocular disorders (degenerative) (inflammatory), bilateral

H26.231 - H26.233
Glaucomatous flecks (subcapsular), right eye - Glaucomatous flecks (subcapsular), bilateral

H26.31 - H26.33
Drug-induced cataract, right eye - Drug-induced cataract, bilateral

H26.8
Other specified cataract
H26.9
Unspecified cataract

H27.01 - H27.03
Aphakia, right eye - Aphakia, bilateral

H27.10
Unspecified dislocation of lens

H27.111 - H27.113
Subluxation of lens, right eye - Subluxation of lens, bilateral

H27.121 - H27.123
Anterior dislocation of lens, right eye - Anterior dislocation of lens, bilateral

H27.131 - H27.133
Posterior dislocation of lens, right eye - Posterior dislocation of lens, bilateral

H28
Cataract in diseases classified elsewhere

H40.021 - H40.023
Open angle with borderline findings, high risk, right eye - Open angle with borderline findings, high risk, bilateral

H40.061 - H40.063
Primary angle closure without glaucoma damage, right eye - Primary angle closure without glaucoma damage, bilateral

H40.1210 - H40.1214
Low-tension glaucoma, right eye, stage unspecified - Low-tension glaucoma, right eye, indeterminate stage

H40.1220 - H40.1224
Low-tension glaucoma, left eye, stage unspecified - Low-tension glaucoma, left eye, indeterminate stage

H40.1230 - H40.1234
Low-tension glaucoma, bilateral, stage unspecified - Low-tension glaucoma, bilateral, indeterminate stage

H40.1310 - H40.1314
Pigmentary glaucoma, right eye, stage unspecified - Pigmentary glaucoma, right eye, indeterminate stage

H40.1320 - H40.1324
Pigmentary glaucoma, left eye, stage unspecified - Pigmentary glaucoma, left eye, indeterminate stage

H40.1330 - H40.1334
Pigmentary glaucoma, bilateral, stage unspecified - Pigmentary glaucoma, bilateral, indeterminate stage

H40.1410 - H40.1414
Capsular glaucoma with pseudoexfoliation of lens, right eye, stage unspecified - Capsular glaucoma with pseudoexfoliation of lens, right eye, indeterminate stage

H40.1420 - H40.1424
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<th>Code Range</th>
<th>Description</th>
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<td>Capsular glaucoma with pseudoexfoliation of lens, left eye, stage unspecified - Capsular glaucoma with pseudoexfoliation of lens, left eye, indeterminate stage</td>
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<tr>
<td>H43.821 - H43.823</td>
<td>Vitreomacular adhesion, right eye - Vitreomacular adhesion, bilateral</td>
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<td>Q12.0 - Q12.4</td>
<td>Congenital cataract - Spherophakia</td>
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<td>Q12.8</td>
<td>Other congenital lens malformations</td>
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<td>Q12.9</td>
<td>Congenital lens malformation, unspecified</td>
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<tr>
<td>T85.21XA</td>
<td>Breakdown (mechanical) of intraocular lens, initial encounter</td>
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<tr>
<td>T85.22XA</td>
<td>Displacement of intraocular lens, initial encounter</td>
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<tr>
<td>T85.29XA</td>
<td>Other mechanical complication of intraocular lens, initial encounter</td>
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<td>T85.72XA</td>
<td>Infection and inflammatory reaction due to insulin pump, initial encounter</td>
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<td>T85.79XA</td>
<td>Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts, initial encounter</td>
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<td>T86.842</td>
<td>Corneal transplant infection</td>
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<td>Z79.83</td>
<td>Long term (current) use of bisphosphonates</td>
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<tr>
<td>Z96.1</td>
<td>Presence of intraocular lens</td>
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**ICD-10 Codes that DO NOT Support Medical Necessity**

**Note:** Performance is optimized by using code ranges.

**Group 1: Paragraph**

**Group 1: Codes**

**Additional ICD-10 Information**

**General Information**

**Associated Information**
The patient's medical record must contain documentation that fully supports the medical necessity for services included within this LCD. (Please 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. This documentation should include at a minimum the patient’s name and date of service, the indications for testing, an order for testing, the results of testing, and the IOL power calculation. Documentation must be available to Medicare upon request.

Not applicable

Ophthalmic biometry using A-scans (76519) and optical coherence biometry (92136) for the same patient should not be billed by the same provider/physician/group during a 12-month period. Claims for either of these services in excess of these parameters will not be considered medically necessary.

The technical portion of either 76519 or 92136 and the respective interpretations for the same patient should not be billed more than once during a 12 month period by the same provider/physician/group unless there is a significant change in vision. Claims in excess of these parameters will not be considered medically necessary.

Please see the “Indications and Limitations of Coverage and/or Medical Necessity” section of this policy to review utilization guidelines for intraocular lens power calculation testing.

Sources of Information and Basis for Decision

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

Revision History Information

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Associated Documents
Attachments
There are no attachments for this LCD.

Related Local Coverage Documents
Article(s)
A52397 - Ophthalmic Biometry for Intraocular Lens Power Calculation – Supplemental Instructions Article

Related National Coverage Documents

All Versions
Updated on 10/14/2015 with effective dates 10/01/2015 - 12/31/2015
Updated on 06/29/2015 with effective dates 10/01/2015 - N/A
Updated on 06/15/2015 with effective dates 10/01/2015 - N/A
Updated on 03/17/2014 with effective dates 10/01/2015 - N/A

Additional Information

Keywords