ENVOLVE VISION BENEFITS, INC.
INCLUDING ALL ASSOCIATED SUBSIDIARIES
CLINICAL POLICY AND PROCEDURE

DEPARTMENT: Utilization Management	**DOCUMENT NAME: YAG Laser Capsulotomy, CPT Code 66821**
PAGE: 1 of 4	**REFERENCE NUMBER: OC.UM.CP.0065**
EFFECTIVE DATE: 01/01/2017	**REPLACES DOCUMENT: 283-UM-R8**
RETIRED:	**REVIEWED: 11/06/2017**
SPECIALIST REVIEW: Yes	**REVISED: 11/10/2016**
PRODUCT TYPE:	**COMMITTEE APPROVAL: 01/09/2018**

IMPORTANT REMINDER:
This Clinical Policy has been developed by appropriately experienced and licensed health care professionals based on a thorough review and consideration of generally accepted standards of medical practice, peer-reviewed medical literature, government agency/program approval status, and other indicia of medical necessity.

The purpose of this Clinical Policy is to provide a guide to medical necessity. Benefit determinations should be based in all cases on the applicable contract provisions governing plan benefits ("Benefit Plan Contract") and applicable state and federal requirements including Local Coverage Determinations (LCDs), as well as applicable plan-level administrative policies and procedures. To the extent there are any conflicts between this Clinical Policy and the Benefit Plan Contract provisions, the Benefit Plan Contract provisions will control.

Clinical policies are intended to be reflective of current scientific research and clinical thinking. This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding results. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members.

SUBJECT:
Medical necessity determination of YAG Laser Capsulotomy.

DESCRIPTION:
YAG Capsulotomy is the incision of an opaque posterior lens capsule in an aphakic or pseudophakic eye. This incision allows the capsule to retract and no longer serve as an obstruction to the passage of light through the media to the retina. The incision is performed with Yttrium Aluminum Garnet (YAG) laser.

POLICY/CRITERIA:
Prior authorization is required for selected health plans.

This procedure is not covered within three months post-cataract surgery unless justified by one of the following indications:

- Posterior capsular plaque/opacity which cannot be safely removed during primary phacoemulsification cataract procedure.
- Capsular block in which cataract remnants and fluid become trapped within the lens capsule and addressed with YAG laser posterior capsulotomy
- Contraction of the posterior capsule with displacement of the intraocular lens.

Envolve Vision will consider YAG capsulotomy medically necessary when the following are met:

- The patient complains of symptoms such as blurred vision, visual distortion and/or glare resulting in reduced ability to carry out activities of daily living due to decreased visual acuity or an increase in glare, particularly under bright light conditions, and/or condition of night driving, and
- The eye examination confirms the diagnosis of posterior capsular opacification and excludes other ocular causes of functional impairment by one of the following methods (date of exam must be maximum of 90 days prior to date of scheduled surgery):
  - The eye examination should demonstrate decreased light transmission (visual acuity worse than 20/30 or 20/25 if the procedure is performed to assist in the diagnosis and treatment of retinal detachment). Manifest refraction must be recorded with decrease in best corrected visual acuity. Automated refractors/refractions are not equivalent to manifest refraction, and cannot be used to determine best corrected visual acuity. After other causes of loss of acuity have been ruled out, or
  - Additional testing must demonstrate:
    1. Contrast sensitivity testing resulting in a decreased visual acuity by two (2) lines, or
    2. A decrease of two (2) lines of visual acuity in the glare tester on low or medium

AUTHORIZATION PROTOCOLS:

Pre-authorization is required for selected health plans. Requests should be submitted to Envolve Vision for review. When pre-authorization is not required, this service is subject to retrospective medical record review.

Professional services provided by duly licensed eye care providers must be within the scope of licensure as defined by applicable State guidelines.

REFERENCES:

Ingenix, Inc. Coding Companion for Ophthalmology, Current Edition

Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative Edits for Physicians

First Coast Service Options, Inc. Local Coverage Determination L33968, YAG Laser Capsulotomy, Florida, Effective 10/01/2015

CODING IMPLICATIONS:

The following codes for treatment and procedures are for informational purposes only. They are current at time of review of this policy. Inclusion or exclusion of any codes does not guarantee coverage. Please refer to your State contract or applicable National and Local Coverage Determination for exact coverage implications.

Medical necessity indications include the following diagnoses:

ICD-10 Code	Description
H26.411	Soemmering's ring, right eye
H26.412	Soemmering's ring, left eye
H26.413	Soemmering's ring, bilateral
H26.491	Other secondary cataract, right eye
H26.492	Other secondary cataract, left eye
H26.493	Other secondary cataract, bilateral

REVIEW/REVISION LOG

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Revision:	**Date**
Annual review	01/2018
Remove unspecified diagnoses as medical indications, update references; remove Attachment A	12/2016
Clarification of manifest refraction requirements.	04/2016
Updated ICD-10 diagnosis codes. Rebranded to Envolve Benefit Options.	12/2015
Clarification of criteria for medical necessity	07/2015
Addition of Attachment A with ICD9/ICD10 code crosswalk	12/2014
Annual review	12/2013
Converted SOP to new format, changed Reference Number to comply with new SOP numbering policy.	08/2012
Addition of statement that OMV follows Local Coverage Determination for the service area in which the full service health plan provides coverage.	12/2011
Change to limitations within 3 months post-cataract surgery, addition of required member complaints; removal of diagnoses that support medical necessity.	02/2006
Policy renumbered	02/2005
Annual review/revision	02/2004
Annual review/revision	02/2003
Policy renumbered	02/2000