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FACT SHEET
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Medicare Vision Services

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

What's Changed?

- Added language explaining what a cataract is and how they develop in older patients (page 3)
- Added language about ambulatory surgical centers and how they cover Intraocular Lenses (IOLs) (page 4)
- Added CPT code 66988 to CPT and HCPCS code section, Group 1, for services provided on or after January 1, 2020 (page 5)
- Added CPT code 66987 to CPT and HCPCS code section, Group 2, for services provided on or after January 1, 2020 (page 6)
- Added language about screening eye and ear disorders code Z13.5 (page 7)
- Added glaucoma screening services billing revenue codes (page 7)
- Added applicable glaucoma screening type of service codes (page 8)

You'll find substantive content updates in dark red font.

Medicare Fee-for-Service (Original Medicare) doesn't usually cover routine vision services, such as eyeglasses and eye exams. We may cover some vision costs related to eye problems because of an illness or injury if they meet these requirements:

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

This fact sheet describes Medicare-covered vision services, including:

- Intraocular Lenses (IOLs), New Technology IOLs (NTIOLs), and related services
- Glaucoma screenings
- Other eye-related, Medicare-covered services

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.

Together we can advance health equity and help eliminate health disparities for all minority and underserved groups. Find resources and more from the CMS Office of Minority Health:

- Health Equity Technical Assistance Program
- Disparities Impact Statement

Intraocular Lenses (IOLs) & New Technology IOLs (NTIOLs)

A "conventional 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 blocking light passage through the lens. This can result in blurred or impaired vision.

60% of adults 65 years or older develop cataracts. Many factors cause cataracts, 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
- 1 pair of prosthetic eyeglasses or contact lenses provided after each cataract surgery with IOL insertion (Durable Medical Equipment [DME] suppliers submit eyeglasses or contact lenses claims to their DME MAC)

Get more prosthetic cataract lenses coverage information.

Ambulatory Surgical Center (ASC) NTIOLs

ASC facility services include FDA-approved IOLs inserted during or after cataract surgery. The 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 an 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 the categories above 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. Get more information on payment adjustments at 42 CFR Section Subpart G.

Presbyopia- and Astigmatism-Correcting IOLs

Common eye problems include presbyopia and astigmatism corrected by presbyopia-correcting IOLs (P-C IOLs) and astigmatism-correcting IOLs (A-C IOLs). A P-C IOL or A-C IOL are 2 separate items or services:

- Implantable conventional IOL (not P-C or A-C)—**Medicare covers**
- Surgical correction, eyeglasses, or contact lenses to correct presbyopia or astigmatism—**Medicare doesn't cover**

When a patient requests a P-C or A-C IOL instead of a conventional IOL, tell the patient before the procedure, Medicare doesn't pay physician and facility services for insertion, adjustment, or other subsequent P-C or A-C IOL functionality treatments.

The voluntary Advance Beneficiary Notice (ABN) helps the patient 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.

Get more information from the CMS-recognized P-C IOLs and A-C IOLs document.

Cataract Removal & IOLs Billing

Table 1 lists approved cataract removal and IOL insertion CPT and HCPCS codes. You must report the appropriate P-C or A-C IOLs code even though Medicare doesn't cover that service part.

Table 1. Cataract Removal, P-C IOLs, & A-C IOLs Billing and Coding

Group 1 Codes	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)
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
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
V2632*	Posterior chamber intraocular lens
V2787**	Astigmatism correcting function of intraocular lens
V2788	Presbyopia correcting function of intraocular lens

Table 2. Cataract Removal, P-C IOLs, & A-C IOLs Billing & Coding

Group 2 Codes	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

* Bill V2632 P-C or A-C conventional IOL functionality in an **office setting only**.

** Bill V2787 to report the non-covered A-C IOL functionality charges of the inserted intraocular lens. Note V2788 is no longer valid to report non-covered A-C IOL charges. However, it's valid to report non-covered P-C IOL charges.

*** Codes 66982 and 66987 (complex cataract extraction) are reasonable and necessary when you use devices or techniques not generally used in routine cataract surgery. Find more examples in the Cataract Extraction Local Coverage Determination Article.

Hospitals and physicians may use the proper CPT code(s) to bill Medicare evaluation and management services usually associated with services following cataract extraction surgery, if appropriate.

Note: Only bill mutually exclusive cataract removal codes once per eye. Get more information at National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services, Chapter 8, Section D.

Glaucoma Screening

We cover high-risk patients' annual glaucoma screenings in at least 1 of these groups:

- Patients with diabetes mellitus
- Patients with family history of glaucoma
- African-Americans aged 50 and older
- Hispanic-Americans aged 65 and older

A covered glaucoma screening includes:

- Dilated eye exam with intraocular pressure measurement
- Direct ophthalmoscopy exam, or slit-lamp bio microscopic exam

We pay glaucoma screening exams by, or under the direct supervision 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.

While glaucoma screening is a Medicare-covered preventive service, apply patients' copayment or coinsurance, and deductible.

Providers in these settings may use appropriate Table 3 HCPCS code 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 (CORF)—use revenue code 770
- Critical Access Hospital (CAH)—CAHs electing optional payment method use revenue codes 96X, 97X, or 98X
- Skilled Nursing Facility (SNF)—use revenue code 770
- Hospital Outpatient—use any valid or appropriate revenue code
- Rural Health Clinic (RHC) paid under All-Inclusive Rate (AIR); include diagnosis code—use revenue code 770
- Federally Qualified Health Center (FQHC)—use revenue code 770

Table 3. Glaucoma Screening Billing & 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

Table 3's type of service code is Q. Applicable glaucoma screening service types of bill include: 13X, 22X, 23X, 71X, 73X, 75X, and 85X.

Other Eye-Related Medicare-Covered Services

- Eye prostheses for patients with absence or shrinkage of an eye due to birth defect, trauma, or surgical removal. We usually cover replacement 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.

MA Plans & Vision Services

An MA plan may offer enhanced vision benefits. Vision benefit costs and coverage vary by plan. An MA vision benefit plan may cover:

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

Get more preventive service information in the Medicare Preventive Services educational tool.

Resources

- Medicare Claims Processing Manual, Chapter 18, Section 70
- NCCI Edits Webpage