2026 Cataract Surgery Billing & Coding Guide

Johnson&Johnson

Billing and coding guides

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Abbreviations

AAO	American Academy of Ophthalmology	HCPCS	Healthcare Common Procedure Coding System
ASCRS	American Society of Cataract and Refractive Surgery	IOL	Intraocular Lens
AT-IOL	Advanced-technology intraocular lens	LCS	Laser cataract surgery
CMS	Centers for Medicare & Medicaid Services	MPPR	Multiple procedure payment reduction rule
CPT®	Current Procedural Terminology		

IOL Billing & Coding

Conventional IOLs versus Advanced Technology IOLs (AT-IOLs)

- After cataract extraction, a "conventional IOL" replaces the eye's natural crystalline lens and provides visual correction at a single predetermined distance (normally distance vision only).[1-4]
- Unlike conventional IOLs, AT-IOLs provide additional correction for astigmatism and/or presbyopia, which may reduce the need for other vision correction after surgery.[1-4]

Centers for Medicare & Medicaid Services (CMS) Guidelines

- CMS reimburses for cataract surgery with the implantation of a conventional IOL (i.e., it is a covered service and item); however, it **does not consider the astigmatism- or presbyopia-correcting properties of AT-IOLs as a covered benefit** and does not reimburse physicians or facilities for any additional services associated with the implantation of an AT-IOL.[2-4]
- CMS rulings allow Medicare beneficiaries to request an AT-IOL in place of a conventional IOL, but the **beneficiary is responsible for the payment of additional physician and facility charges** that exceed those associated with implantation of a conventional IOL; in other words, the implantation of an AT-IOL is only partially covered and the beneficiary is responsible for the non-covered component.[2-4]

CMS Rulings for AT-IOLs[3,4]

CMS Ruling	Date	Description
CMS 05-01	May 2005	Policy on covered and non-covered aspects related to the insertion of **presbyopia-correcting IOLs** following cataract surgery and the Medicare beneficiary's responsibility for non-covered services.
CMS 1536-R	January 2007	Policy on covered and non-covered aspects related to the insertion of **astigmatism-correcting IOLs** following cataract surgery and the Medicare beneficiary's responsibility for non-covered services.

CMS Coverage Guidelines for AT-IOLs[3,4]

Service Provider	Non-covered Charges	Patient Responsibility
 Physician	Physician charge for AT-IOL that exceeds that of a conventional IOL, and for services attributable to the non-covered functionality of AT-IOLs, including additional work and resources required for AT-IOL insertion, fitting, and vision acuity testing.	Payment of the portion of physician charge that exceeds the physician charge for a conventional IOL.
 Facility	Facility charges for insertion of AT-IOLs that exceed those for a conventional IOL, as well as charges for additional resources required for fitting and visual acuity testing with AT-IOLs.	Payment of the portion of facility charge that exceeds the facility charge for insertion and resources furnished for a conventional IOL.

IOL Billing & Coding

CPT® codes for billing cataract removal and IOLs[2,a]

CPT® Code	Description
66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one 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 development stage; **without** endoscopic cyclophotocoagulation
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); **without** endoscopic cyclophotocoagulation
66987	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one 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 development 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 (one-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 (e.g., 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 (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification); with insertion of intraocular (e.g., trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more

[a] CPT® codes are subject to the multiple procedure payment reduction rule (MPPR). This rule states that when multiple procedure codes are used in a single patient claim for services provided on the same day, the lower paid codes are subject to a 50% reduction.

IOL Billing & Coding

HSPCS codes for billing IOLS[2]

HCPCS Code	Description	Notes
V2632	Posterior chamber intraocular lens	Facility may use to account for the covered component of the AT-IOL
V2630	Anterior chamber intraocular lens	
V2787[a]	Astigmatism-correcting function of an IOL	Used by physicians and facilities on Medicare claims to report the non-covered physician and facility charges for astigmatism-correcting IOLs
V2788[a,b]	Presbyopia-correcting function of an IOL	Used by physicians and facilities on Medicare claims to report the non-covered physician and facility charges for presbyopia-correcting IOLs
A9270	Non-covered item or service	Codes for billing non-covered services/items to commercial payers vary. It is important to consult with each payer for guidance.
S9986	Not medically necessary service (patient is aware that service not medically necessary)	

[a] Physicians should bill HCPCS code V2632 in an office setting only for the payable conventional IOL functionality of the presbyopia-correcting or astigmatism-correcting IOL.

[b] V2788 is no longer valid to report non-covered charges associated with the astigmatism-correcting IOL. However, this code continues to be valid to report non-covered charges of a presbyopia-correcting IOL.

IOL Billing & Coding

HSPCS and CPT® commonly used codes for billing Johnson & Johnson IOLs[5-8]

Model	Model Number(s)	HCPCS Code	CPT® Codes
Monofocal IOLs			
TECNIS™ Monofocal	ZCB00, DCB00	V2632	66982, 66983, 66984, 66988, 66898, 66991
TECNIS Eyhance™	DIB00	V2632	66982, 66983, 66984, 66988, 66898, 66991
Presbyopia-correcting IOLs[a]			
TECNIS Odyssey™	DRN00V	V2788	66984
TECNIS Symfony™ OptiBlue™	DXR00V	V2788	66984
TECNIS™ Multifocal	ZKB00, ZLB00	V2788	66984
Astigmatism-correcting IOLs[a,b]			
TECNIS™ Toric II 1-Piece	ZCU150, ZCU225, ZCU300, ZCU375, ZCU450, ZCU525, ZCU600	V2787	66984
TECNIS Eyhance™ Toric II	DIU150, DIU225, DIU300, DIU375, DIU450, DIU525, DIU600	V2787	66984
TECNIS Odyssey™ Toric II	DRT150, DRT225, DRT300, DRT375	V2787	66984
TECNIS Symfony™ OptiBlue™ Toric II	DXW150U, DXW225U, DXW300U, DXW375U	V2787	66984
TECNIS™ Multifocal Toric II	ZKU150, ZKU225, ZKU300, ZKU375, ZLU150, ZLU225, ZLU300, ZLU375	V2787	66984

[a] Physicians should bill V2632 as the covered conventional IOL component. When determining the patient's responsibility for the non-covered aspect of the AT- IOL, it is important to recognize that the service/item is partially covered. The patient should only be charged for the additional services provided by the physician that are clearly identifiable and solely related to the refractive component. The facility should only bill the patient for the AT-IOL and any extra services related to the implantation of the AT-IOL.

[b] Combination presbyopia- and astigmatism-correcting lenses are billed as astigmatism-correcting IOLs.

LCS Billing & Coding

Billing Guidelines for Laser Cataract Surgery (LCS)

The American Academy of Ophthalmology (AAO) and the American Society of Cataract and Refractive Surgery (ASCRS) jointly issued guidelines for billing LCS to Medicare beneficiaries:[9,10]

- The allowable Medicare reimbursement for cataract surgery does not change according to the surgical methods used.
- Balance billing is the practice of submitting a bill to the patient for the balance of charges remaining on the bill that the insurer did not cover.
- Providers may **not balance bill** a Medicare patient or his/her secondary insurer for any additional fees to perform **covered components of cataract surgery** with LCS.
- **Non-covered services can be charged to a patient**; however, it is important to know what aspects of LCS are considered covered and not covered and in what situation.
- When LCS is used in cataract surgery, **utilize CPT® code 66982 or 66984** (surgery for treatment of cataracts) as customary and follow the guidelines below for non-covered charges.

Guidelines for Non-covered and Covered Services

Non-covered services billable to patient[9,10]

- Imaging performed as part of the LCS procedure when inserting a premium IOL.
- Imaging (and computation) performed to determine aspects of a capsulotomy for a patient receiving a premium IOL.
- Advanced imaging for placement and alignment of a premium IOL.
- Arcuate and limbal relaxing incision associated with refractive error correction.

Covered services <u>not</u> billable to patient[9,10]

- Use of LCS to perform usual and customary steps common to all types of cataract surgery such as primary and secondary incisions, capsulotomy creation, and lens fragmentation.
- Imaging when a refractive procedure is not performed for a patient receiving a conventional IOL, such as the TECNIS Eyhance™ IOL.

"Medicare coverage and payment for cataract surgery is the same irrespective of whether the surgery is performed using conventional surgical techniques or a bladeless, computer-controlled laser… If the bladeless, computer-controlled laser cataract surgery includes implantation of a presbyopia-correcting IOL or astigmatism-correcting IOL, only charges for those non-covered services may be charged to the beneficiary. These charges could possibly include charges for additional services, such as imaging, necessary to implant a presbyopia-correcting IOL or an astigmatism-correcting IOL but that are not performed when a conventional IOL is implanted." – CMS guidance on laser cataract surgery, November 2012[10]

An example of a non-covered service is advanced imaging with a femtosecond laser (e.g., CATALYS™ Precision Laser System) to aid in placement and alignment of an astigmatism-correcting IOL (e.g., TECNIS Eyhance™ Toric II IOL).

Co-management Billing & Coding

What is co-management?

- Co-management refers to the “relationship between an operating ophthalmologist and a non-operating practitioner for shared responsibility in the patient’s postoperative care”.[11]
- Transfer of care refers to the transfer of responsibility for a patient's care from one healthcare provider to another.[11]
- Guidelines are in place to ensure that providers are ethically and legally reimbursed for their services when postoperative responsibilities are shared.[11]

What are the key elements of co-management and transfer of care?[11,12]

- The patient must agree to be co-managed beforehand.
- The surgeon and co-managing provider must retain records of the signed written transfer agreement.
- The specific date for transfer of care cannot be made before surgery.
- A transfer of care form can be omitted if both providers are within the same group.

 -54	**When billing for surgical care (only) provided to the patient, use modifier -54 on the CMS-1500 claim form** where the surgeon initiates the co-management by submitting the claim and designates the date of service as the surgery date.	 -55	**When billing for postoperative care provided to the patient, use modifier -55 on the CMS-1500 claim form** where the co-manager can bill for the postoperative care using the same CPT® code as the surgeon after services are rendered.
-79	**When cataract surgery is performed on the second eye shortly after the first eye, use modifier -79 <u>in addition to</u> -54 (for surgical care) or -55 (for postoperative care)** to indicate that the second surgery is unrelated to the first (i.e., performed on a different eye); claims for each surgery are handled separately.		

Additional billing considerations related to co-management of Medicare beneficiaries:

- For Medicare claims, postoperative care for ophthalmic procedures is valued at 20% of the global surgical fee.[12]
- Co-managers must provide at least one service before they can bill for any part of postoperative care included in the 90-day global period.[12]
- Surgeons and co-managing providers may bill Medicare beneficiaries for non-covered refractive services, including those associated with astigmatism-correcting and presbyopia-correcting IOLs (i.e., AT-IOLs); the patient should be informed and consent to (in writing) to the non-covered portion of the services in advance.[2-4,11]

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