

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



Medicare Vision Services

Fact Sheet

Overview

Routine services, like eyeglasses and eye exams, are not normally covered under original Medicare. Some beneficiaries may have a Medicare Advantage (MA) plan or retirement benefits that help with these services, but this is not part of original Medicare, Medicare supplements, or many MA plans.

Medicare may cover some vision costs if they are associated with other covered expenses (i.e. eye problems that result from an illness or injury could be covered).

In general, items or services covered by Medicare must satisfy three basic requirements:

1. They must fall within a statutorily-defined benefit category;
2. They must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part; and
3. The item or service must not be excluded from coverage.

Medicare Covered Vision Services

Intraocular Lenses (IOLs)

A conventional IOL is covered when implanted following cataract surgery. A cataract is an opacity or cloudiness in the crystalline lens of the eye, blocking the passage of light through the lens, sometimes resulting in blurred or impaired vision. A conventional IOL is a small, lightweight, clear disk that replaces the distance focusing power of the eye's natural crystalline lens. Medicare specifically excludes certain items and services from coverage, including eyeglasses and contact lenses. Congress, however, has provided an exception for one pair of eyeglasses or contact lenses covered as a prosthetic device furnished after each cataract surgery with insertion of an IOL.

The following are benefits for which Medicare makes payment:

- A conventional IOL implanted following cataract surgery;
- Facility and physician services, and supplies required to insert a conventional IOL following cataract surgery; and
- One pair of eyeglasses or contact lenses as a prosthetic device furnished after each cataract surgery with insertion of an IOL.

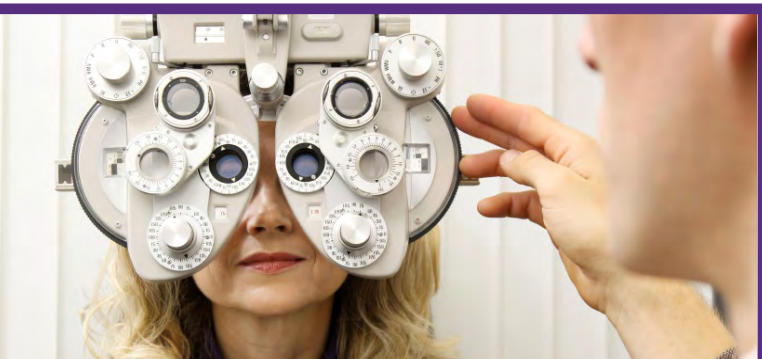
Other Vision Covered Services

Medicare policyholders enrolled in Parts A and B of the original Medicare Program are eligible for the following types of vision coverage:

- Glaucoma screening can be obtained once every 12 months for individuals with diabetes, with a family history of glaucoma, who are African-American over age 50, or who are Hispanics aged 65 and older. Glaucoma screening consists of a comprehensive eye examination, including dilation and intraocular pressure measurement.
- Cataract surgery may be needed for one or both eyes, involving implantation of an IOL that is an artificial replacement for your eye's natural crystalline lens. Medicare will cover the basic costs of these lenses.
- Eyeglass frames and lenses (or one pair of contact lenses) after cataract surgery that implants an IOL, if necessary, may be covered under Medicare.
- Eye prostheses are covered for patients with absence or shrinkage of an eye due to birth defect, trauma or surgical removal. Medicare generally covers replacement every 5 years. Polishing and resurfacing is covered twice per year.

A Medicare policy holder who opts for a MA plan may have access to additional vision care benefits. Vision benefits vary from plan to plan with respect to cost and coverage. In general, however, a MA vision benefit plan will likely cover the following:

- Routine eye exams including pupil dilation;
- Eyeglass frames (once every 24 months); and
- One pair of eyeglass lenses or contact lenses every 24 months.



Presbyopia-Correcting Intraocular Lenses (P-C IOLs)

Presbyopia, a type of refractive error, is an age-associated progressive loss of the focusing power of the lens of the eye resulting in difficulty seeing objects at near distance, or close-up. Presbyopia occurs as the natural lens of the eye becomes thicker and less flexible with age. As noted above, except following cataract surgery with insertion of an IOL, Medicare does not cover eyeglasses or contact lenses. Additionally, Medicare also does not cover the accommodative change in eyeglass or contact lens power that is required to compensate for the gradual loss of near vision as presbyopia progresses.

A presbyopia-correcting IOL is indicated for primary implantation in the capsular bag of the eye for the visual correction of aphakia (absence of the lens of the eye) in patients, and is also intended to provide near, intermediate, and distance vision without the need for eyeglasses or contact lenses for many patients.

Astigmatism-Correcting Intraocular Lenses (A-C IOLs)

Regular astigmatism is a visual condition where part of an image is blurred due to uneven corneal curvature. A normal cornea has the same curvature at all axes, whereas the curvature of an astigmatic cornea differs in two primary axes, resulting in vision that is distorted at all distances.

The A-C IOL is intended to provide what is otherwise achieved by two separate items; an implantable conventional IOL (one that is not astigmatism-correcting) that is covered by Medicare, and the surgical correction, eyeglasses or contact lenses that are not covered by Medicare.

Non-Coverage Policy for A-C IOL and P-C IOL

Medicare statute specifically states that one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an IOL is covered. A single P-C IOL or A-C IOL essentially provides what is otherwise achieved by two separate items: an implantable conventional IOL (one that is not presbyopia-correcting), and eyeglasses or contact lenses. Although P-C IOLs and A-C IOLs may serve the same function as eyeglasses or contact

lenses furnished following cataract surgery, IOLs are neither eyeglasses nor contact lenses.

Therefore, the P-C IOLs and A-C IOLs do not fall into the benefit category and are not covered. Any additional provider or physician services required to insert the P-C IOL or A-C IOL or to monitor a patient receiving a P-C IOL or A-C IOL are also not covered. For example, eye examinations performed to determine the refractive state of the eyes following insertion of a presbyopia-correcting IOL are non-covered.

When a beneficiary requests insertion of a P-C or A-C IOL instead of a conventional IOL following removal of a cataract prior to the procedure to remove a cataractous lens and insert a P-C or A-C lens, the facility and the physician must inform the beneficiary that Medicare will not make payment for services that are specific to the insertion, adjustment or other subsequent treatments related to the P-C or A-C functionality of the IOL.

Specific Coverage Exclusions

- Medicare does not make separate payment to the hospital or Ambulatory Surgical Center (ASC) for an IOL inserted subsequent to extraction of a cataract. Payment for the IOL is packaged into the payment for the surgical cataract extraction/lens replacement procedure.
- There is no Medicare benefit category that allows payment of facility charges for services and supplies required to insert and adjust a P-C or A-C IOL following removal of a cataract that exceeds the facility charges for services and supplies required for the insertion and adjustment of a conventional IOL.
- There is no Medicare benefit category that allows payment of facility charges for subsequent treatments, services, and supplies required to examine and monitor the beneficiary who receives a P-C or A-C IOL following removal of a cataract that exceeds the facility charges for subsequent treatments, services and supplies required to examine and monitor a beneficiary after cataract surgery followed by insertion of a conventional IOL.



- A physician may not bill Medicare separately for a P-C or A-C IOL inserted during a cataract procedure performed in a hospital or ASC setting because this lens is considered by Medicare to be part of the facility portion of this service and therefore must be billed by the hospital or ASC performing the procedure.

For a P-C IOL or A-C IOL inserted in a physician's office

- There is no Medicare benefit category that allows payment of physician charges for services and supplies required to insert and adjust a P-C or A-C IOL following removal of a cataract that exceeds the physician charges for services and supplies for the insertion and adjustment of a conventional IOL.
- There is no Medicare benefit category that allows payment of physician charges for subsequent treatments, services and supplies required to examine and monitor a beneficiary following removal of a cataract with insertion of a P-C or A-C IOL that exceeds physician charges for services and supplies to examine and monitor a beneficiary following removal of a cataract with insertion of a conventional IOL.

Note: The beneficiary is responsible for payment of that portion of the charge for the P-C IOL and A-C IOL and associated services that exceed the charge for insertion of a conventional IOL following cataract surgery.

Billing and Coding for Presbyopia-correcting IOLs

Provider Type	Service/Procedure	Coding Requirement
Physicians, hospitals, and ASCs	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique, complex requiring devices or techniques not generally used in routine cataract surgery or performed on patients in the amblyogenic development stage.	66982
	Intracapsular cataract with insertion of intraocular lens prosthesis (one stage procedure)	66983
	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)	66984
Physicians inserting a P-C IOL or A-C IOL in an office setting (POS 11)	Posterior chamber intraocular lens (A physician must bill for a conventional IOL, regardless of whether a conventional, P-C IOL, or A-C IOL is inserted.)	V2632 (in addition to above codes)
Physician, hospitals (12X, 13X, 83X and 85X) and ASCs	Non-covered charges related to the P-C function of the IOL <i>Note:</i> Hospitals pay CAHs method 2 claims under current payment methodologies for conditional IOLs.	HCPCS code V2788
	Non-covered charges related to the A-C function of the IOL.	HCPCS code V2787
Hospitals and physicians	Evaluation and management services usually associated with services following cataract extraction surgery, if appropriate.	E/M CPT Codes

Glaucoma Screening

Coverage

Medicare provides coverage of a comprehensive annual glaucoma screening exam for beneficiaries in at least one of the following high risk groups:

- Individuals with diabetes mellitus;
- Individuals with a family history of glaucoma;
- African-Americans age 50 and older; and
- Hispanic-Americans age 65 and older.

A covered glaucoma screening includes:

- A dilated eye examination with an intraocular pressure (IOP) measurement; and
- A direct ophthalmoscopy examination or a slit-lamp biomicroscopic examination.

Medical record documentation must show that the beneficiary is a member of one of the high risk groups. The documentation must also show that the appropriate screening was performed (i.e., either a dilated eye examination with an intraocular pressure (IOP) measurement and a direct ophthalmoscopic examination or a slit-lamp biomicroscopic examination).



Billing and Coding for Glaucoma Screening

Provider Type	Service/Procedure	Coding Requirement
Physician or optometrist	Glaucoma screening for high-risk patients Special screening for neurological, eye, and ear diseases, glaucoma	HCPCS G0117 Screening diagnosis code V80.1
Under the direct supervision of an optometrist, physician.	Glaucoma screening for high-risk patients	HCPCS G0118 Screening diagnosis code V80.1
CORF, CAH, SNF	Glaucoma screening for high-risk patients	HCPCS G0117 or G0118 Screening diagnosis code V80.1 Revenue Code (RC) 0770 CAH-optional method- RC 96x,97x,98x)
Hospital Outpatient	Glaucoma screening for high-risk patients	HCPCS G0117 or G0118 Screening diagnosis code V80.1 Any valid/appropriate revenue code.
RHC and FQHC	Glaucoma screening for high-risk patients	Screening diagnosis code V80.1 Bill Type 71X or 73X RC and HCPCS not required. Use revenue code 0520 or 0521, as appropriate. Payment is made under the all-inclusive rate

Note: Effective January 1, 2011, the Affordable Care Act waives the Part B deductible and the 20 percent coinsurance that would otherwise apply to most preventive services, specifically for Medicare covered preventive services that have been recommended with a grade of A (“strongly recommends”) or B (“recommends”) from the U.S. Preventive Services Task Force, as well as the initial preventive physician examination and the annual wellness visit.

Age-related Macular Degeneration

Medicare covers a treatment for macular degeneration called ocular photodynamic therapy with verteporfin under some circumstances. Medicare covers 80 percent of the Medicare-approved amount for diagnosis and treatment of diseases and conditions. This is a Part B benefit and both the deductible and coinsurance apply.

Resources

The Centers for Medicare & Medicaid Services has developed several educational products related to Medicare-covered preventive services, including glaucoma screenings:

- The “Glaucoma Screening” brochure is available at <http://www.cms.hhs.gov/MLNProducts/downloads/glaucoma.pdf> and provides information on risk factors, coverage, and documentation for Medicare-covered Glaucoma screenings.
- The Medicare Learning Network® (MLN) “Preventive Services Educational Products” web page is available at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp and provides descriptions and ordering information for Medicare Learning Network® (MLN) preventive services educational products and resources for health care professionals and their staff, including products related to Medicare-covered glaucoma screening.

- “Quick Reference Information: Medicare Preventive Services” is available at http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf and provides coverage and coding information on Medicare-covered preventive services, including Medicare-covered glaucoma screenings.
- “The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals” is available at http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf and provides in-depth information about the many preventive services Medicare covers, including glaucoma screenings.
- MLN Matters® Article #MM5527, “Instructions for Implementing the Centers for Medicare & Medicaid (CMS) Ruling CMS 1536-R; Astigmatism-Correcting Intraocular Lens (A-C IOLs)” is available at <http://www.cms.gov/MLNMattersArticles/downloads/mm5527.pdf> on the CMS website.
- MLN Matters® Article #MM3927 “Implementation of the Centers for Medicare & Medicaid Services (CMS) Ruling 05-01 Regarding Presbyopia-Correcting Intraocular Lenses (IOLs) for Medicare Beneficiaries” is available at <http://www.cms.gov/MLNMattersArticles/downloads/MM3927.pdf> on the CMS website.



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