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Comments and Responses Regarding Draft Local Coverage Determination Cataract Extraction

As an important part of Medicare Local Coverage Determination (LCD) development, National Government Services solicits comments from the provider community and from members of the public who may be affected by or interested in our LCDs. The purpose of the advice and comment process is to gain the expertise and experience of those commenting.

We would like to thank those who suggested changes to the draft Cataract Extraction LCD. The official notice period for the final LCD begins on May 15, 2008, and the final determination will become effective on July 1, 2008.

Comment: A Carrier Advisory Committee (CAC) member was concerned that the paragraph in "Indications" regarding the situations in which the decision to remove the cataract from each eye is made prior to the removal of the first cataract was not clear that the documentation should support the medical necessity for both eyes.

Response: "Both procedures" was changed to "each procedure."

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.

Comment: Visual acuity testing in the Capsule Opacification Following Cataract Surgery: Discussion and YAG Laser Capsulotomy LCD draft includes information regarding consensual light testing or glare testing that is not included in the Cataract Extraction LCD.

Response: Although the response to glare can be quite different in capsule opacification compared to the presence of a cataract, it was decided to add the information. Therefore, the "Indications" bullet regarding visual acuity now reads as follows.

- 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; and

Comment: Complex cataract surgery should include a code for intraoperative floppy iris syndrome (IFIS).

Response: We agree. The ICD-9-CM code 364.81 (Floppy iris syndrome) is present on the draft and the final LCD.

Comment: Stretch techniques should be included with dilation devices for those complex procedures performed with a diagnosis of miosis. A stretch procedure breaks posterior synechia more thoroughly than an expansion device. Retraction with a second instrument is often required.

Response: We agree. Therefore, we added, “synechialysis utilizing pupillary stretch maneuvers” in the table listing examples of “Documentation Requirements for Complex Cataract Surgery (CPT Code 66982),” to the ICD-9-CM range of diagnosis codes 379.40 – 379.49 (Anomalies of papillary function). The term was also added to other conditions in which synechialysis utilizing papillary stretch maneuvers might be required as well as the narrative portion of “Indications.”

Comment: Traumatic cataracts requiring vitrectomy, special maneuvers for incision scarred anterior capsules, capsular support rings, and endocapsular rings should be considered complex cataract surgery.

Response: We agree. The ICD-9-CM codes for traumatic cataracts (366.20 – 366.23) were added to the group containing ICD-9-CM code 366.30 (Cataracta complicate, unspecified) in the examples of “Documentation Requirements for Complex Cataract Surgery (CPT Code 66982).”

Comment (Internal): The “ICD-9-CM codes that Support Medical Necessity” for cataract on the “Ophthalmic Biometry for Intraocular Lens Power Calculation” LCD should be listed on the Cataract Extraction LCD.

Response: We agree. The ICD-9-CM code 366.12 (Incipient senile cataract) was removed. The ICD-9-CM code range 743.30 – 743.39 (Congenital cataract and lens anomalies) was added.

Comment (Internal): The ICD-9-CM codes listed as supporting the medical necessity for cataract extraction identified with an asterisk indicating the requirement to code the underlying diagnosis need review.

Response: Asterisks were added to additional ICD-9-CM codes describing posterior segment disease. Asterisks were removed from the ICD-9-CM code range 366.41 – 366.46 (Cataract associated with other disorders).

Comment: Concern was raised at one CAC meeting about post-operative patient co-management and the billing instructions. In addition, a comment was submitted questioning the modifier -56 (Preoperative management only) verbiage in the Supplemental Instructions Article (SIA).

Response: We agree that the coding instructions needed clarification. Therefore, the SIA applicable paragraph in “Coding Guidelines”/“General Guidelines” was changed to read as follows.

If there is no sharing of pre- or post-operative care, the surgeon should bill the CPT code(s) without the use of modifier(s) “-54,” “-55” or “-56.” If the ophthalmologist shares post-operative care with another physician, modifier -54 (Surgical care only) must be appended to the procedure code for the operative date. Modifier -55 (Postoperative management only) must be appended for any dates of post-operative care.