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PRINT-FRIENDLY VERSION

MEDICARE VISION SERVICES

Medicare Fee-For-Service (original Medicare) does not normally cover routine vision services, such as eyeglasses and eye exams. Medicare may cover some vision costs associated with eye problems resulting from an illness or injury.

Generally, Medicare covers items or services if they satisfy three basic requirements. The item or service must:

1. Fall within a statutorily defined benefit category
2. Be reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body part
3. Not be excluded from coverage

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

- Intraocular lenses (IOLs) and related services
- Glaucoma screenings
- Other related Medicare-covered services

When we use "you," we are referring to physicians and providers submitting claims for IOL-related services provided to Medicare beneficiaries.

Some beneficiaries may have a Medicare Advantage (MA) plan, Medicare Supplement Insurance, or retirement benefits that help with routine vision services, but these are not part of the original Medicare Program.

Target Audience: Medicare Fee-For-Service Providers

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
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INTRAOCULAR LENSES (IOLs)

A conventional IOL is a small, lightweight, clear disk that replaces the focusing power of the eye's natural crystalline lens. Medicare covers a conventional IOL when it is implanted as part of 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.

Medicare specifically excludes certain items and services from coverage, including eyeglasses and contact lenses. However, Medicare does cover the following IOL items and services:

- A conventional IOL implanted during cataract surgery
- Facility and physician services and supplies required to insert a conventional IOL during cataract surgery
- One pair of eyeglasses or contact lenses as a prosthetic device furnished after each cataract surgery with an IOL insertion
  - Durable Medical Equipment (DME) suppliers billing for eyeglasses or contact lenses should submit claims to their DME Medicare Administrative Contractor (DME MAC).

Presbyopia- and Astigmatism-Correcting IOLs

Presbyopia and astigmatism are common eye problems corrected by presbyopia-correcting IOLs (P-C IOLs) and astigmatism-correcting IOLs (A-C IOLs). A P-C IOL or A-C IOL provides what is otherwise achieved by two separate items or services:

- An implantable conventional IOL (one that is not P-C or A-C) that **Medicare covers,** and
- The surgical correction, eyeglasses, or contact lenses to correct presbyopia or astigmatism that **Medicare does not cover**

When a beneficiary requests a P-C or A-C IOL instead of a conventional IOL, inform the beneficiary before the procedure that Medicare does not pay for the physician and facility services specific to the insertion, adjustment, or other subsequent treatments that are attributable to the functionality of the P-C or A-C IOLs.

For more information about Medicare IOL P-C or A-C coverage rules, refer to MLN Matters® Articles, Implementation of the Centers for Medicare & Medicaid Services (CMS) Ruling 05-01 Regarding Presbyopia-Correcting Intraocular Lenses (IOLs) for Medicare Beneficiaries and Instructions for Implementing the Centers for Medicare & Medicaid (CMS) Ruling CMS 1536-R; Astigmatism-Correcting Intraocular Lens (A-C IOLs).

The voluntary Advance Beneficiary Notice (ABN) allows the beneficiary to make an informed decision about whether to get the item or service that may not be covered, and accept financial responsibility if Medicare does not pay. When you issue the ABN as a voluntary notice, it has no effect on financial liability, and the beneficiary is not required to check an option box or sign and date the notice.

Billing for Cataract Removal and IOLs

Table 1 lists the approved Current Procedural Terminology (CPT) and HCPCS codes for cataract removal and IOL insertion. You must report the appropriate HCPCS code for P-C or A-C IOLs even though Medicare does not cover that part of the service.

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

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

* Physicians should bill HCPCS code V2632 in an **office setting only** for the payable conventional IOL functionality of the P-C or A-C IOL.

** V2787 should be billed to report the non-covered charges for the A-C IOL functionality of the inserted intraocular lens. Additionally, note that V2788 is no longer valid to report non-covered charges associated with the A-C IOL. However, this code continues to be valid to report non-covered charges of a P-C IOL.

NOTE: Cataract removal codes are mutually exclusive and billed only once per eye. For more information, refer to the National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services, Chapter 8, Section D.

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

GLAUCOMA SCREENING

Medicare covers annual glaucoma screenings 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
- Hispanic-Americans age 65 and older

A covered glaucoma screening includes:

- A dilated eye examination with an intraocular pressure measurement
- A direct ophthalmoscopy examination, or a slit-lamp bio microscopic examination

While glaucoma screening is a Medicare-covered preventive service, beneficiary deductible and copayment/coinsurance apply to these claims.

Medical record documentation must show the beneficiary is a member of one of the high-risk groups. The documentation must also show you performed the covered screening services. Include diagnosis code Z13.5 on your claim.

Providers in the following settings may use the appropriate HCPCS code from Table 2 to bill for glaucoma screening services:

- Independent or clinic-based ophthalmologists or optometrists (or qualified providers under the direct supervision of these professionals)
- Comprehensive Outpatient Rehabilitation Facility (CORF)
- Critical Access Hospital (CAH)
- Skilled Nursing Facility (SNF)
- Hospital Outpatient

- Rural Health Clinic (RHC) paid under the all-inclusive rate (AIR); include diagnosis code
- Federally Qualified Health Center (FQHC)

Table 2. Billing and Coding for Glaucoma Screening

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

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. Medicare generally covers replacement every 5 years. Medicare covers polishing and resurfacing.
  - DME suppliers billing for eyeglasses or contact lenses should submit claims to their DME MAC.
- Eye exams to evaluate for eye disease for patients with diabetes or signs and symptoms of

eye disease. Annual examinations by an ophthalmologist or optometrist are recommended for asymptomatic diabetics.

- Certain diagnostic tests and treatments for patients with age-related macular degeneration.

MA Plans and Vision Services

An MA plan may cover additional vision care benefits. Vision benefits costs and coverage vary from plan to plan. In general, however, an MA vision benefit plan will likely cover:

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

RESOURCES

For more information about preventive services, use the Medicare Preventive Services Educational Tool. Table 3 provides resources for additional information.

Table 3. Resources

Resource	Website
Medicare Benefit Policy Manual, Chapter 15, Section 120.B.	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
Medicare Claims Processing Manual, Chapter 18, Section 70	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf
Medicare Learning Network® (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	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM3927.pdf
MLN Matters Article MM5527, Instructions for Implementing the Centers for Medicare & Medicaid (CMS) Ruling CMS 1536-R; Astigmatism-Correcting Intraocular Lens (A-C IOLs)	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM5527.pdf
MLN Matters Article MM9269, Required Billing Updates for Rural Health Clinics	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9269.pdf

Table 3. Resources (cont.)

Resource	Website
MLN Matters Special Edition Article SE1319, Cataract Removal, Part B	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1319.pdf
NCCI Edits Website	CMS.gov/Medicare/Coding/NationalCorrectCodInitEd
Your Medicare Benefits Publication	Medicare.gov/Pubs/pdf/10116-Your-Medicare-Benefits.pdf

Table 4. Hyperlink Table

Embedded Hyperlink	Complete URL
Implementation of the Centers for Medicare & Medicaid Services (CMS) Ruling 05-01 Regarding Presbyopia-Correcting Intraocular Lenses (IOLs) for Medicare Beneficiaries	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM3927.pdf
Instructions for Implementing the Centers for Medicare & Medicaid (CMS) Ruling CMS 1536-R; Astigmatism-Correcting Intraocular Lens (A-C IOLs)	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM5527.pdf
Medicare Preventive Services	https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html
National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services	https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd