Chapter 4 Section 21.1

Eye And Ocular Adnexa

Issue Date: August 26, 1985
Authority: 32 CFR 199.4(c)(2), (c)(3) and (g)(46)

1.0 CPT[1] PROCEDURE CODES

0192T, 0308T, 65091 - 65755, 65772 - 66175, 66180 - 68899, 77600 - 77615

2.0 DESCRIPTION

The eye is the organ of vision and the ocular adnexa are the appendages or adjunct parts; i.e., eyelids, lacrimal apparatus.

3.0 POLICY

3.1 Services and supplies required in the diagnosis and treatment of illness or injury involving the eye or ocular adnexa are covered.

3.2 Phototherapeutic Keratectomy (PTK) is covered for corneal dystrophies.

3.3 Strabismus. Surgical procedures and eye examinations to correct, treat, or diagnose strabismus are covered.

3.4 Corneal transplants. A corneal transplant (keratoplasty) is a covered surgical procedure. Relaxing keratotomy to relieve astigmatism following a corneal transplant is covered.

3.5 Transpupillary thermotherapy (laser hyperthermia, CPT[1] procedure codes 77600 - 77615), with chemotherapy, is covered for the treatment of retinoblastoma. See also Chapter 5, Section 5.1.

3.6 Intrastromal Corneal Ring Segments (Intacs®) is covered for U.S. Food and Drug Administration (FDA) approved indications for beneficiaries with keratoconus who meet all of the following criteria: (1) are unable to achieve adequate vision using lenses or spectacles; and (2) for whom corneal transplant is the only remaining option. Coverage allowed effective July 17, 2005.

3.7 Optonal ExPRESS Mini glaucoma Shunt (CPT[1] procedure code 0192T) to reduce Intraocular Pressure (IOP) in the treatment of glaucoma, that cannot be controlled effectively with medications.

3.8 Off-label use of Photodynamic Therapy (CPT[1] procedure code 67221) with Visudyne (HCPCS J3396) may be considered for cost-sharing for the treatment of retinal astrocytic hamartoma in Tuberous Sclerosis. The effective date is February 1, 2008.

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3.9 Transpupillary thermotherapy (CPT[2] procedure code 67299) with Plaque Radiotherapy (Brachytherapy) is covered for the treatment of choroidal melanoma. See also Chapter 5, Section 3.2.

3.10 Photodynamic Therapy for the treatment of Central Serous Chorioretinopathy in accordance with the TRICARE provisions for the treatment of rare diseases.

3.11 Implantable Miniature Telescope (IMT) is covered for FDA approved indications for beneficiaries with end-stage age-related macular degeneration.

3.12 Canaloplasty for the treatment of primary open angle glaucoma (CPT[2] procedure codes 66174 and 66175) is covered.

4.0 EXCLUSIONS

4.1 Refractive corneal surgery except as noted in paragraph 3.4 (CPT[2] procedure codes 65760, 65765, 65767, 65770, 65771).

4.2 Eyeglasses, and contact lenses except as noted in Chapter 7, Section 6.2.

4.3 Orthokeratology.

4.4 Orthoptics, also known as visual training, vision therapy, eye exercises, eye therapy, is excluded by 32 CFR 199.4(g)(46) (CPT[2] procedure code 92065).

4.5 Epikeratophakia for treatment of aphakia and myopia is unproven.

4.6 Transpupillary thermotherapy (CPT[2] procedure code 67299) as primary treatment of choroidal melanoma is unproven.

4.7 Autologous serum eye drops for the treatment of dry eye syndrome, keratitis, or ocular hypertension is unproven.

5.0 EFFECTIVE DATES

5.1 April 1, 2011, coverage for Optonal ExPRESS Mini Glaucoma Shunt.

5.2 December 1, 2014, coverage for Photodynamic Therapy for Central Serous Chorioretinopathy.

5.3 February 14, 2015, coverage for Canaloplasty for the treatment of glaucoma.

5.4 June 17, 2015, coverage date for IMT.

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