NOTE: This policy has been revised. The revised policy will be effective May 1, 2024. To view the revised policy, click here.

Medicare Advantage Policy Manual **Policy ID:** M-SUR227

Laser Trabeculotomy and Trabeculostomy

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IMPORTANT REMINDER

The Medicare Advantage Medical Policy manual is not intended to override the member Evidence of Coverage (EOC), which defines the insured's benefits, nor is it intended to dictate how providers are to practice medicine. Physicians and other health care providers are expected to exercise their medical judgment in providing the most appropriate care for the individual member, including care that may be both medically reasonable and necessary.

The Medicare Advantage medical policies are designed to provide guidance regarding the decision-making process for the coverage or non-coverage of services or procedures in accordance with the member EOC and Centers of Medicare and Medicaid Services (CMS) policies and manuals, along with general CMS rules and regulations. In the event of a conflict, applicable CMS policy or EOC language will take precedence over the Medicare Advantage Medical Policy. In the absence of a specific CMS coverage determination for a requested service, item or procedure, the health plan may apply CMS regulations, as well as their Medical Policy Manual or other applicable utilization management vendor criteria developed with an objective, evidence-based process using scientific evidence, current generally accepted standards of medical practice, and authoritative clinical practice guidelines.

Some services or items may appear to be medically indicated for an individual, but may be a direct exclusion of Medicare or the member's benefit plan. Medicare and member EOCs exclude from coverage, among other things, services or procedures considered to be investigational (experimental) or cosmetic, as well as services or items considered not medically reasonable and necessary under Title XVIII of the Social Security Act, §1862(a)(1)(A). In some cases, providers may bill members for these non-covered services or procedures. Providers are encouraged to inform members in advance when they may be financially responsible for the cost of non-covered or excluded services. Members, their appointed representative, or a treating provider can request coverage of a service or item by submitting a pre-service organization determination prior to services being rendered.

DESCRIPTION

Glaucoma is usually caused by fluid build-up in the eye, which leads to optic nerve damage. Various minimally-invasive techniques, including excimer laser trabeculostomy (also known as excimer laser trabeculotomy) and femtosecond laser trabeculotomy have been proposed to improve fluid drainage from the eye to treat this disorder.

MEDICARE ADVANTAGE POLICY CRITERIA

Notes: This policy does not apply to laser trabeculoplasty.

N*ew and emerging medical technologies reported with Category III CPT*

Codes are created to track new, unproven therapies, devices, and tests. There are a number of reasons a service may be non-covered, including but not limited to, national coverage determination (NCD) guidance, lack of FDA approval, or the service is not considered "medically reasonable or necessary" under Title XVIII of the Social Security Act, §1862(a)(1)(A).

CMS Coverage Manuals*	None
National Coverage Determinations (NCDs)*	None
Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCDs) and Articles (LCAs)*	None
Medical Policy Manual	*Medicare coverage guidance is not available for laser trabeculotomy and trabeculostomy. Therefore, the health plan's medical policy is applicable.* Laser Trabeculotomy and Trabeculostomy, Surgery, Policy No. 227 *(see "NOTE" below)*

NOTE: If a procedure or device lacks scientific evidence regarding safety and efficacy because it is investigational or experimental, the service is noncovered as not reasonable and necessary to treat illness or injury. (*Medicare IOM Pub. No. 100-04, Ch. 23, §30 A*). According to Title XVIII of the Social Security Act, §1862(a)(1)(A), only medically reasonable and necessary services are covered by Medicare. In the absence of a NCD, LCD, or other coverage guideline, CMS guidelines allow a Medicare Advantage Organization (MAO) to make coverage determinations, applying an ***objective, evidence-based process, based on authoritative evidence***. (*Medicare IOM Pub. No. 100-16, Ch. 4, §90.5*). The Medicare Advantage Medical Policy - Medicine Policy No. M-149 - provides further details regarding the plan's evidence-assessment process (see Cross References).

POLICY GUIDELINES

REGULATORY STATUS

There are currently no ELT or FLT systems that are approved by the U.S Food and Drug Administration (FDA). The ExTra ELT laser platform is available in Europe.

As of most recent review, the Category III codes 0621T and 0622T have not received FDA approved guidance.

The fact a new service or procedure has been issued a CPT/HCPCS code or is FDA approved for a specific indication does not, in itself, make the procedure medically reasonable and necessary. The FDA determines safety and effectiveness of a device or drug, but does not establish medical necessity. While Medicare may adopt FDA determinations regarding safety

and effectiveness, Medicare or Medicare contractors evaluate whether or not the drug or device is reasonable and necessary for the Medicare population under §1862(a)(1)(A)

CROSS REFERENCES

Investigational (Experimental) Services, New and Emerging Medical Technologies and Procedures, and Other Non-Covered Services, Medicine, Policy No. M-149

REFERENCES

None

CODING

NOTE: According to CPT guidelines, "If a category III code is available, this code must be reported instead of a Category I unlisted code." If a different CPT code (including an unlisted code, such as 64999) is used instead of one of the applicable Category III codes, the service is still noncovered per the Medicare reference noted in the “Medicare Advantage Policy Criteria” section of the policy.

Codes	Number	Description
CPT	0621T	Trabeculostomy ab interno by laser; (e.g., ExTra ELT)
	0622T	Trabeculostomy ab interno by laser; with use of ophthalmic endoscope
	0730T	Trabeculotomy by laser, including optical coherence tomography (OCT) guidance
HCPCS	None	

***IMPORTANT NOTE:** Medicare Advantage medical policies use the most current Medicare references available at the time the policy was developed. Links to Medicare references will take viewers to external websites outside of the health plan's web control as these sites are not maintained by the health plan.*