Priority Health	BILLING POLICY No. 123
CATARACTS	
Date of origin: Aug. 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

A same-day surgical procedure performed to extract a cloudy lens from the eye and implant an artificial intraocular lens when necessary.

MEDICAL POLICY

- Vision Care - 91538

FOR MEDICARE

For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

- Each patient's main complaint should be clearly documented and specific.
- Include common complaints with trouble performing daily activities like reading, watching TV, driving, or working.
- Record the patient's visual acuity (VA) and best-corrected visual acuity (BCVA). For near vision problems, include BCVA at near vision.
- If the patient reports glare, glare test results should be documented.
- Examinations should show that other eye conditions (like macular degeneration or diabetic retinopathy) are not the main reason for vision loss.
- If other eye diseases are present, the doctor should state that the cataract is a major factor in the visual impairment.
- The patient has been educated on the surgery's risks, benefits, and alternatives, and give informed consent.
- The patient must express that they can no longer function well with current vision function and desires surgery.

Reimbursement specifics

Aphakia - Absence of the lens may be either surgical (cataract extraction) or congenital. Coverage for aphakia is available only if an intraocular lens (IOL) is not present and lenses are paid at the prosthetic benefit level.

Tinted lenses (V2745), including photochromatic lenses (V2744) used as sunglasses, prescribed in addition to regular prosthetic lenses to an aphakic beneficiary.

Anti-reflective coating (V2750), tints (V2744, V2745) or oversize lenses (V2780) are covered only when medical necessity is documented by the treating physician. When provided as a beneficiary preference item and billed with an EY modifier, they will be denied as not reasonable and necessary.

UV protection is considered reasonable and necessary following cataract extraction. Additional documentation beyond inclusion on the order is not necessary.
UV coating (V2755) is not reasonable and necessary for polycarbonate lenses (V2784). Claims for code V2755 billed in addition to code V2784 will be denied as not reasonable and necessary.

Lenses made of polycarbonate or other impact-resistant materials (V2784) are covered only for beneficiaries with functional vision in only one eye. In this situation, if eyeglasses are covered, V2784 is covered for both lenses. Claims that do not meet this coverage criterion will be denied as not reasonable and necessary.

Billing details

Ophthalmology services are reimbursed at the intraoperative global surgical package percentage. An ophthalmologist who performs the preoperative, intraoperative and postoperative cataract surgery services should bill the global surgery code without any modifiers.

When billing post-operative portion only:

- List the exact dates you performed postoperative care in the notes section of the claim so we can reimburse surgical and postoperative services rendered by each provider.
- Effective for dates of service on or after January 1, 2018, report postoperative days in units (1 day = 1 unit) to reflect the number of days of postoperative care when postoperative care is split between the ophthalmologist and optometrist providers (not to exceed a total of 90 units).

According to the "National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services," Chapter 8, Section D #3, cataract removal codes are mutually exclusive of each other and can only be billed once for the same eye. Because CPT codes describing cataract extraction (66830-66984) are mutually exclusive of one another, providers may not report multiple codes for the same eye even if more than one technique is used or more than one code could be applicable. Only one code from this CPT code range may be reported for an eye.

Coding specifics

66982 - Extracapsular cataract removal with insertion of intraocular lens prosthesis (1- stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) 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 technique (e.g., irrigation and aspiration or phacoemulsification)

66985 - Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal

66987 - Extracapsular cataract removal with insertion of intraocular lens prosthesis (1- stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with endoscopic cyclophotocoagulation

66988 - Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification); with endoscopic cyclophotocoagulation

66989 - Extracapsular cataract removal with insertion of intraocular lens prosthesis (1- stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., 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

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

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

- 50 – bilateral procedure
- 54 – Surgical care services only
- 55 – Post-operative services only
- EY – No Physician or other licensed health care provider order for this item/service
- RT – right side
- LT – left side
- 79 - Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

Place of Service

Coverage will be considered for services furnished in the appropriate setting to the patient’s medical needs and condition. Authorization may be required. Click here for additional information.
22 – outpatient hospital
24 – Ambulatory Surgical Center

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

Each procedure is paid according to the global split percentages for preoperative, intraoperative and postoperative care.

REFERENCES

- https://www.priorityhealth.com/provider/manual/services/medical/cataract-surgery
- https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=59805&ver=14
- https://www.aao.org/eyenet/article/fact-sheet-documenting-need-for-cataract-surgery

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made