

Clinical Policy: Yttrium Aluminum Garnet (YAG) Laser Capsulotomy

Reference Number: CP.VP.65

Last Review Date: 08/2025

[Coding Implications](#)

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See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

This policy describes the medical necessity requirements for yttrium aluminum garnet (YAG) laser capsulotomy.

Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation[®] (Centene) and Envolve Vision, Inc.[®] (Envolve) that YAG laser capsulotomy is **medically necessary** for the following indications:
 - A. Posterior capsular opacification following cataract surgery resulting in best corrected visual acuity of 20/30 or worse associated with symptoms of blurred vision, visual distortion or glare affecting activities of daily living;
 - B. Contraction of the posterior capsule with resulting displacement of the intraocular lens; or
 - C. Posterior capsular opacification resulting in best corrected visual acuity of 20/25 or worse, reducing the ability to evaluate and treat retinal detachment.

Background

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 YAG laser.

The eye examination must confirm the diagnosis of posterior capsular opacification and excludes other ocular causes of functional impairment by one of the following methods:

- 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.
- Additional testing must demonstrate:
 - Contrast sensitivity testing resulting in a decreased visual acuity by two (2) lines, or
 - A decrease of two (2) lines of visual acuity in the glare tester on low or medium

Coding Implications

This clinical policy references Current Procedural Terminology (CPT[®]). CPT[®] is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
66821	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (e.g., YAG laser) (1 or more stages)

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code requiring an additional character

ICD-10® Codes	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

Reviews, Revisions, and Approvals	Date	Approval Date
Annual Review	12/2019	12/2019
Converted to new template	07/2020	10/2020
Annual Review	12/2020	12/2020
Annual Review; Updated References	12/2021	01/2022
Annual Review; Updated References	11/2022	12/2022
Annual Review	11/2023	12/2023
Annual Review	11/2024	12/2024
Annual Review	08/2025	10/2025

References

- Schrieftl SM, Leydolt C, Stifter E, Menapace R. Posterior capsular opacification and Nd:YAG capsulotomy rates with the iMics Y-60H and Micro AY intra-ocular lenses: 3-year results of a randomized clinical trial. *Acta Ophthalmol.* 2015;93:4:342-7.
- Steinert R. Nd:YAG Laser Posterior Capsulotomy, American Academy of Ophthalmology. The Ophthalmic News and Education Network. <https://www.aao.org/current-insight/ndyag-laser-posterior-capsulotomy-3>. November 4, 2013.
- American Academy of Ophthalmology Cataract and Anterior Segment Panel, Preferred Practice Panel® Guidelines, Cataract in the Adult Eye, San Francisco, CA, American Academy of Ophthalmology, 2021, <https://www.aao.org/preferred-practice-pattern/cataract-in-adult-eye-ppp-2021-in-press>
- Aron-Rosa D, Aron JJ, Griesemann M, Thyzel R. Use of the neodymium-YAG laser to open the posterior capsule after lens implant surgery: a preliminary report. *Journal of American Intraocular Implant Society.* 1980;6(4):352-354.
- Baratz KH, Cook BE, Hodge DO. Probability of Nd:YAG laser capsulotomy after cataract surgery in Olmsted County, Minnesota. *American Journal of Ophthalmology.* 2001;131(2):161-166.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. 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. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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CLINICAL POLICY
Yttrium Aluminum Garnet (YAG) Laser Capsulotomy



Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <https://www.cms.gov> for additional information.

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