

Policy Name	Clinical Policy – Posterior Capsulotomy
Policy Number	1305.00
Department	Clinical Product & Development
Subcategory	Medical Management
Initial Approval Date	02/06/2018
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Company Entities Supported (Select All that Apply)

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ACRONYMS

ACO	Anterior capsule opacification
ADL	Activities of Daily Living
PCO	Posterior capsule opacification
PE	Phacoemulsification
YAG	Yttrium Aluminum Garnet
IOL	Intraocular Lens
FDA	Food and Drug Administration

PURPOSE

To provide the medical necessity criteria to support the indication(s) for posterior laser capsulotomy. Applicable procedure codes are also defined.

POLICY
A. Background

Posterior capsulotomy, with or without YAG laser, is performed to correct opacification of the posterior capsule after cataract surgery.

B. Medical Necessity Criteria

Posterior capsulotomy may be considered medically necessary for the following indications:

1. To ameliorate blurred vision that impairs Activities of Daily Living (ADLs) when:
 - a. There is documented symptomatic visual impairment not correctable with a change in glasses or contact lenses; and,
 - b. There is clinical documentation showing that the decreased vision is from the opacified capsule, fibrinous membrane on the anterior surface of IOL, or a pseudo membrane on the IOL. This clinical documentation must rule out other causes of decreased vision (e.g., retinal disease, glaucoma, corneal opacification, macular edema, etc.) through examination of the anterior segment and a dilated examination of the retina and optic nerve; and,
 - c. The patient has undergone a formal, written functional evaluation¹. The evaluation describes the patient's inability to function due to visual impairment (in the proposed surgical eye) while performing various activities of daily living (e.g., reading, watching TV, driving, completing occupational or vocational tasks); and,
 - d. This documented evaluation must occur after any previous treatment or procedure on either eye and within 90 days of the anticipated posterior capsulotomy procedure; and,
 - e. Glare testing is completed when appropriate. Glare testing results are only required when the only identified ADL deficit is glare.
2. Treatment for capsular bag distension syndrome (i.e., capsular block syndrome² capsular bag hyperdistention, capsulorhexis block syndrome).³
3. To prevent impending intraocular lens dislocation or malposition or displacement of an intra-ocular lens due to uneven capsular fibrosis resulting in the "Z Syndrome."
4. Posterior capsulotomy may also be considered medically necessary, independent of functional impairment, if the physician believes the blurred view interferes with the diagnosis and management of posterior segment disease.

C. Documentation

Medical necessity is supported by adequate and complete documentation in the patient's medical record that describes the procedure and the medical rationale. At a minimum, all the following items are required. For any retrospective review, a full operative report and the medical plan of care is needed.

¹ VF-8, VF-14 or other comparable assessment tool as referenced in the American Academy of Ophthalmology Preferred Practice Patterns-Cataract in the Adult Eye).

² Kanclerz, 2019.

³ Vlasenko, 2019.

Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, date(s) of service). Services provided/ordered must be authenticated by the author with either a handwritten or electronic signature. Stamped signatures are not acceptable.

The following documentation is required for posterior capsulotomy:

1. Eye exam with description of medical justification for the posterior capsulotomy and absence of contraindications for the surgery.
2. Questionnaire documenting functional impairment in specific activities of daily living (e.g., VF-8 or VF-14). The results of glare testing must be included if the only significant ADL deficit identified is glare.
3. The evaluation must be performed while the patient is wearing their best corrected refraction. It must be signed by the patient (or patient's representative), maintained in the patient's medical record, and submitted with the prior authorization request, and be available upon request for claim payment.
4. Detailed operative report that incorporates:
 - a. Indications
 - b. Type of laser (only FDA approved lasers are appropriate)
 - c. Laser setting: wavelength, power setting
 - d. Treatment details: size and number of applications, duration of laser, placement of spots, operated eye
 - e. The postoperative clinical notes should be available upon request.

D. Procedural Detail

CPT Codes	
66820	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); stab incision technique (Ziegler or Wheeler Knife)
66821	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (e.g., YAG laser) (1 or more stages)
66830	Removal of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid) with corneo-scleral section, with or without iridectomy (iridocapsulotomy, iridocapsulectomy)
Required Modifiers	
RT	Right Side
LT	Left Side
50	Bilateral

Invalid Modifiers	
24	EM visit during post-op visit
25	EM visit same day as minor procedure
57	EM visit same day as major procedure
26	Professional Component
TC	Technical Component

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RELATED POLICY

1300	Cataract Surgery
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DOCUMENT HISTORY

<i>Approval Date</i>	<i>Revisions</i>	<i>Effective Date</i>
03/21/2018	Initial publication	03/21/2018
10/18/2019	Addition of anterior capsulotomy code – clarification of criteria	01/01/2020
12/18/2019	Lessened restrictions: BCVA to be done within 90 days instead of 60 days within date of proposed surgery.	01/01/2020
02/19/2020	Lessened restrictions: removed Snellen criteria for surgery	06/01/2020
01/06/2021	Clarified B.3 with posterior segment disease; clarified B.5 with Z syndrome.	07/01/2021
10/06/2021	Criteria changed for bilateral sequential YAG capsulotomy with measurements, deletion of requirement for ADL assessment for each eye.	04/01/2022
04/06/2022	Annual review; no criteria changes	05/01/2022
10/12/2022	Administrative removal of code 66999; no additional review or criteria change.	01/01/2023
04/12/2023	Change policy name deleting the word YAG; clarified criteria for posterior capsulotomy is same w or w/o YAG; deleted BCV measurement requirements; revise glare testing criteria; add CPT code 66830.	10/01/2023
04/03/2024	Removed criteria for sequential posterior capsulotomies; removed anterior hyaloid conditions which are outside of policy scope; added conditions of capsular bag distension syndrome.	07/01/2024

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