



UM-CDG-073 Cataract Surgery

Approved By:
Director, Health Services

Effective Date:
10/20/2025

This Policy applies to all SECUR affiliates, associates, and subsidiaries.

Approved by Courtney Gonzales, Director of Health Services on behalf of the Utilization Management Committee.

PURPOSE

This coverage determination guideline serves to address surgical procedures to correct cataracts. Cataracts are defined as an opacity or loss of optical clarity in the crystalline lens. Development follows a continuum extending from minimal changes in the crystalline lens to the extreme stage of total opacity. They may be due to a variety of causes including age, trauma, toxicity, or secondary to another disease process. Most are invisible to the naked eye until they become dense enough to cause blindness. However, dilation will reveal the cataract using a slit lamp biomicroscope. In general, surgery is performed to alleviate visual impairments associated with lens opacity. There are rare instances when lens extraction may become medically necessary for anatomic rather than optic reasons.

For SECUR Health Plan members, National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) will be applied to requests when applicable. SECUR Health Plan Coverage Determination Guidelines (CDG) will be utilized in the absence of an appropriate NCD and/or LCD.

DEFINITIONS

None

POLICY

SECUR Health Plan does not consider opacity of the lens(es) as the sole determinant of medical necessity for cataract surgery. Lens extraction is considered medically necessary when one (1) or more of the following are met:

1. Cataract causing symptomatic impairment of visual function not correctable with a tolerable change in glasses or contact lenses, lighting, or non-operative measures resulting in specific activity limitations and/or participation restrictions, including but not limited to, reading, watching television, driving, or meeting vocational or recreational needs.
2. Concomitant intraocular disease monitoring or treatment that is prevented by the presence of the cataract.
3. Lens-induced disease threatening vision or ocular health.
4. High probability of accelerating cataract development because of a concomitant or subsequent procedure and treatments such as external beam radiation.
5. Cataract interfering with the performance of vitreoretinal surgery.
6. Intolerable anisometropia or aniseikonia uncorrectable with glasses or contact lenses exists because of lens extraction in the first eye.

The Snellen chart is often used as a screening tool to measure visual acuity. Testing using high contrast letters

viewed in a dark room can underestimate the functional impairments caused by some cataracts in common, real-life situations. An evaluation of visual acuity alone can neither rule out or confirm the need for surgery. Visual acuity should be recorded and considered in the context of the member's visual impairment and ocular findings.

Surgery is typically not performed for both eyes during the same surgical procedure because of the potential of bilateral vision loss. The publication, [Cataract in the Adult Eye, Preferred Practice Pattern](#)®, by the American Academy of Ophthalmology®, describes circumstances under which bilateral cataract surgery might be indicated. SECUR Health Plan will follow this guidance in determining medical necessity of bilateral surgery.

In the more common scenario where surgery is performed sequentially on separate days for bilateral visually symptomatic cataracts, the appropriate interval between the first and second surgery is influenced by the following:

1. Member's visual needs.
2. Member preference.
3. Visual function in the second eye.
4. Medical and refractive stability of the first eye.
5. Need to restore binocular vision and resolve anisometropia.
6. Adequate interval of time elapsed to evaluate and treat early postoperative complications in the first eye such as endophthalmitis.
7. Logistical and travel considerations for the member.

The following ancillary tests are not routinely indicated in the preoperative workup for cataract surgery and are considered not medically necessary unless supporting documentation provides evidence to support the medical need.

1. Potential vision testing
2. Corneal topography
3. Anterior or posterior segment ocular coherence tomography
4. Formal visual fields
5. Fluorescein angiography
6. External photography
7. Corneal pachymetry/specular microscopy
8. Specialized color vision testing
9. Electrophysiologic testing
10. Fundus photography
11. Extended ophthalmoscopy
12. Ophthalmic ultrasound B scan

In general, any performed ancillary testing must be conducted so as to not deliberately bias the decision toward the performance of surgery.

References:

1. American Academy of Ophthalmology. Cataract and Anterior Segment Panel. *Cataract in the Adult Eye Preferred Practice Pattern*®. San Francisco, CA. 2016.
2. Centers for Disease Control and Prevention (CDC). Vision Health Initiative (VHI). [About Common Eye Disorders and Diseases](#). Accessed 10/15/24.
3. Gayer S, Zuleta J. Perioperative management of the elderly undergoing eye surgery. *Clin Geriatr Med*. 2008;24(4):687-700.
4. U.S. National Library of Medicine. Medical Encyclopedia. [Cataract removal](#). Accessed 10/15/24.

5. National Eye Institute (NIH). [Cataracts](#). Accessed 10/15/24.
6. Obstbaum SA, American Academy of Ophthalmology, American Society of Cataract and Refractive Surgery, European Society of Cataract and Refractive Surgeons. Utilization, appropriate care, and quality of life for patients with cataracts. *Ophthalm*. 2006;113(10):1878-1882.
7. World Health Organization. [Blindness and vision impairment](#). Accessed 10/15/24.
8. Yanoff M, Duker JS. *Yanoff & Duker: Ophthalmology*. 3rd ed. Mosby, An Imprint of Elsevier. 2008.
9. Local Coverage Determination (LCD) L34413, Cataract Surgery, 11/21/2024, <https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=34413>