Sentara Health Plans

Medicaid

Photodynamic Therapy with Verteporfin

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Effective Date	5/2002
Next Review Date	4/15/2024
Coverage Policy	Medical 171
Version	4

All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Purpose:

This policy addresses the medically necessity of Photodynamic Therapy with Verteporfin.

Description & Definitions:

Photodynamic Therapy with Verteporfin is a minimally invasive, non-thermal laser treatment in which medication/ photosensitizing agent (dye) is administered intravenously to mark the abnormal cells in the retina and reacts with the laser.

Criteria:

Photodynamic therapy with verteporfin is considered medically necessary for **1 or more** of the following:

- Chronic central serous chorioretinopathy and **ALL** of the following:
  - Duration 3 months or longer
  - Fluorescein angiography results confirm diagnosis of chronic central serous chorioretinopathy.
  - Glucocorticoids have been discontinued
- Myopic choroidal neovascularization, and treatment with vascular endothelial growth factor inhibitor contraindicated
- Neovascular age-related macular degeneration with subfoveal choroidal neovascularization and **ALL** of the following:
  - Fluorescein angiography results show choroidal neovascularization that is predominantly well-delineated.
  - Treatment with vascular endothelial growth factor inhibitor is contraindicated or refused by patient, or patient is unresponsive to treatment
- Polypoid choroidal vasculopathy with active juxtafoveal or subfoveal lesions and **1 or more** of the following:
  - Fluorescein angiography results show leakage at retinal pigment epithelium.
  - Pigment epithelium detachment

- Subretinal fluid or intraretinal fluid
- Subretinal hemorrhage or subretinal pigment epithelium hemorrhage
- Vision loss attributable to polypoid choroidal vasculopathy

Photodynamic therapy with verteporfin is considered **not medically necessary** for uses other than those listed in the clinical criteria.

Coding:

Medically necessary with criteria:

Coding	Description
67221	Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy (includes intravenous infusion)
67225	Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy, second eye, at single session (List separately in addition to code for primary eye treatment)
J3396	Injection, verteporfin, 0.1 mg

Considered Not Medically Necessary:

Coding	Description
	None

U.S. Food and Drug Administration (FDA) - approved only products only.

Document History:

Revised Dates:

- 2023: April
- 2019: December
- 2015: April, September
- 2013: June
- 2012: January, June
- 2011: May, June, December
- 2010: July, September
- 2009: June
- 2008: June
- 2007: December
- 2004: November, December

Reviewed Dates:

- 2022: April
- 2021: April
- 2020: April
- 2018: September, November
- 2017: November
- 2016: June
- 2015: June
- 2014: June
- 2010: June, August
- 2006: March
- 2005: October, November
- 2004: October
- 2003: May, November

Effective Date:

- May 2002

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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DRUG: Verteporfin. (2021, May 26). Retrieved Mar 3, 2023, from FDA: https://www.fda.gov/science-research/fda-science-forum/profiling-in-vitro-release-verteporfin-visudyne-liposomal-formulation-and-investigating-kinetics-human

Fact Sheet for Documenting the Need for Photodynamic Therapy (PDT). (2021, May). Retrieved Mar 10, 2023, from American Academy of Ophthalmology (AAO): https://www.aao.org/eyenet/article/fact-sheet-for-documenting-the-need-for-pdt

NCD Verteporfin (80.3.1). (2013, Jul 16). Retrieved Mar 6, 2023, from Centers for Medicare & Medicaid Services NCD: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=350&ncdver=2&keyword=Verteporfin&keywordType=starts&areaId=all&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance&bc=1

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Verteporfin. (2023). Retrieved Mar 3, 2023, from HAYES: https://evidence.hayesinc.com/search?q=%257B%2522text%2522:%2522Verteporfin%2522,%2522title%2522:null,%2522termsource%2522:%2522searchbar%2522,%2522page%2522:%257B%2522page%2522:0,%2522size%2522:50%257D,%2522type%2522:%2522all%2522,%2522sources%2522:%255B

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Special Notes: *

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

Keywords:

SHP Photodynamic Therapy with Verteporfin, SHP Medical 171, Chronic central serous chorioretinopathy, Myopic choroidal neovascularization, Neovascular age-related macular degeneration, subfoveal choroidal neovascularization, Polypoid choroidal vasculopathy, AMD, CNV, Coherent Opal Photoactivator laser, Zeiss VISULAS 690s laser, Quantel Activis Laser, Ceralas I Laser System