Local Coverage Article: Billing and Coding: YAG Laser Capsulotomy (A56815)

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Contractor Information

<table>
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<tr>
<th>CONTRACTOR NAME</th>
<th>CONTRACT TYPE</th>
<th>CONTRACT NUMBER</th>
<th>JURISDICTION</th>
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<tr>
<td>First Coast Service Options, Inc.</td>
<td>A and B MAC</td>
<td>09102 - MAC B</td>
<td>J - N</td>
<td>Florida</td>
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<td>First Coast Service Options, Inc.</td>
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<td>First Coast Service Options, Inc.</td>
<td>A and B MAC</td>
<td>09302 - MAC B</td>
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<td>Virgin Islands</td>
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Article Information

General Information

**Article ID**
A56815

**Article Title**
Billing and Coding: YAG Laser Capsulotomy

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contact us at ub04@healthforum.com.

Article Guidance

Article Text:

This First Coast Billing and Coding Article for Local Coverage Determination (LCD) L33968 YAG Laser Capsulotomy
provides billing and coding guidance for frequency limitations as well as diagnosis limitations that support diagnosis
to procedure code automated denials. However, services performed for any given diagnosis must meet all of the
indications and limitations stated in the LCD, the general requirements for medical necessity as stated in CMS
payment policy manuals, any and all existing CMS national coverage determinations, and all Medicare payment rules.

Refer to the LCD for reasonable and necessary requirements and limitations.

The redetermination process may be utilized for consideration of services performed outside of the reasonable and
necessary requirements in the LCD.

Coding Guidelines

Report procedure code 66821 with the -50 modifier if the procedure is done bilaterally.

Report procedure code 66821 with a -LT or -RT modifier if performed on one eye only.

Report procedure code 66821 with a -78 modifier if performed within 90 days of cataract surgery.

When a series of procedures is planned for the removal of a posterior dense fibrotic capsule, it will be covered as a
single procedure.

Notice: It is not appropriate to bill Medicare for services that are not covered (as described by the entire LCD) as if
they are covered. When billing for non-covered services, use the appropriate modifier.

Documentation Requirements

1. All documentation must be maintained in the patient's medical record and made available to the contractor
upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g.,
complete name, dates of service[s]). The documentation must include the legible signature of the physician or
non-physician practitioner responsible for and providing the care to the patient.
3. The submitted medical record must support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS code must describe the service performed.
4. Documentation such as the patient’s medical record should demonstrate very clearly why Nd:YAG laser capsulotomy was performed. This should include the results of a visual acuity test and/or a glare test.
5. If the procedure is performed on the same patient, on the same eye and is not part of a series of posterior capsule removal, documentation must be submitted to determine the medical necessity of the subsequent procedure(s).

Utilization Guidelines

Generally, the Nd:YAG laser capsulotomy is expected to be performed only once per eye per lifetime of a beneficiary.

In accordance with CMS Ruling 95-1 (V), utilization of these services should be consistent with locally acceptable standards of practice.

Compliance with the provisions in LCD L33968 YAG Laser Capsulotomy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

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.

<table>
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<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>999x</td>
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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.

<table>
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CPT/HCPCS Codes

Group 1 Paragraph:
**Group 1 Codes:**

<table>
<thead>
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<th>CODE</th>
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<tr>
<td>66821</td>
<td>DISCUSSION OF SECONDARY MEMBRANOUS CATARACT (OPACIFIED POSTERIOR LENS CAPSULE AND/OR ANTERIOR HYALOID); LASER SURGERY (EG, YAG LASER) (1 OR MORE STAGES)</td>
</tr>
</tbody>
</table>

**ICD-10 Codes that are Covered**

**Group 1 Paragraph:**

The following ICD-10-CM codes support medical necessity and provide limited coverage for CPT code: 66821

It is the provider’s responsibility to select codes carried out to the highest level of specificity and selected from the ICD-10-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

**Group 1 Codes:**

<table>
<thead>
<tr>
<th>ICD-10 CODE</th>
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<tr>
<td>H26.40</td>
<td>Unspecified secondary cataract</td>
</tr>
<tr>
<td>H26.411</td>
<td>Soemmering's ring, right eye</td>
</tr>
<tr>
<td>H26.412</td>
<td>Soemmering's ring, left eye</td>
</tr>
<tr>
<td>H26.413</td>
<td>Soemmering's ring, bilateral</td>
</tr>
<tr>
<td>H26.491</td>
<td>Other secondary cataract, right eye</td>
</tr>
<tr>
<td>H26.492</td>
<td>Other secondary cataract, left eye</td>
</tr>
<tr>
<td>H26.493</td>
<td>Other secondary cataract, bilateral</td>
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**ICD-10 Codes that are Not Covered**

**Group 1 Paragraph:**

All those not listed under the “ICD-10 Codes that are covered” section of this article.

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