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Medicare Vision Services

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

What's Changed?

- Added CPT code 66985 (page 7)
- Added guidance on billing evaluation and management (E/M) services during the global surgical period for eye surgery (page 8)
- Added information on intravitreal injections (page 9)

Substantive content changes are in dark red.

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Medicare Fee-for-Service (Original Medicare) usually doesn't cover routine vision items and services like eyeglasses, contacts, and eye exams. But we may cover some vision costs related to eye problems if they:

- Fall within a statutorily defined benefit category
- Are reasonable and necessary to diagnose or treat an illness or injury, or to improve the functioning of a malformed body part
- Aren't excluded from coverage

Some patients may have a Medicare Advantage (MA) plan, Medicare supplement insurance, or retirement benefits that help with routine vision services, but these aren't part of the Original Medicare Program.

Glaucoma Screening

We cover annual glaucoma screenings for patients with Medicare Part B who meet at least 1 of these high-risk criteria:

- Have diabetes mellitus
- Have glaucoma in their family history
- Are Black or African American and aged 50 or older
- Are Hispanic or Latino and aged 65 or older

A covered glaucoma screening includes a:

- Dilated eye exam with an intraocular pressure measurement
- Direct ophthalmoscopy exam or slit-lamp biomicroscopic exam

While a glaucoma screening is a Medicare-covered preventive service, you should apply a patient's copayment or coinsurance and their deductible.

We pay for glaucoma screening exams by, or under the direct supervision and in the office of, an ophthalmologist or optometrist legally authorized under state law. Medical record documentation must show the patient's high-risk group.

Use **diagnosis code Z13.5** (Encounter for screening for eye and ear disorders) to bill glaucoma screening claims.

Providers in these settings may use the appropriate HCPCS code in Table 1 to bill glaucoma screening services:

- **Independent or clinic-based ophthalmologists or optometrists (or qualified providers under direct professional supervision):** Use revenue code 770
- **Comprehensive outpatient rehabilitation facility:** Use revenue code 770
- **Critical access hospital:** Use revenue code 770 or, if the facility elects the optional payment method, revenue codes 96X, 97X, or 98X
- **Skilled nursing facility:** Use revenue code 770
- **Hospital outpatient:** Use any valid or appropriate revenue code
- **Rural health clinic (RHC) paid under the all-inclusive rate:** Use revenue code 770 and related visit revenue code 520 or 521 (we don't pay unless you include the visit code)
- **Federally Qualified Health Center (FQHC):** Use revenue code 770 and related visit revenue code 520 or 521 (we don't pay unless you include the visit code)

Note: For more information on billing for RHC and FQHC preventive services, see the Medicare Claims Processing Manual, Chapter 9, section 70.

Table 1. Glaucoma Screening Billing & HCPCS Coding

Code	Descriptor
G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist
G0118	Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist

The type of service code for Table 1's codes is Q. The applicable glaucoma screening service types of bill are 13X, 22X, 23X, 71X, 73X, 75X, and 85X.

Intraocular Lenses & New Technology Intraocular Lenses

A **conventional intraocular lens (IOL)** is a small, lightweight, clear disk replacing the focusing power of the eye's natural crystalline lens. We cover a conventional IOL when it's implanted during cataract surgery. A cataract is an opacity or cloudiness in the eye's crystalline lens that blocks light from passing through the lens and can result in blurred or impaired vision.

Many adults 65 years or older develop cataracts, which are caused by various factors, including ultraviolet-b radiation exposure, diabetes complications, drug and alcohol use, smoking, and the natural aging process.

We cover these IOL items and services:

- Conventional IOL implanted during cataract surgery
- Facility and physician services and supplies needed to insert a conventional IOL during cataract surgery
- One pair of prosthetic eyeglasses or contact lenses provided after each cataract surgery with an IOL insertion (DME suppliers should submit claims for eyeglasses or contact lenses to their DME Medicare Administrative Contractor (MAC))

Get more prosthetic cataract lens coverage information.

Ambulatory Surgical Center

Ambulatory surgical center (ASC) facility services include FDA-approved IOLs inserted during or after cataract surgery. FDA classified IOLs into these categories:

- Anterior chamber angle fixation lenses
- Iris fixation lenses
- Irido-capsular fixation lenses
- Posterior chamber lenses

ASCs providing an IOL designated as a new technology IOL (NTIOL) must submit claims to their MAC to get the NTIOL payment adjustment. The MAC determines if the item or service falls into 1 of these categories and processes the claims. It's possible to get an IOL insertion payment adjustment for a new class of NTIOLs during the 5-year period established for that class. 42 CFR Subpart G has more information on payment adjustments. Currently, there are no active NTIOL classes eligible for separate payment.

Presbyopia- and Astigmatism-Correcting IOLs

Common eye problems include presbyopia and astigmatism corrected by presbyopia-correcting IOLs (PC IOLs) and astigmatism-correcting IOLs (AC IOLs).

Medicare covers an implantable conventional IOL (not a PC or AC IOL). When a patient requests a PC or AC IOL instead of a conventional IOL, tell them before the procedure that we don't pay physician and facility services for insertion, adjustment, or other subsequent PC or AC IOL functionality treatments.

Medicare doesn't cover surgical correction, eyeglasses, or contact lenses to correct presbyopia or astigmatism.

Note: The CMS-recognized PC IOLs and AC IOLs document has more information.

The Advance Beneficiary Notice of Non-coverage (ABN) helps patients decide whether to get the item or service Medicare may not cover and accept financial responsibility if we don't pay. When you issue a voluntary ABN, it has no effect on financial liability, and the patient isn't required to select an option or sign and date the notice.

Cataract Removal & IOLs Billing

Tables 2–5 list approved cataract removal and IOL insertion CPT and HCPCS codes. Report the appropriate PC or AC IOLs code even though we don't cover that service part.

Bill mutually exclusive cataract removal codes only once per eye. National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services, Chapter 8, section D and NCCI Edits have more information.

Table 2. Cataract Removal CPT Coding

Code	Descriptor
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	Removal of lens material; aspiration technique, 1 or more stages
66850	Removal of lens material; phacofragmentation technique (mechanical or ultrasonic) (eg, phacoemulsification), with aspiration
66852	Removal of lens material; pars plana approach, with or without vitrectomy
66920	Removal of lens material; intracapsular
66930	Removal of lens material; intracapsular, for dislocated lens
66940	Removal of lens material; extracapsular (other than 66840, 66850, 66852)

Table 3. IOL Insertion CPT Coding

Code	Descriptor
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 technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation
66985	Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal
66988	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with endoscopic cyclophotocoagulation
66991	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more

Note: Use CPT code 66985 when you insert an IOL during a subsequent surgery.

Table 4. Conventional IOL, PC IOL & AC IOL HCPCS Coding

Code	Descriptor
V2632*	Posterior chamber intraocular lens
V2787†	Astigmatism correcting function of intraocular lens
V2788†	Presbyopia correcting function of intraocular lens

* HCPCS code V2632 is the most commonly reported conventional IOL code. We continue to bundle payment for the conventional IOL portion of the AC or PC IOL, or both, with the facility procedure payment for ASCs and hospital outpatient departments (HOPDs).

† Bill V2787 to report the non-covered AC IOL functionality charges of the inserted intraocular lens. V2788 is valid only for reporting non-covered PC IOL charges.

Table 5. Complex Cataract Removal & IOL Insertion CPT Coding

Code	Descriptor
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 capsulorrhexis) or performed on patients in the amblyogenic development stage; without endoscopic cyclophotocoagulation
66987	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 capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with endoscopic cyclophotocoagulation
66989	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 capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more

Note: CPT codes 66982, 66987, and 66989 (complex cataract extraction) are reasonable and necessary when you use devices or techniques not generally used in routine cataract surgery. Find more examples in Article: Billing and Coding: Cataract Extraction (A56544) and Article: Billing and Coding Complex Surgery: Appropriate Use and Documentation (A53047).

Hospitals and physicians may bill Medicare for evaluation and management (E/M) services during the global surgical period for cataract surgery and other eye procedures with a global surgical period, like intravitreal injections. The E/M service must be significant and separately identifiable and not included in the global surgical period; use modifier 25 with the E/M service code. See Evaluation and Management Services and Global Surgery for more information.

Other Eye-Related Medicare-Covered Services

- Eye prostheses for patients with an absence or shrinkage of an eye due to a birth defect, trauma, or surgical removal. We usually cover replacements every 5 years. We also cover polishing and resurfacing (DME suppliers submit eyeglasses or contact lenses claims to their DME MAC).
- Eye exams to evaluate eye disease or signs and symptoms of eye disease in patients with diabetes. We recommend annual ophthalmologist or optometrist exams for asymptomatic diabetics.
- Certain diagnostic tests and treatments for patients with age-related macular degeneration.
- Intravitreal injections for:
  - Neovascular (wet) age-related macular degeneration
  - Macular edema following retinal vein occlusion
  - Diabetic macular edema
  - Diabetic retinopathy

MA Plans & Vision Services

An MA vision benefit plan may cover:

- Routine eye exams
- Eyeglass frames once every 24 months
- One pair of eyeglass lenses or contact lenses once every 24 months

For MA plan patients, check with the MA plan for information on eligibility, coverage, and payment. Each plan can have different out-of-pocket costs and specific rules for getting and billing services. Follow the plan's terms and conditions for payment.

Resources

- Article: Billing and Coding: Aflibercept (EYLEA®) (A53387)
- Article: Billing and Coding: Cataract Surgery (A56613)
- Article: Billing and Coding: Cataract Surgery in Adults (A57195)
- Article: Billing and Coding: Complex Cataract Surgery: Appropriate Use and Documentation (A53047)
- Article: Billing and Coding: Micro-Invasive Glaucoma Surgery (MIGS) (A56491)
- Medicare Benefit Policy Manual, Chapter 15, section 280.1
- Medicare Benefit Policy Manual, Chapter 16, section 90
- Medicare Claims Processing Manual, Chapter 18, section 70
- Medicare Claims Processing Manual, Chapter 32, section 120
- Medicare Payments for Evaluation and Management Services Provided on the Same Day as Eye Injections Were at Risk for Noncompliance With Medicare Requirements