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

0100T, 0191T, 0253T, 0308T, 0376T, 0402T, 0472T - 0474T, 65091 - 65755, 65772 - 66175, 66179 - 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[1] 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 The Ex-PRESS Mini Glaucoma Shunt (CPT[2] procedure code 66183) and other FDA approved aqueous shunts or stents may be considered for cost-sharing when they are used 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[2] 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[2] 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[2] procedure codes 66174 and 66175) is covered.

4.13 Insertion of aqueous drainage device (iStent®, CyPass®) during cataract surgery to reduce IOP in the treatment of glaucoma, initial insertion (CPT[2] procedure codes 0191T, 0474T, C1783, and L8612), and each additional insertion (CPT[2] 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.

4.15 Insertion, programing, evaluation, and interrogation of retinal prosthesis (CPT[2] procedure codes 0100T, 0472T, and 0473T) is covered for use with Argus® II Retinal Prosthesis System (in accordance with the humanitarian device policy, Chapter 8, Section 5.1).

5.0 EXCLUSIONS

5.1 Refractive corneal surgery except as noted in paragraph 4.4 (CPT[2] 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[2] procedure code 92065).

5.5 Epikeratophakia for treatment of aphakia and myopia is unproven.

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5.6 Transpupillary thermotherapy (CPT[2] 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.

6.0 EFFECTIVE DATES

6.1 April 1, 2011, coverage for Ex-PRESS 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.

6.7 July 29, 2016, for CyPass®.

6.8 January 2, 2017, for insertion of retinal prosthesis.

6.9 August 1, 2017, for programing, evaluation, and interrogation of retinal prosthesis.

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