Medical Policy & Procedure

Policy Name:	Medical Policy: Cataract Removal	Policy #:	MP-267

Policy Information

Owner Department:	Medical UM & Systems Department
Owner:	Assigned Medical Director
Electronic Signature/Date:	Krystal Revai (04/26/2023), Lori Slaughter (04/25/2023)

If there is a discrepancy between a medical policy and a patient's policy or plan document/summary plan description, the policy or plan document/summary plan descriptions provisions and limitations will govern the determination of benefits.

Purpose of the Policy

To make utilization decisions, Health Alliance uses written criteria based on sound clinical evidence for appropriately applying the criteria.

Statement of the Policy

To apply objective and evidence-based criteria when determining the medical appropriateness of health care services.

NOTE: Please refer to plan documents for prior authorization necessity/status.

Interpretations

Health Alliance uses InterQual criteria to determine the medical necessity of cataract removal. The InterQual criteria are available in the Utilization Management software systems and can be accessed by providers when submitting an authorization digitally.

Coverage for intraocular lenses (IOLs), contact lenses, and glasses is addressed in the Vision Prescriptions: Intraocular and Contact Lenses and Glasses Medical Policy.

Medicare Advantage Criteria Details:

- NCD - Phaco-Emulsification Procedure - Cataract Extraction (80.10) (cms.gov)
- Enter the available NCD/LCD/LCA ID in Medicare link/website below for criteria details.
- MCD Search (cms.gov)

Regional Medicare Admin Contractor (MAC) – Member's state	Regional LCD/LCA Identifier	Applicable Criteria
NGS (IL)	L33558/A56544	NGS LCD/LCA
Noridian (WA)	L37027/A57196	Noridian LCD/LCA
Palmetto (NC)	L34413/A56613 L37664/A56792	Palmetto LCD/LCA
WPS (J5) (IA)	None	NCD
WPS (J8) (IN)	None	NCD
CGS (OH)	L33946/A56493 L33954/A56453	CGS LCD/LCA

CPT Codes

*Codes listed are for informational purposes only and do not necessarily indicate prior authorization is or is not required or coverage is guaranteed.	
66820	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); stab incision techniques (Ziegler or Wheeler knife)
66821	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (e.g., YAG laser) (one or more stages)
66830	Removal of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid) with corneo-scleral section, with or without iridectomy (iridocapsulotomy, iridocapsulectomy
66840-66940	Removal of lens material, including intra- and extra-capsular approaches with various techniques

Providers are required to indicate the diagnosis and procedure codes when requesting review of coverage.

References

History

Created Date:	11/18/10		
Effective Date:	11/18/10		
Next Review Date:	04/26/2024		
Revision Date:	04/13/11 – MDC	04/11/12 – MDC	05/14/13 – MDC
	04/25/14 – MDC	11/18/14	03/11/15 – MDC
	06/08/16	08/09/17 – MDC (IQ)	
	07/03/18 – MDC-Reviewed with no changes.		
	08/21/18 – MDC-Approved InterQual 2018 revisions.		
	07/16/19 – MDC-Annual review, no changes.		
	06/24/20 – MDC-Annual review, Clear Coverage language updated to Guiding Care/InterQual.		
	04/20/21 – MDC-Annual review, no changes.		
	04/19/22 – MDC-Annual review, codes added, Medicare information added.		
	04/18/23 – MDC-Annual review, Medicare information updated; otherwise no changes.		