Local Coverage Determination (LCD):
Capsule Opacification Following Cataract Surgery: Discission and YAG Laser Capsulotomy (L33946)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

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**Contractor Information**

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**LCD Information**

**Document Information**

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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.

CMS Publications:

CMS Publication 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Part 2:

140.5 Laser Procedures

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Abstract:

Posterior capsule opacification (PCO) is one of the most common problems following cataract surgery. Anterior capsule opacification (ACO) also occurs, but somewhat less commonly. Both conditions represent the anatomic correlate of a secondary cataract (SC). As capsule opacification increases, the patient begins to notice a decrease in vision that can lead to functional impairment. The approach to the management of functional impairment due to SC, whether the result of ACO or PCO, or both, is similar to that of functional impairment due to cataract. Treatment of SC is reserved for those patients who have documented functional impairment that impacts their ability to perform needed and desired activities of daily living.

The time of onset of PCO is variable, as is the frequency with which surgery to treat PCO is performed. PCO severe enough to impair function significantly and thus require surgery is uncommon within three months of cataract surgery and occurs occasionally within the first six months after the surgery. Neodymium-Yttrium-Aluminum-Garnet YAG (Nd:YAG) posterior capsulotomy after cataract extraction has been reported as high as 30% to 50% in the early 1980s to 1990s. Although the rate for some lenses and techniques remains in the 25% - 30% range, the rate for other lenses and techniques has fallen to the single digits in some series.

PCO is a consequence of modern cataract surgery, whether performed by the extracapsular technique or by phacoemulsification (PE). In the past, an invasive procedure involving incision of the capsule with a knife, e.g., discission, was necessary to remove the opacity. Now, with the availability of the Nd:YAG laser, it is possible to perform laser capsulotomy after cataract surgery as an outpatient procedure. YAG capsulotomy for PCO creates an incision in the posterior capsule that normally serves as the boundary between the lens and the vitreous humor of the eye. The laser-created incision allows the capsule to retract, eliminating the obstruction to the passage of light through the media to the retina. YAG capsulotomy is currently the predominant means of treating a secondary cataract, in contrast to discission surgery, which is now only very rarely performed in adults as a primary procedure. However, for PCO due to an extremely dense membrane, or in those patients unable to
tolerate or cooperate with laser surgery, invasive discission of the opacity is still an option.

With the development of modern cataract surgery techniques, specifically the continuous curvilinear capsulorhexis, SC can also develop from opacification of the anterior capsule with, or without, shrinkage of the surgically created anterior capsular opening. Either situation is amenable to a YAG laser anterior capsulotomy for restoration of vision as well as for the prevention of intraocular lens decentration and/or frank dislocation.

The major complications of YAG capsulotomy include elevated intraocular pressure, retinal detachment, cystoid macular edema, damage to the intraocular lens, hyphema, decentration or dislocation of the intraocular lens, corneal edema, vitreous prolapse, endothelial cell loss, uveitis, and pupillary block, among others.

This policy will only address anterior and posterior capsulotomy for secondary cataract after cataract surgery.

**Indications:**

Post-cataract surgery Nd:YAG laser capsulotomy is reasonable and medically necessary only to remedy a functional impairment due to opacification, to prevent possible intraocular damage from dislocation of the intraocular lens implant, or the need to evaluate and treat posterior segment pathology. The procedure will not be covered if it is performed or scheduled concurrently with cataract-removal surgery.

Capsulotomy is covered when each of the following criteria are met and clearly documented:

- The patient has decreased ability to carry out activities of daily living including (but not limited to) reading, watching television, driving, or meeting occupational or a vocational expectations; and
- The patient has a best-corrected visual acuity of 20/50 or worse at distance 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; and
- The patient has determined that he/she is no longer able to function adequately with the current level of visual function; and
- Other eye disease(s), including but not limited to macular degeneration or diabetic retinopathy, has (have) been excluded as the primary cause of visual functional disability, except for the instance in which significant visual debility, in the judgement of the treating physician, is deemed secondary to ACO or PCO and laser treatment would provide the patient with improved functionality; and
- Physician concurrence with significant patient-defined improvement in visual function can be expected as a result of capsulotomy; and
- The patient has been educated about the risks and benefits of capsulotomy and the alternative(s) to surgery (e.g., the avoidance of glare, use of optimal eyeglasses prescription, etc.); and
- The patient has undergone an appropriate preoperative ophthalmologic evaluation.

For patients with a best-corrected visual acuity of 20/40 or better, anterior and/or posterior capsulotomy will be considered if all other criteria have been met and documented to support the medical necessity of the procedure for that patient.

**Limitations:**

YAG capsulotomy secondary to cataract extraction and intra-ocular lens placement should not be required more than once per eye. Claims for a second capsulotomy will require the patient have a non-cataract extraction related underlying diagnosis or condition that poses a high risk for re-opacification of the capsule.

*Medicare recognizes the use of lasers for many medical indications. Procedures performed with lasers are sometimes used in place of more conventional techniques. In the absence of a specific noncoverage instruction, and where a laser has been approved for marketing by the Food and Drug Administration, contractor discretion may be used to determine whether a procedure performed with a laser is reasonable and necessary and, therefore, covered. The determination of coverage for a procedure performed using a laser is made on the basis that the use of lasers to alter, revise, or destroy tissue is a surgical procedure. Therefore, coverage of laser procedures is restricted to practitioners with training in the surgical management of the disease or condition being treated (CMS Publication 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Part 2: 140.5 Laser Procedures).*

**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.

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.

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 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.

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

**CPT/HCPCS Codes**

**Group 1 Paragraph:** N/A

**Group 1 Codes:**

66820 DISCRISSION OF SECONDARY MEMBRANOUS CATARACT (OPACIFIED POSTERIOR LENS CAPSULE AND/OR ANTERIOR HYALOID); STAB INCISION TECHNIQUE (ZIEGLER OR WHEELER KNIFE)

66821 DISCRISSION OF SECONDARY MEMBRANOUS CATARACT (OPACIFIED POSTERIOR LENS CAPSULE AND/OR ANTERIOR HYALOID); LASER SURGERY (EG, YAG LASER) (1 OR MORE STAGES)
**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:**

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<th>ICD-10 Codes</th>
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<tr>
<td>H26.40</td>
<td>Unspecified secondary cataract</td>
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<td>H26.411 - H26.413</td>
<td>Soemmering's ring, right eye - Soemmering's ring, bilateral</td>
</tr>
<tr>
<td>H26.491 - H26.493</td>
<td>Other secondary cataract, right eye - Other secondary cataract, bilateral</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>
</tr>
<tr>
<td>T85.29XA</td>
<td>Other mechanical complication of intraocular lens, initial encounter</td>
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ICD-10 Codes that DO NOT Support Medical Necessity N/A

ICD-10 Additional Information [Back to Top]

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**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 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.

**Sources of Information and Basis for Decision**
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.


Carrier Advisory Committee

Revision History Information

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Associated Documents

Attachments N/A

Related Local Coverage Documents N/A

Related National Coverage Documents N/A

Public Version(s) Updated on 10/31/2016 with effective dates 10/01/2015 - N/A Updated on 10/23/2015 with effective dates 10/01/2015 - N/A Updated on 03/13/2014 with effective dates 10/01/2015 - N/A

Keywords

N/A Read the LCD Disclaimer