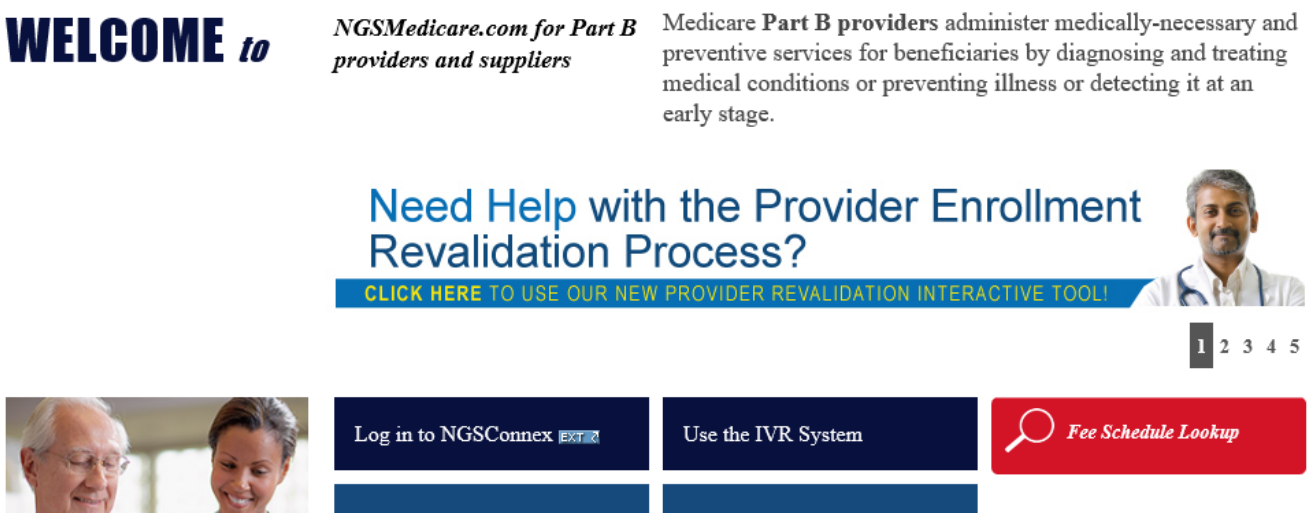
AMERICAN ACADEMY™
OF OPHTHALMOLOGY

**National Government Services (NGS)**
**Jurisdiction JK - Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, and Vermont**
**Local Coverage Determinations (LCDs)**
**Updated 05.05.2016**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| LCD ID | LCD Title | Effective Date | Last Updated |
|---|---|---|---|
| L33646 | BotulinumToxins | 10/01/2015 | 04/01/2016 |
| L33558 | Cataract Extraction | 10/01/2015 | 02/18/2016 |

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|---|---|---|---|
| L33392 | Category III CPT® Codes | 10/01/2015 | 03/18/2016 |
| L33630 | Corneal Pachymetry | 10/01/2015 | 01/07/2016 |
| L33394 | Drugs and Biologicals, Coverage, for Label and Off-Label Uses | 10/01/2015 | 04/22/2016 |
| L33584 | Implantable Miniature Telescope (IMT) | 10/01/2015 | 12/17/2015 |
| L33621 | Ophthalmic Biometry for Intraocular Lens Power Calculation | 10/01/2015 | 01/07/2016 |
| L33567 | Ophthalmology: Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography) | 10/01/2015 | 11/17/2015 |
| L33628 | Panretinal (Scatter) Laser Photocoagulation | 10/01/2015 | 03/03/2016 |
| L34380 | Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) | 10/01/2015 | 11/23/2015 |
| L33574 | Visual Fields Testing | 10/01/2015 | 01/07/2016 |

## L33646 Botulinum Toxins

**Indications and Limitations of Coverage and/or Medical Necessity**

**Blepharospasm**

Botulinum toxin injection therapy is accepted first line treatment for patients with blepharospasm and/or hemifacial spasm. If the upper and lower lid of the same eye and/or adjacent facial muscles, or brow are injected at the same surgery, the procedure is considered to be unilateral. Bilateral procedures will only be considered when both eyes or both sides of the face are injected.

**Headache/Migraine**

Coverage will only be allowed for those patients with chronic daily headaches (headache disorders occurring greater than 15 days a month - in many cases daily with a duration of four or more hours - for a period of at least 3 months) who have significant disability due to the headaches, and have been refractory to standard and usual conventional therapy. The etiology of the chronic daily headache may be chronic tension-type headache or chronic migraine (CM). CM is characterized by headache on > 15 days per month, of which at least 8 headache days per month meet criteria for migraine without aura or respond to migraine-specific treatment. For continuing Botulism toxin therapy the patients must demonstrate a significant decrease in the number and frequency of headaches and an improvement in function upon receiving Botulinum toxin.

**Limitations:**

Medicare will allow payment for one injection per site regardless of the number of injections made into the site. A site is defined as one eye (including all muscles surrounding the eye including both upper and lower lids); one side of the face; the neck; or extremity and/or trunk muscle(s).

Failure of two definitive, consecutive, treatment sessions involving a muscle or group of muscles could preclude further coverage of the serotype used in the treatment for a period of one year after the second session. It may be reasonable, however, to attempt treatment with a different serotype.

Treatment of wrinkles (ICD-10-CM codes L90.8 and L91.8) using Botulinum toxins is considered to be cosmetic, and is not covered under Medicare.

**CPT/HCPCS Codes:** 64612; 64615; 67345; J0585; J0586; J0587; J0588

**ICD-10 Codes that Support Medical Necessity**: See LCD list

**Documentation Requirements:**

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.

For coverage of Botulinum toxin treatment by Medicare, the medical record should include:

- •documentation of the medical necessity for this treatment. For spastic conditions other than upper limb spasticity, blepharospasm, hemifacial spasm, cervical dystonia or other focal dystonias, documentation should include a statement that the spastic condition has been unresponsive to conventional treatment**;**
- •a covered diagnosis;
- •dosage(s), site(s) and frequency(ies) of injection;
- •documentation of the medical necessity for associated electromyography when used; and
- •description of the effectiveness of this treatment.

Due to the short life span of the drug once it is reconstituted, Medicare will reimburse the unused portions of Botulinum toxins. However, the documentation in the medical records must show the precise amount of the drug administered and the amount discarded.
Documentation must be available upon request of the contractor. Peer-reviewed medical literature may be requested for case-by-case determinations.

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## L33558 Cataract Extraction

**Indications and Limitations of Coverage and/or Medical Necessity**

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 who have a cataract, and who meet all of the following criteria:

The patient has impairment of visual function due to cataract(s) and the following criteria are met and clearly documented:

- Decreased ability to carry out activities of daily living including (but not limited to): reading, watching television, driving, or meeting occupational or vocational expectations; and
- 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
- The patient has determined that he/she is no longer able to function adequately with the current visual function; and
- Other eye disease(s) including, but not limited to macular degeneration or diabetic retinopathy, have been ruled out as the primary cause of decreased visual function; and
- Significant improvement in visual function can be expected as a result of cataract extraction; and
- The patient has been educated about the risks and benefits of cataract surgery and the alternative(s) to surgery (e.g., avoidance of glare, optimal eyeglass prescription, etc.); and

- The patient has undergone an appropriate preoperative ophthalmologic evaluation that generally includes a comprehensive ophthalmologic exam and ophthalmic biometry.

Cataract extraction may be covered when an unimpeded view of the fundus is mandatory for proper management of patients with diseases of the posterior segment of the eye(s).

Cataract extraction may be covered during vitrectomy procedures if it is determined that the lens interferes with the performance of the surgery for far peripheral vitreoretinal dissection and excision of the vitreous base, as in cases of proliferative vitreoretinopathy, complicated retinal detachments, and severe proliferative diabetic retinopathy.

For patients with a best corrected visual acuity of 20/40 or better, cataract extraction will be considered if all other criteria have been met and there is substantial documentation of the medical necessity of the procedure for that patient.

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.

Immediate, sequential, bilateral surgery has advantages and disadvantages that must be carefully weighed and discussed by the surgeon and patient. Foremost is the risk of potentially blinding complications in both eyes. For this reason the second eye should be treated like the eye of a different patient using separate povidone iodine prepping, draping, instrumentation, and supplies such as irrigating solutions, OVD, and medications.

***Complex Cataract Surgery (CPT code 66982)***
The code for complex cataract surgery (CPT code 66982) is intended to differentiate the extraordinary work performed during the intraoperative or postoperative periods in a subset of cataract operations including, and not limited to, the following:

- 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 tuilizing papillary stretch maneuvers or sphincterotomies created with scissors.

- 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.

- 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. Furthermore, there is additional postoperative work associated with pediatric cataract surgery.

- 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.

**CPT/HCPCS Codes:** 66840; 66850; 66852; 66920; 66930; 66940; 66982; 66983; 66984
**ICD-10 Codes that Support Medical Necessity**: See LCD List

**Documentation Requirements:**
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 medical record and/or test results documenting medical necessity should be maintained and made available on request.

If cataract extraction is performed due to anisometropia, the medical record must substantiate the presence of significant aniseikonia secondary to anisometropia arising from the first cataract extraction with IOL implant. The medical record must reflect that the aniseikonia is visually significant to the patient by documenting the patient's subjective complaints and must also document that anisometropia is present by determination of the refractive error in both eyes after the first cataract surgery.

If cataract extraction is performed in order to visualize the fundus, the disease being treated must appear in the medical record, and the necessity for visualization must be described in the medical record.

For CPT code 66982, complex cataract extraction, to be reasonable and necessary, the procedure should require devices or techniques not generally used in routine cataract surgery. Please see examples below:

- The operative note indicates the use of an endocapsular ring to partially occlude the pupil.
- The operative note indicates that a permanent intraocular suture or a capsular support ring was employed to place the intraocular lens in a stable position.
- The operative note indicates a capsular support ring was employed or an endocapsular support ring was used for partial occlusion of the pupil.
- The operative note indicates the use of micro iris hooks inserted through four (4) separate cornea incisions, use of a Beechler or similar expansion device, synechialysis utiliziaing papillary stretch maneuvers creation of multiple sphincterotomies with scissors, a sector iridotomy with suture repair of iris sphincter was performed, or a permanent intraocular suture, capsular support ring, or endocapsular support ring was used for partial occlusion of the pupil.
- The operative note indicates dye was used to stain the anterior capsule.
- The operative note indicates Phacolytic glaucoma
- The operative note indicates a primary posterior capsulorhexis was performed
- The operative note or postoperative records indicate an extraordinary amount of work was involved in the preoperative or postoperative care.
- The operative note indicates an artificial prosthetic iris was placed in the eye.

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## L33392 Category III CPT ® Codes

**Indications and Limitations of Coverage and/or Medical Necessity**
Note: Once a Category III CPT code is replaced by a Category I CPT code, the item, service, or procedure should not be presumed to be medically necessary.

**CPT code 0191T** (Effective for dates of service on or after 11/01/2012)
Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach, into the trabecular meshwork; initial insertion (when billed for patients with mild to moderate glaucoma on medication and performed with cataract surgery).

**CPT/HCPCS Codes:** All CPT Category III codes including medically necessary and not medically necessary
**ICD-10 Codes that Support Medical Necessity**: See LCD list
**Documentation Requirements:** N/A
**Utilization Guidelines:** N/A

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## L33630 Corneal Pachymetry

**Indications and Limitations of Coverage and/or Medical Necessity**
Medicare will consider corneal pachymetry to be medically necessary and reasonable when performed to determine the amount of endothelial trauma sustained during surgery, assessment of the health of the cornea pre-operatively in Fuch's dystrophy, post ocular trauma and for the assessment of corneal thickness or (in suspected glaucoma) following the diagnosis of increased intraocular pressure prior to the initiation of a treatment regimen for glaucoma. It is expected that services for the measurement of corneal thickness following the diagnosis of increased intraocular pressure will be performed once in a lifetime, unless there has been interval corneal trauma or surgery.

Medicare will consider corneal pachymetry to be medically necessary and reasonable when performed only by ophthalmologist and optometrists.

Medicare will not pay for use of pachymetry when used in preparation for surgery to reshape the cornea of the eye for the purpose of correcting visual problems (refractive surgery), such as myopia (nearsightedness) and hyperopia (farsightedness).

Whether patients have been previously diagnosed and are under treatment for glaucoma or are newly diagnosed, pachymetry will be covered once per lifetime, or more frequently in cases where there has been surgical or non-surgical trauma.

When there is a question of corneal disease supported by diagnosis, then pachymetry may be performed at the same time as endothelial cell count

**CPT/HCPCS Codes:** 76514; 92499 ( report for optical pachymetry)
**ICD-10 Codes that Support Medical Necessity**: See LCD List

**Documentation Requirements:** Medical record documentation maintained by the ordering/referring physician must indicate the medical necessity for performing the test and the test results. In addition, if the service exceeds the frequency parameter listed in this policy, documentation of medical necessity must be submitted. This information is usually found in the history and physical, office/progress notes, or test results. If the provider of the service is other than the ordering/referring physician, that provider must maintain hard copy documentation of test results and interpretation, along with copies of the ordering/referring physician's order for the studies. The physician must state the clinical indication/medical necessity for the study in his order for the test.
**Utilization Guidelines:** It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject to review for medical necessity.
It is expected that services for the measurement of corneal thickness following the diagnosis of increased intraocular pressure will be performed once in a lifetime, unless there has been interval corneal trauma or surgery.

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## L33394 Drugs and Biologicals, Coverage of, for Label and Off-Label Uses

**Indications and Limitations of Coverage and/or Medical Necessity**

A medically accepted indication, which is covered by National Government Services is one of the following:

1. An FDA approved, labeled indication or a use supported in the American Hospital Formulary Service Drug Information (AHFS-DI), NCCN Drugs and Biologics Compendium, Truven Health Analytics Micromedex DrugDex®, Elsevier/Gold Standard Clinical Pharmacology and Wolters Kluwer Lexi-Drugs® as the acceptable compendia based on CMS' Change Request 6191 (Compendia as Authoritative Sources for Use in the Determination of a "Medically Accepted Indication" of Drugs and Biologicals Used Off-Label in an Anti-Cancer Chemotherapeutic Regimen); or

2. Articles or Local Coverage Determinations (LCDs) published by National Government Services.

The compendia listed above will be accepted at the following levels;

- American Hospital Formulary Service-Drug Information (AHFS-DI) – indication is supportive
- NCCN Drugs and Biologics Compendium - indication is a Category 1 or 2A
- Micromedex DrugDex® – indication is Class I, Class IIa, or Class IIb or
- Clinical Pharmacology – indication is supportive
- Lexi-Drugs - indication is rated as “Evidence Level A”

When new off-label uses for drugs are published in the above compendia at the accepted level of recommendation, the effective date for National Government Services coverage of those off-label uses is the date of publication of our revised coverage article, not the date of inclusion in the compendia.

Regardless of the evidence supporting coverage for a particular off-label use, payment may only be made if the use is reasonable and necessary for the treatment of illness or injury of the specific patient receiving the drug.

Services related to non-covered services or drugs are also not covered (e.g., administration services).

**Documentation Requirements**

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 medical record must include the following information:

- The name of the drug or biological administered;
- The route of administration;
- The dosage (e.g., mgs, mcgs, cc's or IU's);
- The duration of the administration (for CPT codes that are time based); and
- When modifier –JW is used to report that a portion of the drug or biological is discarded, from single use vials, the medical record must clearly document the amount administered and the amount wasted or discarded.

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## L33584 Implantable Miniature Telescope (IMT)

**Indications and Limitations of Coverage and/or Medical Necessity**

The Implantable Miniature Telescope (IMT) is a telescope prosthetic device that replaces the natural lens in one eye of patients with bilateral, advanced age-related macular degeneration in order to enlarge the retinal image to such a degree that it is visualized outside of vision-impairing central scotomas.

The intraocular telescope is indicated for monocular implantation to improve vision in patients greater than or equal to 65 years of age with stable severe to profound vision impairment (best corrected distance visual acuity 20/160 to 20/800) caused by bilateral central scotoma associated with untreatable end-stage age-related macular degeneration.
Patients must:

- •Have retinal findings of geographic atrophy or disciform scar with foveal involvement, as determined by fluorescein angiography
- •Have untreatable end-stage, non-exudative, age-related macular degeneration
- •Have evidence of visually significant cataract (≥ Grade 2)
- •Agree to undergo pre-surgery training and assessment (typically 2 to 4 sessions) with low vision specialists in the use of an external telescope sufficient for patient assessment and for the patient to make an informed decision regarding the potential risks and benefits of the IMT
- •Achieve at least 5-letter improvement on the ETDRS chart with an external telescope during the pre-implant evaluation
- •Have adequate peripheral vision in the eye not scheduled for surgery
- •Complete and agree to the “Acceptance of risk and informed consent agreement” provided in the device labeling documentation
- •Agree to participate in post-implant visual training with a low vision specialist

**Limitations:**

- •Due to significantly increased risk of corneal endothelial cell loss, patients should not be considered for implantation if they have a minimum endothelial cell density of <2000 for age 75-84, or <1800 for patients 85 or greater, or
- •Anterior chamber depths of <3.0 mm, or
- •Corneal guttae

**CPT/HCPCS Codes:** C1840; 0308T
**ICD-10 Codes that Support Medical Necessity**: H35.31, H35.32

**Documentation Requirements**
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.

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## L33621 Ophthalmic Biometry for Intraocular Lens Power Calculation

**Indications and Limitations of Coverage and/or Medical Necessity**
Cataract surgery with an intraocular lens (IOL) implant is a high volume Medicare procedure. Along with the surgery, a substantial number of preoperative tests 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. (CMS Publication 100-03, Medicare National Coverage Determinations(NCD)Manual, Chapter 1, Part 1, Section 10.1)
Accordingly, where the only diagnosis is cataract(s), 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. Claims for additional tests are denied as not reasonable and necessary unless there is an additional diagnosis and the medical need for the additional tests is fully documented. (CMS Publication 100-03, Medicare National Coverage Determinations (NCD) Manual, Chapter 1, Part 1, Section 10.1)

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. To the extent the additional tests are considered reasonable and necessary by the carrier's medical staff, they are covered. (CMS Publication 100-03, Medicare National Coverage Determinations(NCD)Manual, Chapter 1, Part 1, Section 10.1)

A second complete A scan/OCB will be covered if a different surgeon, unaffiliated with the surgeon who performed the first cataract extraction, performed the extraction on the second eye. We would not anticipate a high frequency of these instances.

**Limitations**

Prior to cataract surgery on the second, contralateral eye, allowance for the power calculation can be made. However, allowance for the technical component of the A-scan or OCB CPT code cannot be made since this bilateral procedure was performed and reimbursed at the time of the first surgery.

The technical component of the scan will generally provide valid information for twelve months. A repeat scan in less than twelve months would not be covered without documentation of significant change in vision (unless required because a second unaffiliated surgeon performed the second cataract extraction.) Generally, when bilateral cataracts are noted at examination, extraction of the second cataract is only performed after results of the first cataract extraction are known and symptoms or findings support the medical necessity for removal of the cataract in the other eye. If ophthalmic biometry is performed and later the surgery is canceled, it is reasonable to allow a repeat scan if significant time, e.g., greater than one (1) year, has elapsed when surgery is rescheduled.

Ophthalmic biometry for lens power calculation should not be performed unless a decision to remove the cataract has been made by the patient and surgeon. If the biometry is performed by an optometrist, he/she should do so in coordination with the operating surgeon so that only one procedure is necessary. If the biometry is repeated by the operating surgeon due to inadequacy of the study, the original eye care physician/provider should anticipate not being reimbursed for the study.

**CPT/HCPCS Codes:** 76519; 92136
**ICD-10 Codes that Support Medical Necessity**: See LCD List

**Documentation Requirements**

The patient's medical record must contain documentation that fully supports the medical necessity for services included within this LCD. (Please 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. This documentation should include at a minimum the patient's name and date of service, the indications for testing, an order for testing, the results of testing, and the IOL power calculation. Documentation must be available to Medicare upon request.

**Utilization Guidelines**

Ophthalmic biometry using A-scans (76519) and optical coherence biometry (92136) for the same patient should not be billed by the same provider/physician/group during a 12-month period. Claims for either of these services in excess of these parameters will not be considered medically necessary.

The technical portion of either 76519 or 92136 and the respective interpretations for the same patient should not be billed more than once during a 12 month period by the same provider/physician/group unless

there is a significant change in vision. Claims in excess of these parameters will not be considered medically necessary.

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## L33567 Ophthalmology: Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography)

**Indications and Limitations of Coverage and/or Medical Necessity**

***Fundus photography***

- Fundus photography may be indicated to document abnormalities of disease processes affecting the eye, or to follow the progress of such disease.
- In order to document a disease process or follow the progress of a disease, photographs and an interpretation and report of the test may be necessary. Photographs and an interpretation and report of the test may also be necessary to plan treatment for a disease process.
- Fundus photography may be used for the diagnosis of conditions such as macular degeneration, retinal neoplasms, choroid disturbances and diabetic retinopathy, glaucoma, multiple sclerosis or other central nervous system anomalies.
- Fundus photography may be indicated for examination of the retina in diabetic patients, in whom symptoms of visual disturbances may be present and in whom retinal examination may be unremarkable or normal.

***Extended ophthalmoscopy***

Extended ophthalmoscopy is indicated when the level of examination requires a complete view of the posterior segment of the eye and documentation is greater than that required for general ophthalmoscopy. An extended ophthalmoscopy may be considered medically reasonable and necessary for the following conditions:

A. Malignant neoplasm of the retina or choroid.

B. Retained (old) intraocular foreign body, either magnetic or nonmagnetic. Signs and symptoms may include a statement by the patient that something has hit his/her eye (foreign body sensation), normal or blurred vision, pain or no discomfort, and tearing.

C. Retinal hemorrhage, edema, ischemia, exudates and deposits, hereditary retinal dystrophies or peripheral retinal degeneration.

D. Retinal detachment with or without retinal defect. The patient may complain of light flashes, dark floating specks, and blurred vision that becomes progressively worse. This may be described by the patient as "a curtain came down over my eyes."

E. Symptoms suggestive of retinal defect (ex: flashes and/or floaters).

F. Retinal defects without retinal detachment.

G. Diabetic retinopathy (i.e., background retinopathy or proliferative retinopathy), retinal vascular occlusion, or separation of the retinal layers. This may be evidenced by microaneurysms, cotton wool spots, exudates, hemorrhages, or fibrous proliferation.

H. Experienced sudden visual loss or transient visual loss.

I. Chorioretinitis, chorioretinal scars or choroidal degeneration, dystrophies, hemorrhage and rupture, or detachment.

J. Sustained a penetrating wound to the orbit resulting in the retention of a foreign body in the eye.

K. Sustained a blunt injury to the eye or pariorbita.

L. Disorders of the vitreous body (i.e., vitreous hemorrhage or posterior vitreous detachment). Spots before the eyes (floaters) and flashing lights (photopsia) can be signs/symptoms of these disorders.

M. Posterior scleritis. Signs and symptoms may include severe pain and inflammation, proptosis, limited ocular movements, and a loss of a portion of the visual field.

N. Vogt-Koyanagi syndrome. A condition characterized by bilateral uveitis, dysacousia, meningeal irritation, whitening of patches of hair (poliosis), vitiligo, and retinal detachment. The disease can be initiated by a severe headache, deep orbital pain, vertigo, and nausea.

O. Degenerative disorders of the globe.

P. Retinoschisis and retinal cysts. Patients may complain of light flashes and floaters.

Q. Signs and symptoms of endophthalmitis, which may include severe pain, redness, photophobia, and profound loss of vision.

R. Glaucoma or is a glaucoma suspect. This may be evidenced by increased intraocular pressure or progressive cupping of the optic nerve.

S. Systemic disorders which may be associated with retinal pathology.

T. High axial length myopia

U. Retinal edema

V. Metamorphopsia

W. High-risk medication for retinopathy or optic neuropathy.

X. Choroidal nevus being evaluated for malignant transformation.

Y. Macular degeneration.

**Limitations**

If the study is performed as a screening service, it is not covered by Medicare.

*Fundus photography*

- All tests must include a written interpretation. If an interpretation is not included in the same medical record with the photograph, then both the technical and professional components will be considered not medically necessary.

- Fundus photography is a bilateral service on the Medicare Physician Fee Schedule Data Base. Services performed unilaterally are subject to a reduction in fee.

- Fundus photography is not a substitute for an annual dilated examination by a qualified professional (e.g., in diabetic patients). Fundus photographs taken by a non-eye professional and sent (transtelephonically, via internet, or by other means) to a qualified professional for interpretation will be considered without Medicare benefit category. Such tests will be denied as non-covered. Fundus photography of a normal retina will be denied as not medically necessary.

- Remote imaging for detection of retinal disease (CPT code 92227) is considered screening and will be denied as non-covered.

*Extended ophthalmoscopy*

- Extended ophthalmoscopy of a fellow eye without signs or symptoms or new abnormalities on general ophthalmoscopic exam will be denied as not medically necessary. Repeated extended ophthalmoscopy at each visit without change in signs, symptoms or condition may be denied as not medically necessary.

- General ophthalmoscopy and biomicroscopy are part of an ophthalmologic examination (92002-92004) and are not separately payable, but these should still be documented in the patient's medical record.

- If indirect ophthalmoscopy is done without a drawing or does not meet the standards indicated in the attached Appendix A, the service is not separately payable and will be considered part of a general ophthalmologic exam (92002-92014) or E&M service.

- Extended ophthalmoscopy (codes 92225, 92226) performed during the global surgery period of an ophthalmologic surgery procedure, by the same provider performing the surgery, will not be separately payable unless unrelated to the condition for which the surgery was performed.

- If the medical record does not include the interpretation and report, the extended ophthalmoscopy will be denied as not medically necessary.

- Extended ophthalmoscopy will be denied as not medically necessary when it is done in lieu of routine ophthalmoscopy unless the indication for this more extensive examination is documented in the medical record.

- When other ophthalmological tests (e.g., fundus photography, fluorescein angiography, ultrasound, optical coherence tomography, etc.) have been performed, extended ophthalmoscopy will be denied as not medically necessary unless there was a reasonable medical expectation that the multiple imaging services might provide additive (non-duplicative) information.

**CPT/HCPCS Codes:** 92225; 92226; 92227; 92228; 92250
**ICD-10 Codes that Support Medical Necessity**: See LCD List

**Documentation Requirements**
**Fundus photography**

The patient's medical record must contain documentation that fully supports the medical necessity for fundus photography as it is covered by Medicare. (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.
A copy of the fundus photographs must be retained in the patient's medical records. An interpretation and report of the test must also be included, in addition to the photographs themselves.

The medical record should document whether the pupil was dilated, and which drug was used.
Documentation supporting the medical necessity should be legible, maintained in the patient's record, and must be available to the carrier upon request.

**Extended ophthalmoscopy**

The patient's medical record must contain documentation that fully supports the medical necessity for extended ophthalmoscopy for each eye, as it is covered by Medicare. (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.

Retinal drawings meeting the specifications indicated in the attached Appendix A of this policy must be maintained in the patient's record.• There must be a separate detailed sketch, minimal size of 3-4 inches.

- All items noted must be identified and labeled.
- Drawings in four (4) - six (6) standard colors are preferred. However, non-colored drawings are also acceptable, if clearly labeled.
- Optic nerve abnormalities should be separately drawn.
- An extensive scaled drawing must accurately represent normal, abnormal and common findings such as: lattice degeneration, hypertensive vascular changes, proliferative diabetic retinopathy, as well as retinal detachments, holes, tears or tumors.

Documentation in the patient’s medical record for a diagnosis of glaucoma (ICD-10-CM codes H40.001-H40.152 Glaucoma ) must include all of the following:

- A separate detailed drawing of the optic nerve along with an interpretation that affects the plan of treatment,
- Documentation of cupping, disc rim, pallor, and slope,
- Documentation of any surrounding pathology around the optic nerve.

Documentation specific to the method of examination (e.g., lens, scleral depression, instrument used) should be maintained in the medical record.
The medical record should document whether the pupil was dilated, and which drug was used.
All findings and a plan of action should be documented in notes.
Although routine ophthalmoscopy and biomicroscopy are part of an ophthalmologic examination and are not separately payable, these should still be documented in the patient's medical record.
Documentation supporting the medical necessity should be legible, maintained in the patient's record, and must be available to the carrier upon request.

**Utilization Guidelines**

Patients actively being treated with intravitreal injections of medication for exudative AMD (ICD-10-CM code H35.32) may require up to 12 extended ophthalmoscopies per eye, per year.
Conditions coded with other ICD-10-CM codes in the ranges A18.53; A18.54; E08.311-E08.359 Diabetes mellitus due to underlying condition with ophthalmic complications E09.311-E09.359 Drug or chemical induced diabetes mellitus with ophthalmic complications;E10.311-E10.359 Type 1 diabetes mellitus with ophthalmic complications; E11.311-E11.359 Type 2 diabetes mellitus with ophthalmic complications; E13.311-E13.359 Other specified diabetes mellitus with ophthalmic complications; H16.241-H16.249 Ophthalmia nodosa; H20.00-H21.1X1; G45.3 Diseases of the eye and adnexa may require up to six (6) extended ophthalmoscopic examinations per eye, per year.

For ICD-10-CM codes C69.20-C69.42 Malignant neoplasm of eye and adnexa; C79.89-C79.9 Secondary malignant neoplasm of other and unspecified sites; D31.20-D31.32 Benign neoplasm of eye and adnexa up to four (4) extended ophthalmoscopic examinations may be required per eye, per year.
Other conditions usually require no more than two (2) extended ophthalmoscopic examinations per eye, per year.
Extended ophthalmoscopy is a physician service (examination of the eye) commonly occurring during the global post-operative period of ophthalmic surgery. As a physician service, it is included in the aftercare of the patient and is not separately billable.
Fundus photography is usually medically necessary no more than two times per year.
Fundus photography of a normal retina will be considered not medically necessary.
Services exceeding these parameters will be considered not medically necessary.

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## L33628 Panretinal (Scatter) Laser Photocoagulation

**Indications and Limitations of Coverage and/or Medical Necessity**

Panretinal laser photocoagulation is indicated for the treatment or management of patients with proliferative or pre-proliferative diabetic retinopathy and patients with severe levels of diabetic macular edema associated with pre-proliferative retinopathy, and other proliferative retinopathies.
While panretinal laser photocoagulation greatly reduces the risk of visual loss in all states of proliferative retinopathy, treatment is withheld until the risk of visual loss outweighs the risks and side effects of the treatment.

**Limitations**

- Medicare coverage of panretinal laser photocoagulation using a laser or xenon arc is limited to management of proliferative or pre-proliferative retinopathies.

- Panretinal laser photocoagulation is usually performed in two or more sessions (staged surgery). Payment may be made only once during the global period of the initial procedure. Reimbursement for subsequent sessions in the postoperative period of the initial procedure is included in the allowance of the initial procedure.

- Medicare allowance generally includes reimbursement for related procedures performed on the same eye during the global surgery period of the first procedure. Therefore, procedure codes 67208, 67210 or 67227 would be covered only if they represented clearly distinct and different procedures with different indications and were not re-operations or treatment of complications. Such services, and other totally unrelated services, should be billed with a modifier -79 (unilateral procedure or service by the same physician during the post-operative period).

**CPT/HCPCS Codes:** 67228
**ICD-10 Codes that Support Medical Necessity**: See LCD List

**Documentation Requirements:** 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.

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## L34380 Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)

**Indications and Limitations of Coverage and/or Medical Necessity**

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Anterior segment SCODI is used in the evaluation and treatment planning of diseases affecting the cornea, iris, and other anterior chamber structures. The procedure also may be used to provide additional information during the planning and follow-up for corneal, iris, and cataract surgeries.

Posterior segment optical coherence tomography (OCT) is considered to be reasonable and necessary to:

- Diagnose and manage medically and surgically retinal and neuro-ophthalmic diseases which involve changes in the optic nerve, subretinal and intraretinal changes, vitreo-retinal relationships and changes in the nerve fiber layer.
- Diagnose early glaucoma and monitor glaucoma treatment
- Differentiate causes of other optic nerve disorders when a diagnosis is in doubt.
- Diagnose and manage the patient's condition when visual field results are insufficient; or when reliable visual field testing cannot be performed, due to visual, physical, mental, or age constraints.
- Differentiate when a discrepancy exists between the clinical appearance of the optic nerve and the visual fields
- Detect further loss of optic nerve or retinal nerve fiber layer changes in the presence of advanced optic nerve damage and advanced visual field loss.
- Follow glaucoma suspects.

Anterior segment OCT is considered to be reasonable and necessary to:

- Evaluate narrow angle, suspected narrow angle, mixed narrow and open angle glaucoma, and angle recession as all determined by gonioscopy
- Determine the proper intraocular lens for a patient who has had prior refractive surgery and now requires cataract extraction
- Evaluate iris tumor
- Evaluate corneal edema or opacity that precludes visualization or study of the anterior chamber
- Calculate lens power for cataract patients who have undergone prior refractive surgery. (Reimbursement will only be made for the cataract codes as long as additional documentation is available in the patient record of the prior refractive procedure. Reimbursement will not be made in addition to A-scan or IOL master.)
- Evaluate and plan treatment for patients with diseases affecting the cornea, iris, lens and other anterior segment structures.
- Provide additional information during the planning and follow-up for corneal, iris, cataract, glaucoma and other anterior segment surgeries.

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**LIMITATIONS OF COVERAGE:**
◦ Absence of an indication
◦ Screening

**CPT/HCPCS Codes:** 92132; 92133; 92134
**ICD-10 Codes that Support Medical Necessity**: See LCD List

**Documentation Requirements**
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.

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## L33574 Visual Fields Testing

**Indications and Limitations of Coverage and/or Medical Necessity**
Visual field examinations are considered medically necessary for the conditions listed below:

1. The patient has a disorder of the eyelid(s) potentially affecting the visual field(s).

2. The patient has a visual field defect detected on gross visual field testing (e.g., confrontational testing).

3. The patient has a documented diagnosis of glaucoma.

   It should be noted that the progression of, and effects of treatment on glaucoma can be monitored only through periodic visual field testing. The frequency of such examinations is dependent on changes in intraocular pressure (IOP), retinal damage and changes at the optic disc.
4. The patient is suspected of having glaucoma; signs include increased intraocular pressure, asymmetric IOP measurements, notching or thinning of the neuroretinal rim, splinter hemorrhages and asymmetric appearance of the discs.

5. The patient has a documented disorder of the optic nerve, the retina or the neurologic visual pathway.

6. The patient has a recent intracranial hemorrhage, an intracranial mass or a recent increased intracranial pressure measurement (with or without visual symptoms).

7. The patient has a recent occlusion / stenosis of cerebral or precerebral arteries.

8. The patient has a history of a cerebral aneurysm, pituitary or occipital tumor potentially affecting the visual fields.

9. The patient is being evaluated for buphthalmos, congenital anomalies of the posterior segment or congenital ptosis.

10. The patient has a disorder of the orbit potentially affecting the visual field.

11. The patient has sustained a significant eye injury.

12. The patient has unexplained visual loss.

13. The patient has a pale or swollen optic nerve on a recent examination.
14. The patient is having new functional limitations which may be due to visual field loss (e.g., reports by family of patient bumping into objects). (change to e.g.,)
15. The patient is taking a medication with a high risk of affecting the visual system (e.g., Plaquenil).
16. The patient is being evaluated for macular degeneration, or has experienced central vision loss (< 20/70). (Repeated examinations for diagnosis of macular degeneration or central vision loss are not medically necessary unless changes in vision are documented, or to evaluate the results of a surgical intervention).

**Limitations**
Gross visual field testing (e.g., confrontation testing) is a part of general ophthalmological service and should not be reported separately.

**CPT/HCPCS Codes:** 92081; 92082; 92083
**ICD-10 Codes that Support Medical Necessity**: See LCD List

**Documentation Requirements:** 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.

## Ophthalmology Articles

**A52370 Bevacizumab (e.g., Avastin™) – Related to LCD L33394**

**A52837 Blepharoplasty – Medical Policy Article**

**A52848 Botulinum Toxins – Supplemental Instructions Article**

**A52819 Cataract Extraction – Supplemental Instructions Article**

**A52820 Corneal Pachymetry – Supplemental Instructions Article**

**A52855 Drugs and Biologicals, Coverage of, for Label and Off-Label Uses – Supplemental Instructions Article**

**A5285 Implantable Miniature Telescope (IMT)- Supplemental Instructions Article**

**A52419 Ocular Blood Flow Tests**

**A52821 Ophthalmic Biometry for Intraocular Lens Power Calculation – Supplemental Instructions Article**

**A52861 Ophthalmology: Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography) –Supplemental Instructions Article**

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**A52822 Panretinal (Scatter) Laser Photocoagulation – Supplemental Instructions Article**

**A52451 Ranibizumab (e.g., Lucentis™) and Alfibercept (e.g., EYLEA™) – Related to LCD L33394**

**A54602 Removal of Benign Skin Lesions**

**A52445 Verteporfin (e.g., Visudyne™) – Related to LCD L25820**

**A52829 Visual Fields Testing - Supplemental Instructions Article**

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**Over the next several years, CMS will consolidate ten A/B MAC workloads to form five consolidated A/B MAC workloads:**

•Jurisdictions 2 and 3 will be combined to form A/B MAC Jurisdiction F; complete
•Jurisdictions 4 and 7 will be combined to form A/B MAC Jurisdiction H; complete
•Jurisdictions 14 and 13 will be combined to form A/B MAC Jurisdiction K; complete
•Jurisdictions 8 and 15 will be combined to form A/B MAC Jurisdiction I; and
•Jurisdictions 5 and 6 will be combined to form A/B MAC Jurisdiction G.

See the consolidated jurisdictions map below: