BACKGROUND

A cataract is an opacity or cloudiness in the lens of the eye(s), blocking the passage of light through the lens, sometimes resulting in impaired vision. Cataract development occurs in 60% of adults 65 years of age or greater. There are multiple factors associated with cataract development. Some causes of cataracts may include: ultraviolet-β radiation exposure, complications of diabetes, drug and/or alcohol use, smoking, and the natural process of aging. Medicare coverage for cataract extraction and cataract extraction with intraocular lens implant is based on services that are reasonable and medically necessary for the treatment of beneficiaries with cataract(s).1,9

Clinical Coverage Guideline

The American Academy of Ophthalmology (AAO) defines a cataract as a degradation of the optical quality of the crystalline lens and affects vision. Most cataracts are related to aging. Cataracts are very common in older people. Cataracts are the leading cause of blindness worldwide and remain an important cause of blindness and visual impairment in the United States, accounting for approximately 50% of visual impairment in adults over the age of 40. By age 80, more than half of all Americans either have a cataract or have had cataract surgery. Cataracts are the leading cause of treatable blindness among Americans of African descent age 40 and older and are the leading cause of visual impairment among Americans of African, Hispanic/Latino, and European descent.²

Cataract surgery is cost-effective in its effect on quality-adjusted life years gained compared with other medical procedures. Data from a Medicare database, comparing hip fracture rates in patients with cataract who did or did not undergo cataract surgery, found a 16 percent decrease in the adjusted odds ratio for hip fracture within one year in patients who had surgery and a 23 percent decrease of patients who had surgery. In one cohort study the number of motor vehicle crashes in older adult patients was (4.74 crashes per million miles).³

There is no technical advantage to taking out a cataract sooner except in cases in which cataract limits monitoring for retinal or optic nerve disease, or in the rare instance in which it is inducing glaucoma. The choice of whether to pursue surgery should be determined by the informed patient rather than the surgeon.⁴

Types of Cataracts¹

**Nuclear cataracts** consist of a central opacification or coloration that interferes with visual function. There are different types of nuclear cataracts, accompanied by either brunescence, opalescence, or both. This type of cataracts tends to progress slowly and affect distance vision more than near vision. In advanced cases, the lens becomes brown and opaque.

**Cortical cataracts** can be central or peripheral and sometimes are best visualized by retroillumination or retinoscopy. Patients commonly complain of glare. When the entire cortex becomes white and opaque, the cataract is referred to as a mature cortical cataract.

**Posterior subcapsular (PSC) cataracts** can cause substantial visual impairment if they affect the axial region of the lens. This type of cataract is found more often in younger patients than other types. Glare, poor vision with bright lighting and near vision is more affected than distance vision. Research demonstrates that PSC cataracts are associated with the greatest rate of cataract surgery. In an older population (mean age 79 years) undergoing cataract surgery, however, nuclear cataracts were most frequently encountered.

Centers for Medicare and Medicaid Services¹

CMS guidelines state lens extraction is considered medically necessary when one or more of the following conditions is present:¹⁰

1. Cataract causing symptomatic (i.e., causing the patient to seek medical attention) impairment of visual function not correctable with a tolerable change in glasses or contact lenses resulting in specific activity limitations and/or participation restrictions including, but not limited to reading, viewing television, driving, or meeting vocational or recreational needs
2. Concomitant intraocular disease (e.g., diabetic retinopathy or intraocular tumor) requiring monitoring or treatment that is prevented by the presence of cataract
3. Lens-induced disease threatening vision or ocular health (including, but not limited to, phacomorphic or phacolytic glaucoma)
4. High probability of accelerating cataract development as a result of a concomitant or subsequent procedure (e.g., pars plana vitrectomy, iridocyclectomy, procedure for ocular trauma) and treatments such as external beam irradiation
5. Cataract interfering with the performance of vitreoretinal surgery
6. Intolerable anisometropia or aniseikonia uncorrectable with glasses or contact lenses that exists as a result of lens extraction in the first eye (despite satisfactorily corrected monocular visual acuity).

Any circumstances not listed will be considered based on the standard of care and other factors related to medical necessity.
Surgery is not deemed to be medically necessary purely on the basis of lens opacity in the absence of symptoms.

Recommendations for Care

1. Surgery is recommended when indicated because of proven effectiveness in enhancing quality of life.
2. Surgery is recommended when indicated because of cost-effectiveness compared to other treatments.
3. The decision to recommend cataract surgery should be based on consideration of the following factors: visual acuity, visual impairment, and potential for functional benefits.
4. Cataract surgery is a procedure appropriately utilized in the United States.
5. Ophthalmologists and other physicians managing patients taking alpha-antagonists should be aware of the risks of intraoperative floppy iris syndrome (IFIS).
6. The intraocular pressure (IOP) lowering effect of cataract surgery should be considered in the overall management of the patient.
7. Ophthalmologists should be aware of increased antibiotic resistance in the general population.
8. The optimum dosing and route of administration of antibiotics should be considered in order to achieve a high intraocular concentration immediately following surgery.
9. Although the incidence is rare, ophthalmologists should be aware of the potential risk of toxic anterior segment syndrome (TASS).
10. Absent a normal capsular bag, ophthalmologists should determine whether the power and design of an intraocular lens (IOL) intended for capsular bag fixation is or is not appropriate for ciliary sulcus placement.
11. Safety protocols should be in place to prevent the occurrence of wrong-site surgery.

Recommended Examination Components

- Patient history including an assessment of visual function status and interference with activities of daily living (ADLs) and/or occupation.
- Specific complaints pertaining to blurred and/or decreased vision.
- Identification of other causes for decreased visual acuity (which should be documented).
- Demonstration of retinal potential.

Floppy Iris Syndrome. Flomax (tamsulosin) is a popular drug prescribed for the relief of symptoms of benign prostatic hyperplasia (BPH) however, the drug increases the risk of complications associated with the treatment of cataracts. Intraoperative floppy iris syndrome (IFIS) is described as progressive intraoperative miosis, iris prolapse or billowing iris during any stage of cataract surgery. Several studies have reported the incidence of this syndrome among alpha-blocker users as ranging from 33 percent to as high as 78 percent. The most commonly seen complications are iris trauma, posterior capsular tears and vitreous loss. Flomax relaxes the smooth muscle of the bladder neck—and, inadvertently, the iris dilator as well—by specifically targeting the alpha1A receptors. Its specificity significantly reduces the postural hypotension that is common to nonselective alpha blockers used to treat BPH. The blockade of this receptor subtype, however, renders ineffective the conventional dilator drops used in cataract surgery. There have been cases in which a mere two weeks of Flomax therapy led to IFIS. While Flomax is not the only drug implicated, it is by far the most common. But many studies have shown a statistically increased risk of IFIS among users of other alpha1 blockers, such as terazosin (Hytrin) and alfuzosin (Uroxatral), which are used to relieve symptoms of BPH. Doxazosin (Cardura), used to treat systemic hypertension as well as BPH, also falls in this category.

The ophthalmologist can take a few steps in advance of surgery to improve the chance of successful outcomes.

Atropine. The use of atropine drops—1 percent three times a day starting one to three days before surgery—has met with limited success. Atropine provides excellent preoperative pupil dilation but is not as good at controlling pupil size during phacoemulsification. Cases of urinary retention following topical atropine use have been reported.

Epinephrine. Off-label use of intracameral epinephrine—a dilution of 1:1,000 sulfite-free and preservative-free epinephrine further diluted 1:3 with BSS to yield a concentration of 1:4,000—to improve iris tone has been used with great success. The potential for endothelial toxicity has been greatly reduced in recent years by the elimination...
of preservatives in selected formulations of epinephrine. It is one of the most popular practices used by surgeons today for the management of IFIS. Joel K. Shugar, MD, MSC, reported his use of the same solution but using BSS Plus instead and then mixing that dilution further with one part unpreserved 4 percent lidocaine. Some surgeons have reported not needing an adjunct method for maintaining iris dilation with the use of Dr. Shugar’s solution, not even atropine drops. And its 6.9 pH avoids the conjunctival irritation that can be seen with epinephrine without lidocaine. This method is recommended, along with adjunctive measures if needed, to minimize the complications.

Intraoperative Techniques

Several intraoperative strategies may aid in delivering optimal results.

**Well-constructed corneal incisions.** It is essential, in potential IFIS cases, to create a triplanar, self-sealing corneal incision. A well-constructed incision may prevent iris prolapse through the wound. Incisions that are too short or are biplanar are more likely to have the iris prolapsed toward them. Some surgeons also report creating a slightly longer incision within the clear cornea plane for this reason.

**Trypan blue.** Some surgeons use trypan blue to stain the anterior capsule in Flomax cases as it helps the surgeon view and stay clear of the rim of the capsulorhexis if the pupil becomes miotic or other signs of IFIS occur during phacoemulsification. Trypan blue also helps the surgeon view areas of the capsule not well exposed by iris hooks. More recently, it has been suggested that use and subsequent exposure to light for one minute, actually makes the capsule tougher and, hence, less susceptible to tearing. Some have not experienced a difference.

**Low fluidics.** The use of less aggressive irrigation and aspiration is a logical step in managing a billowing iris. Surgeons have reported greatest success with simply reducing the fluidics parameters on the phaco machines by 10 to 15 percent (e.g., lowering bottle height from 95 cm to 84 cm). Newer phaco machines feature automated settings for use in IFIS patients. A single-port phaco tip has been developed that is expected to reduce turbulence in the anterior chamber. Up to 95 percent of IFIS cases have been reported as successfully managed when low fluidics were used in combination with a viscoadaptive ophthalmic viscosurgical device such as Healon 5.

**Iris retractors.** Popular in managing IFIS, IRs require at least two extra incisions and placement after the capsulorhexis can be difficult and may increase surgical time. Intervening success of methods like intracameral epinephrine and low fluidics, make the use of IRs less popular. As there is no risk of midprocedure pupil constriction with iris retractors, they are appropriate in patients who have already demonstrated poor dilation in the clinic or before surgery. IRs may be arranged in a diamond configuration for greatest effectiveness.

**Retractor rings.** Specialized training is required to use the rings as their successful placement requires a narrow range of pupil size (between 4 and 7 mm). They are difficult to place if the anterior chamber is shallow, or after the capsulotomy or hydrodissection has been performed. Success rates are comparable with those of iris retractors.

**Intraocular Lens Implant**

An Intraocular lens (IOL) implant consists of a small, clear, plastic lens which can replace a member’s natural lens after it has been removed. Used to improve vision, IOLs are often placed after cataract surgery. The IOL becomes permanent and is unable to be felt or seen.

Four types of IOLs are commonly used:

1. **Monofocal** are a single, fixed length lens and for distance vision only. Reading glasses are often needed after an implant is inserted. Types of monofocal IOLs include (but are not limited to) Akreos™, CeeOn™ Edge Model 911A, PAL™, Softec HD™, and iSpheric™ Model YA-60BB.

2. **Multifocal** are lenses for near and distant vision. Types of multifocal IOLs include (but are not limited to) AcrySof® ReSTOR®, ReZoom®, and Tecnis® Model ZM900 and ZMA00.

3. **Accommodating (accommodative)** are said to duplicate the accommodation of the natural lens and known as presbyopia correcting lenses. A common types of multifocal IOLs includes (but is not limited to) the Crystalens™ Model AT-45.
4. **Ultraviolet Light Absorbing** lenses consist of a special polymeric material that absorbs ultraviolet light as well as blue light (short wavelength) which is said to improve vision clarity. Options include monofocal or multifocal. Types of multifocal IOLs include (but are not limited to) C-Flex™, Allergan Model AC21B, and the XACT® Model X-60 and X-70.

In addition, for members having cataract removal surgery, IOL implants must be inserted during removal of member’s natural lens during cataract surgery. If bilateral removal is being done along with IOL implants, cataract removal surgery should be done on one eye at a time in order to allow sufficient healing time (typically 2 to 6 weeks).

*For member’s undergoing non-cataract related surgery, IOL must be placed during surgery, and should not be performed on both eyes on the same day because of the potential for visual loss.*

**Bilateral Extraction.** 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. Bilateral cataract extraction should not be performed on both eyes on the same day because of the potential for bilateral visual loss. If the first cataract extraction is performed and a subsequent contralateral cataract extraction is considered, the criteria for coverage of the procedure in the contralateral eye are the same as the criteria for the first cataract extraction.¹

**Visual Tests Prior to and General Anesthesia During IOL Implantation Surgery.** Cataract surgery with an intraocular lens (IOL) implant is should include a substantial number of preoperative tests that 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.⁷

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. 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. The use of general anesthesia in cataract surgery may be considered reasonable and necessary if, for particular medical indications, it is the accepted procedure among ophthalmologists in the local community to use general anesthesia.¹⁰

The following ophthalmologic services are considered medically necessary prior to surgery when indicated due to other ophthalmological conditions:
- Optical coherence biometry
- Ultrasound, A-scan, diagnostic
- Ultrasound, A-scan, ophthalmic biometry
- Ultrasound, with intra-ocular lens (IOL) power calculation.

**POSITION STATEMENT**

**Applicable To:**
- [x] Medicaid
- [x] Medicare

**For Standard and Complex Reviews**

**Exclusions**

CMS cites the following contraindications to cataract surgery:⁷

1. Glasses or visual aids provide satisfactory functional vision.
2. The patient’s lifestyle is not compromised by the cataract.
3. The patient is unable to undergo surgery because of coexisting medical or ocular conditions.
4. The patient does not desire surgery.
5. Surgery will not improve visual function.
6. A legal consent cannot be obtained.

Premium IOL implants are not medically necessary or a covered benefit for the following:

1. Premium IOL implant for any condition, including aphakia. Such implants reduce the need for reading glasses – this is not considered medically necessary as it is a convenience.
2. Lenses that correct a refractive error – these include (but are not limited to):
   - presbyopia correcting IOL such as Array® Model SA40, ReZoom™, AcrySof® ReStor®, Tecnis ZM900, Crystalens™ Model AT-45, Crystalens HD™, and Crystalens Aspheric Optic™.
   - astigmatism correcting IOL (Toric IOLs)
   - phakic IOL (ARTISAN®, STAR Visian ICL™)

### Coverage

Cataract removal surgery is considered medically necessary and a covered benefit when one of following criterion below are met:

1. Cataract causing symptomatic (i.e., causing the patient to seek medical attention) impairment of visual function not correctable with a tolerable change in glasses or contact lenses resulting in specific activity limitations and/or participation restrictions including, but not limited to, reading, viewing television, driving, or meeting vocational or recreational needs; OR,
2. Concomitant intraocular disease (e.g., diabetic retinopathy or intraocular tumor) requiring monitoring or treatment that is prevented by the presence of cataract; OR
3. Lens-induced disease threatening vision or ocular health (including, but not limited to, phacomorphic or phacolytic glaucoma); OR,
4. High probability of accelerating cataract development as a result of a concomitant or subsequent procedure (e.g., pars plana vitrectomy, iridocyclectomy, procedure for ocular trauma) and treatments such as external beam irradiation; OR
5. Cataract interfering with the performance of vitreoretinal surgery; OR
6. Intolerable anisometropia or aniseikonia uncorrectable with glasses or contact lenses that exists as a result of lens extraction in the first eye (despite satisfactorily corrected monocular visual acuity).

NOTE: A comprehensive eye examination to include a diagnostic A-mode ultrasound (A-scan) prior to surgery may be necessary.

### Second Step Review Needed for Complex Cataract Surgeries

**Coverage**

Complex cataract surgery is intended to differentiate the extraordinary work performed during the intraoperative or postoperative periods in a subset of cataract operations. Complex Cataract Surgery is considered medically necessary when surgery requires devices or techniques not generally used in a routine cataract surgery; or extraordinary work required during the postoperative period. Members must meet one of the following criteria:

1. **Pediatric members (age up to and including 18).** Pediatric cataract surgery may be more difficult intraoperatively because of an anterior capsule which is more difficult to tear, cortex which is more difficult to remove, and the need for a primary posterior capsulotomy or capsulorhexis. Additional postoperative work is associated with pediatric cataract surgery.
2. **Surgery will involve the use of Trypan or Indocyanine Green (ICG) Dye** to aid with visualization during cataract procedures, used for:
   - Mature, White, Dense Cataracts
   - Traumatic Cataracts
   - Cataracts with corneal opacity
   - Pediatric Cataracts
Trypan or ICG dyes can be used for other indications aside from mature or hypermature cataracts. Dyes may be used as outlined above and hence are categorized as “complex” and not typically used during standard procedures.\textsuperscript{15}

3. **Member has a miotic pupil, Floppy Iris Syndrome, or a pupil that will not dilate.** The iris may become flaccid (or floppy) during surgery and **pupil won’t dilate**. This occurs as a result of certain medications (alpha 1 blockers) such as:
- Tamulosin (Flomax)*
- Terazosin (Hytrin)*
- Doxazosin (Cardura)\textsuperscript{^}
- Alfuzosin (Uroxatral)*
- Finasteride (Proscar)*

\* Prescribed for hypertension and prostate conditions such as benign prostatic hyperplasia (BPH)
\^ Prescribed for hypertension and prostate conditions

A miotic pupil which will not dilate sufficiently to allow adequate visualization of the lens in the posterior chamber of the eye and which requires the insertion of four (4) iris retractors through four (4) additional incisions, Beechler or similar expansion device, a sector iridectomy with subsequent suture repair of iris sphincter, synechialysis utilizing papillary stretch maneuvers or sphincterotomies created with scissors.

4. **Member had a previous eye surgery.** For example, a vitrectomy, or some other procedure in the past which makes performing a cataract surgery more difficult.

5. **Surgical or Post-Op Complications.** Extraordinary work may occur during the postoperative period. This is the case with pediatric cases mentioned above and very rarely when there is extreme postoperative inflammation and pain.

6. **Surgery is to Produce Lens Support.** The presence of a disease state that produces lens support structures that are abnormally weak or absent. This requires the need to support the lens implant with permanent intraocular sutures and/or a capsular support ring (approved by the FDA) may be necessary to allow placement of an intraocular lens.

\*NOTE: A mature cataract is one in which there is no clear cortex detectable beneath the anterior capsule and the best corrected vision is “hand motion” or worse.

**iSTENT Procedure in Conjunction with Cataract Surgery**

The use of the iStent Trabecular Micro-Bypass Stent System is considered medically necessary and a covered benefit for the treatment of members with mild or moderate open-angle glaucoma and a cataract when medication therapies (e.g., ocular hypotensive medication) have failed to control intraocular pressure. The iSTENT Trabecular Micro-Bypass stent is indicated for use in conjunction with cataract surgery for the reduction of IOP in adult subjects with mild to moderate open-angle glaucoma currently treated with ocular hypotensive medication.\textsuperscript{5,8}

**Inpatient Cataract Surgery**

Inpatient cataract removal surgery is typically not medically necessary. In the event a patient cannot have outpatient surgery, the following medical necessity should be followed:

- Additional medical conditions require prolonged post-operative observation by a nurse or other skilled personnel and the member requires general medical and nursing care for a particularly complex ocular procedure(s); OR;
- Multiple ocular conditions are present (e.g., best correctable vision in the non-operated eye is 20/200 or worse); OR;
- Member needs multiple ocular procedures (e.g., medical circumstances exist that make having to undergo anesthesia twice may be dangerous or life-threatening and dual cataract removal is performed); OR;
- Risk of injury exists during the immediate post-operative period due to a member being mentally debilitated.
or diagnosed with a mental illness, or is otherwise functionally incapacitated.

- Successful post-operative care is not likely in an outpatient setting due to member’s physical disability.

### CODING

**Covered CPT® Codes** – when criteria is met

- **66830** Removal of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid) with corneoscleral section, with or without iridectomy (iridocapsulotomy, iridocapsulectomy)
- **66840** Removal of lens material; aspiration technique, 1 or more stages
- **66850** - phacofragmentation technique (mechanical or ultrasonic) (eg, phacoemulsification), with aspiration
- **66852** - pars plana approach, with or without vitrectomy
- **66920** - intracapsular
- **66930** - intracapsular, for dislocated lens
- **66940** - extracapsular (other than 66840, 66850, 66852)
- **66982** Extracapsular Cataract Removal with insertion of intraocular lens prosthesis (1-Stage Procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhesis) or performed on patients in the amblyogenic developmental stage
- **66983** Intracapsular Cataract Extraction with insertion of intraocular lens prosthesis (1-stage procedure)
- **66984** Extracapsular Cataract Removal with insertion of intraocular lens prosthesis (1- stage procedure), manual or mechanical techniques (eg, irrigation and aspiration or phacoemulsification)
- **66985** Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal
- **76511** Ophthalmic ultrasound, diagnostic; quantitative A-scan only
- **76516** Ophthalmic biometry by ultrasound echography, A-scan
- **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
- **99070** Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (intraocular lens prosthesis)
- **0191T** Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; initial insertion (iSTENT)
- **+0376T** - each additional device insertion (iSTENT)

**CPT® Modifiers**

- **RT** Right (used to identify procedures performed on the right side of the body)
- **LT** Left (used to identify procedures performed on the left side of the body)
- **50** Bilateral (Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5 digit code.

### Covered HCPCS Codes

- **C1780** Lens, intraocular (new technology)
- **C1840** Lens, intraocular (telescopic)
- **V2630** Anterior chamber intraocular lens
- **V2631** Iris supported intraocular lens
- **V2632** Posterior chamber intraocular lens

### Non-Covered HCPCS Codes

- **Q1004** New technology intraocular lens category 4 as defined in federal register notice (monofocal only)
- **Q1005** New technology intraocular lens category 5 as defined in federal register notice (monofocal only)
- **S0596** Phakic intraocular lens for correction of refractive error
- **V2787** Astigmatism correcting function of intraocular lens
- **V2788** Presbyopia correcting function of intraocular lens
**Covered ICD-10-PCS Codes** – when criteria is met
- **08DJ3ZZ** Extraction of right lens, percutaneous approach
- **08DK3ZZ** Extraction of left lens, percutaneous approach
- **08RJ3JZ** Replacement of right lens with synthetic substitute, percutaneous approach
- **08RK3JZ** Replacement of left lens with synthetic substitute, percutaneous approach

**Covered ICD-10-CM Diagnosis Codes** – *This list may not be all inclusive*
- **E08.311-E08.36** Diabetes mellitus due to underlying condition with ophthalmic complications
- **E09.311-E09.36** Drug or chemical induced diabetes mellitus with ophthalmic complications
- **E10.311-E10.39** Type 1 diabetes mellitus with ophthalmic complications
- **E11.311-E11.39** Type 2 diabetes mellitus with ophthalmic complications
- **E13.311-E13.39** Other specified diabetes mellitus with ophthalmic complications
- **H21.81** Floppy iris syndrome
- **H25.011-H25.9** Age-related cataract
- **H26.001-H26.9** Other cataract
- **H27.10-H27.139** Dislocation of lens
- **H28** Cataract in diseases classified elsewhere
- **H33.001-H33.059** Retinal detachment with retinal break
- **H33.8** Other retinal detachments
- **H40.061-H40.069** Primary angle closure without glaucoma damage
- **H40.10X-H40.159** Open-angle glaucoma
- **H40.211-H40.219** Acute angle-closure glaucoma
- **H40.50X-H40.53X4** Glaucoma secondary to other eye disorders
- **H40.89** Other specified glaucoma
- **H44.19** Other enophthalmitis
- **H52.31** Anisometropia
- **H52.32** Aniseikonia
- **H54.0X33-H54.8** Blindness and low vision
- **H57.03** Miosis
- **H59.021-H59.029** Cataract (lens) fragments in eye following cataract surgery
- **Q12.0-Q12.9** Congenital lens malformations
- **Q15.0** Congenital glaucoma
- **T85.21XA-T85.29XS** Mechanical complication of intraocular lens
- **T85.79XA-T85.79XS** Infection and inflammatory reaction due to other internal prosthetic devices, implants, and grafts
- **T85.810A-T85.9XXS** Other specified complications of internal prosthetic devices, implants and grafts, not elsewhere classified
- **Z98.41-Z98.49** Cataract extraction status
- **Z98.83** Filtering (vitreous) bleb after glaucoma surgery status

**Non-Covered ICD-10-CM Diagnosis Codes**
- **H35.89** Other specified retinal disorders (phakoma)
- **H52.201-H52.229** Astigmatism
- **H52.4** Presbyopia

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

**REFERENCES**

4. Bass EB, Willis S, Scott IU, Javitt JC, Tielsch JM, Schein OD, Steinberg EP. Preference values for visual states in patients planning to...


MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/7/2017</td>
<td>Approved by MPC. No changes.</td>
</tr>
<tr>
<td>11/3/2016</td>
<td>Approved by MPC. Updated information re: visual acuity, premium lenses.</td>
</tr>
<tr>
<td>6/2/2016</td>
<td>Approved by MPC.</td>
</tr>
<tr>
<td>2/4/2016, 2/5/2015</td>
<td>Approved by MPC. No changes.</td>
</tr>
<tr>
<td>9/4/2014</td>
<td>Approved by MPC. Changes to criteria for visual acuity.</td>
</tr>
<tr>
<td>6/5/2014</td>
<td>Approved by MPC. Changes due to CMS LCD for iSTENT.</td>
</tr>
<tr>
<td>4/3/2014</td>
<td>Approved by MPC. No changes.</td>
</tr>
<tr>
<td>4/11/2013</td>
<td>Approved by MPC. New guideline.</td>
</tr>
</tbody>
</table>