Policy Name	Clinical Policy – Laser Photocoagulation and Cryotherapy of the Retina and Choroid
Policy Number	1326.00
Department	Clinical Product & Development
Subcategory	Medical Management
Original Approval Date	05/01/2018
Current CCO/MPC Approval Date	07/10/2024
Current Effective Date	10/01/2024

Company Entities Supported (Select All that Apply)
X Superior Vision Benefit Management
X Superior Vision Services
X Superior Vision of New Jersey, Inc.
X Block Vision of Texas, Inc. d/b/a Superior Vision of Texas
X Davis Vision
(Collectively referred to as 'Versant Health' or 'the Company'

ACRONYMS	
AMD	Age Related Macular Degeneration
BVO	Branch Vein Occlusion
CME	Cystoid Macula Edema
CNVM	Choroidal Neovascular Membrane
CVO	Central Vein Occlusion
DME	Diabetic Macula Edema
FA	Fluorescein Angiogram
NPDR	Non-Proliferative Diabetic Retinopathy
OCT	Optical Coherence Tomography
OPT	Ocular Photodynamic Therapy
PDR	Proliferative Diabetic Retinopathy
PRC	Pan retinal Cryotherapy
PRP	Pan retinal Photocoagulation
RD	Retinal detachment
ROP	Retinopathy of Prematurity
TTT	Trans pupillary thermotherapy

PURPOSE

To provide the medical necessity criteria to support the indications for laser photocoagulation and cryotherapy of the retina and choroid procedures. Applicable procedure codes are also defined.

POLICY

A. BACKGROUND

This policy does not apply to children one year or less with diagnoses of retinopathy of prematurity.

Laser treatment of the retina and choroid is an effective treatment for certain disorders of the eye to prevent vision loss and/or improve vision. While commonly used in diabetic eye disease, other ophthalmic conditions may benefit from laser photocoagulation including macular edema (in branch or central vein occlusions), central serous chorioretinopathy, retinal holes, retinal tears, retinal detachments, and tumors of the retina or choroid. Infrequently, laser photocoagulation is used to treat exudative macular degeneration. In some ophthalmic conditions retinal cryotherapy may also be used.

B. Medically Necessary

1. Pan retinal photocoagulation or cryotherapy[1] may be medically necessary for the treatment of rubeosis irides,[2] proliferative retinopathy,[3] pre-proliferative retinopathy, and related etiologies of retinovitreal neovascularization.

2. Focal laser treatment of localized lesion may be medically necessary for the following lesions and conditions:

    a. Localized lesions of the retina or choroid (e.g., choroidal neovascularization, macro aneurysm, retinal or choroidal tumors, central serous choroidopathy).[4]
    b. Macular edema from retinal vein occlusion and diabetic retinopathy;[5]
    c. Retinal holes at risk to progressing to retinal detachment;[6]
    d. Prophylaxis for retinal detachment.[7]

[1] Ng, 2001.
[2] Rehak, 1992.
[3] Myslík, 2024.
[4] Rolfe, 2024.
[5] Thomley, 2021
[6] Wilkinson, 2014
[7] Wilkinson, 2014.

3. Trans pupillary thermotherapy (TTT) may be medically necessary for the following indications:

    a. Retinoblastoma[8] involving less than 50% of the retina, and without associated vitreal or subretinal seeds at the time of thermotherapy; or,
    b. Choroidal melanomas in the posterior globe.
    c. Choroidal vascular tumors
    d. Other primary retinal or choroidal tumors

C. Documentation

Medical necessity is supported by adequate and complete documentation in the patient's medical record that describes the procedure and the medical rationale. Documentation requires at a minimum all the following items. For retrospective reviews, the full operative report and medical plan of care are required.

All items must be available upon request to initiate or sustain previous payments. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, date(s) of service). The physician must authenticate all services ordered and provided using handwritten or electronic signature. Stamped signatures are not acceptable.

Medical necessity of laser photocoagulation and trans pupillary thermotherapy is supported by the following clinical records:

1. A complete examination of the eye with dilated pupils that includes:

    a. An examination of the anterior segment and posterior segment with documented pertinent findings; and,
    b. the interpretation and report from the most recent and previous tests performed including B-scan, OCT, and FA, where indicated; and,
    c. the covered condition, the need for the treatment contemplated, and the absence of contraindications for the surgery; and,

2. Other allied diagnostic testing supportive of the treatment plan with physician's order, medical rationale, findings, interpretation, and report; and,

3. Use of a laser that is FDA approved for the procedure; and,

4. Documentation, including dates, and outcomes of the preceding retinal laser photocoagulation performed to either the right and or left eye; and,

5. The detailed operative report is provided upon request. The operative report should include the procedure description including wavelength, duration, energy and number of applications of laser for the patient's specific indications.

[8] Rao, 2017

D. Procedural Detail

CPT and HCPCS Codes	
67101	Repair of retinal detachment, including drainage of subretinal fluid, when performed; cryotherapy
67105	Repair of retinal detachment, including drainage of subretinal fluid when performed; photocoagulation
67141	Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage, 1 or more sessions; cryotherapy, diathermy
67145	Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage, 1 or more sessions; photocoagulation
67208	Destruction of localized lesion of retina (e.g., macular edema, tumors), 1 or more sessions; cryotherapy, diathermy
67210	Destruction of localized lesion of retina (e.g., macular edema, tumors), one or more sessions; photocoagulation
67218	Destruction of localized lesion of retina (e.g., macular edema, tumors), 1 or more sessions; radiation by implantation of source (includes removal of source)
67220	Destruction of localized lesion of choroid (e.g., choroidal neovascularization); photocoagulation (e.g., laser), one or more sessions
67227	Destruction of extensive or progressive retinopathy (e.g., diabetic retinopathy), cryotherapy, diathermy
67228	Treatment of extensive or progressive retinopathy (e.g., diabetic retinopathy), photocoagulation
67299	Unlisted posterior segment procedure (used for retinal lasers in cryotherapy or thermotherapy procedures)
G0186	Destruction of localized lesion of choroid (for example, choroidal neovascularization); photocoagulation, feeder vessel technique (one or more sessions)

Every effort has been made to ensure that the information in this clinical policy is accurate and complete, however the Company does not guarantee that there are no errors in this policy or that the display of this file on a website is without error. The company and its employees are not liable for any errors, omissions, or other inaccuracies in the information, product, or processes disclosed. Neither the Company nor the employees represent that the use of such information, product, or processes will not infringe on privately owned rights. In no event shall the Company be liable for direct, indirect, special, incidental, or consequential damages arising out of the use of such information, product, or process.

RELATED POLICIES AND PROCEDURES	
1305	YAG Capsulotomy
1317	Intravitreal Injections
1345	Verteporfin (Visudyne)

DOCUMENT HISTORY		
Approval Date	***Revisions***	***Effective Date***
05/01/2018	Initial policy	05/01/2018
07/25/2019	Code additions; no substantive criteria change	08/01/2019
12/18/2019	No substantive criteria change	01/01/2020
06/03/2020	Removed indications for pediatric retinopathy of prematurity.	12/01/2020
01/06/2021	Removed criteria for A-VEGF therapy as a pre-requisite treatment for diabetic macular edema.	07/01/2021

10/06/2021	Added indication pre-proliferative retinopathy to B.1. criteria for Pan retinal Photocoagulation And. Pan retinal Cryotherapy; removed extraneous diagnoses (variations of neovascularization) from B.1. criteria for Pan Retinal Photocoagulation and Pan Retinal Cryotherapy; improved wording for indications for B.2. Focal Laser Treatment of Localized Lesion; removed entirety of criteria for B.2. Ocular Photodynamic, as redundant of policy 1345; Removed extraneous listings in D. Documentation requirements. Added CPT code 67229, deleted CPT codes J3396, 67221, and 67225 which are in policy 1345.	04/01/2022
07/06/2022	Criteria for photocoagulation and cryotherapy rewritten for retinovitreal neovascularization. Criteria for focal laser specifies macular edema from retinal vein occlusion and diabetic retinopathy.	01/01/2023
07/12/2023	Add indication of primary retinal or choroidal tumors to TTT procedure; remove required measure of spot size.	10/01/2023
07/10/2024	Add indication rubeosis irides; remove measurement requirements for choroidal melanomas and choroidal vascular tumors.	10/01/2024

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