

## Chapter 4

## Section 21.1

# Eye And Ocular Adnexa

Issue Date: August 26, 1985

Authority: [32 CFR 199.4\(c\)\(2\)](#), [\(c\)\(3\)](#) and [\(g\)\(46\)](#)

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### 1.0 CPT<sup>1</sup> PROCEDURE CODES

0191T, 0192T, **0204T**, 0253T, 0308T, 0376T, 65091 - 65755, 65772 - 66175, 66180 - 68899, 77600 - 77615

### 2.0 HCPCS PROCEDURE CODES

C1783, L8612

### 3.0 DESCRIPTION

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

### 4.0 POLICY

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

**4.2** Phototherapeutic Keratectomy (PTK) is covered for corneal dystrophies.

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

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

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

**4.6** 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.

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**4.7** Optonal ExPRESS Mini glaucoma Shunt (CPT<sup>2</sup> procedure code 0192T) to reduce Intraocular Pressure (IOP) in the treatment of glaucoma, that cannot be controlled effectively with medications.

**4.8** Off-label use of Photodynamic Therapy (CPT<sup>2</sup> 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.

**4.9** Transpupillary thermotherapy (CPT<sup>2</sup> procedure code 67299) with Plaque Radiotherapy (Brachytherapy) is covered for the treatment of choroidal melanoma. See also [Chapter 5, Section 3.2](#).

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

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

**4.12** Canaloplasty for the treatment of primary open angle glaucoma (CPT<sup>2</sup> procedure codes 66174 and 66175) is covered.

**4.13** Insertion of anterior segment aqueous drainage device (iStent®), without extra ocular reservoir, internal approach, during cataract surgery to reduce IOP in the treatment of glaucoma, initial insertion (CPT<sup>2</sup> procedure codes 0191T, 0253T, C1783, and L8612), and each additional insertion (CPT<sup>2</sup> procedure code 0376T).

**4.14** Collagen Cross-linking for the treatment of corneal ectasia due to the rare disease Keratoconus is safe and effective and may be considered for cost-sharing.

## **5.0 EXCLUSIONS**

**5.1** Refractive corneal surgery except as noted in [paragraph 4.4](#) (CPT<sup>2</sup> procedure codes 65760, 65765, 65767, 65770, 65771).

**5.2** Eyeglasses, and contact lenses except as noted in [Chapter 7, Section 6.2](#).

**5.3** Orthokeratology.

**5.4** Orthoptics, also known as visual training, vision therapy, eye exercises, eye therapy, is excluded by [32 CFR 199.4\(g\)\(46\)](#) (CPT<sup>2</sup> procedure code 92065).

**5.5** Epikeratophakia for treatment of aphakia and myopia is unproven.

**5.6** Transpupillary thermotherapy (CPT<sup>2</sup> procedure code 67299) as primary treatment of choroidal melanoma is unproven.

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

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**TRICARE Policy Manual 6010.57-M, February 1, 2008**

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**6.0 EFFECTIVE DATES**

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

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

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

**6.4** June 17, 2015, coverage date for IMT.

**6.5** October 7, 2015, coverage date for iStent®.

**6.6** April 15, 2016, for Collagen Cross-linking for corneal ectasia due to the rare disease Keratoconus.

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