Ophthalmic Procedures, Surgical 60

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Effective Date	6/1/2026
Next Review Date	2/2027
Coverage Policy	Surgical 60
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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 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.*.

Description & Definitions:

Aqueous Shunt is a device inserted to promote drainage of fluid reducing intraocular pressure. (Ahmed glaucoma implant, Baerveldt seton, Glaucoma pressure regulator, Ex-PRESS Mini Glaucoma Shunt, Krupin-Denver valve implant, Molteno implant, Schocket shunt)

Canaloplasty (Ab Interno Canaloplasty (ABiC) is a less invasive surgery to insert a micro-catheter to open the natural eye canal to drain fluid, reducing intraocular pressure (IOP).

Cataracts – are the clouding of the eyes natural lens causing blurry vision or glaring of light.

Corneal Cross-Linking - Corneal cross-linking is a minimally invasive procedure designed to strengthen corneal tissue. The procedure involves removal of the corneal epithelial layer, followed by application of a riboflavin solution, which acts as a photosensitizer.

Glaucoma - a medical condition where there is increased pressure in the eyeball causing optic nerve damage. There are several procedures to alleviate this condition.

Micro-Invasive Glaucoma Surgery (MIGS) is group of surgical interventions performed ab interno to reduce complications and increased rate of a rapid recovery. The devices are placed into the eyes to help open and enlarge drainage for IOP.

Trabeculotomy (i.e., **Goniotomy**, trabeculotomy ab interno) the creation of a new channel for drain the buildup of fluid from the eye causing intraocular pressure (IOP) through the Trabecular meshwork.

Combined glaucoma and cataract surgery

Iris and Retinal prosthesis are the replacement of the iris or retina.

Intracanalicular plugs are small, absorbable polyethylene glycol hydrogel plugs that are used to deliver a sustained, therapeutic level of medication to targeted ocular tissue. The intracanalicular plug is designed to be

absorbed and exit the nasolacrimal system without need for removal. The plugs contain a visualization agent for retention monitoring throughout the treatment period.

Intrastromal corneal ring segments (ICRS) are semicircular plastic implants surgically inserted between layers on the outer edge of the cornea to flatten lens.

Keratoconus lenses are gas permeable lenses (‘rigid gas permeable’ or ‘gas permeable’ (RGP or GP) worn on the eye of an individual with keratoconus, the thinning and bulging of the cornea.

Piggyback contact lens also known as a “bandage or combination” contact lenses are two sets of lenses worn at the same time. A soft lens is placed on the eye first with a gas permeable lens (hard) on top to help improve vision for an individual with keratoconus.

Transpupillary Thermotherapy (TTT) uses an infrared laser to heat small and medium-sized tumors causing sclerosis (hardening or thickening of tissues) of the vessels supplying the tumor.

Criteria:

Ophthalmic procedures are considered medically necessary for **1 or more** of the following:

- Corneal Cross-Linking - Epithelium-off procedure using riboflavin (Photrexa) is considered medically necessary for **ALL of the following:**
  - Age 14 years or older
  - Corneal condition, as indicated by **1 or more** of the following:
    - Corneal ectasia following refractive surgery
    - Keratoconus, progressive
  - See Pharmacy PA for New Drug Applications (NDA) if using Unclassified drug code **J3490** for Corneal cross-linking (CXL)
- **Glaucoma surgery** for individual with request for **1 or more** of the following:
  - **Micro-Invasive Glaucoma Surgery (MIGS)** for **1 or more** of the following:
    - **Canaloplasty**, whether performed (ab externo or ab interno (OMNI, iTrack, Ellex, and ABiC)) for **ALL** of the following:
      - Individual with diagnosis of primary open-angle glaucoma
  - **Endocyclophotocoagulation (ECP) 66710, 66711** or Transscleral Cyclophotocoagulation for the treatment of glaucoma for **ALL** of the following:
    - Mild to severe or refractory disease
    - As a last resort when all other treatments have failed.
  - **XEN45® device** (one per eye) **0449T, 0450T** for **ALL** of the following:
    - Management of refractory glaucoma, as indicated by **1 or more** of the following:
      - Previous surgery has surgical treatment has failed
      - Primary open glaucoma
      - Unresponsive to medical therapy
- **Implantable miniature telescope (IMT) 0308T** for monocular implantation in members aged 65 years and older with stable, untreatable, severe-to-profound central vision impairment caused by blind spots (bilateral central scotoma) associated with end-stage Age-Related Macular Degeneration (ARMD) as determined by fluorescein angiography when **ALL** of the following are met:
  - Achieve at least a 5-letter improvement on the Early Treatment Diabetic Retinopathy Study (ETDRS) visual acuity chart in the eye scheduled for surgery using an external telescope
  - Adequate peripheral vision in the eye not scheduled for surgery, to allow for orientation and mobility
  - Agree to undergo 2 to 4 pre-surgical training sessions with low vision specialist (optometrist or occupational therapist)
  - Evidence of a visually significant cataract (grade 2 or higher)
  - No active wet ARMD (no sign of active choroidal neovascularization in either eye)
  - No sign of eye disease other than well-controlled glaucoma
  - Not been treated for wet ARMD in the previous 6 months
  - Visual acuity poorer than 20/160, but not worse than 20/800 in both eyes
  - Willingness to participate in a post-operative visual rehabilitation program
- Keratoconus lenes, treatment for individuals diagnosed with moderate to advanced keratoconus is considered medically necessary with **1 or more** of the following:
  - **Piggyback contact lens** treatment (**V - CODE**) with **1 or more** of the following:
    - Rigid lenses are a poor fit
    - Rigid lenses cause the individual discomfort
  - **Intrastromal corneal ring segments** (**65785**), (e.g., INTACS™) with **ALL** of the following:
    - Individual is 21 years of age or older
    - Individual has progressive deterioration in vision, such that individual can no longer achieve adequate functional vision on a daily basis with their contact lenses or spectacles
    - Individual has presence of a clear central cornea
    - Individual has corneal thickness of .45 mm or more at the proposed incision site
    - Individual's remaining option to improve functional vision is corneal transplantation
  - **Replacement lenses** for individuals who has a change in physical condition (does not included refractive changes)
- **Transpupillary thermotherapy (TTT) 67299** is medically necessary for one or more of the following:

- Choroidal melanomas
- Extrafoveal or Metastases treatment of retina
- Retinoblastoma
- Uveal Melanoma

Ophthalmic procedures are considered **not medically necessary** for any use other than those indicated in clinical criteria, to include but not limited to:

- Beta Radiation
- Clear lens extraction
- Combined phacoemulsification and viscocanalostomy
- Computer-aided animation and analysis of time series retinal images for the monitoring of disease progression, unilateral or bilateral, with interpretation and report
- Corneal Hysteresis Measurement
- CyPass Micro-Stent
- Device without FDA approval.
- Evacuation of Meibomian Glands
- **Excimer laser trabeculostomy (ELT)** not approved in US as of 2025
- Fistulization of sclera for glaucoma, through ciliary body
- Insertion of iris prosthesis
- Measurement of ocular blood flow by repetitive intraocular pressure sampling, with interpretation and report
- Micro Shunt EyePass
- Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral
- Near-infrared dual imaging of meibomian glands
- Placement of a subconjunctival retinal prosthesis receiver and pulse generator, and implantation of intra-ocular retinal electrode array, with vitrectomy (Premium Intraocular lenses
- Retinal prosthesis/ARGUS
- SOLX® Gold Shunt
- Suprachoroidal injection of a pharmacologic agent
- Suprachoroidal shunt
- Tear film imaging
- Transcilliary Filtration (e,g., Fugo Blade transciliary filtration, Singh filtration)
- Upgrades to any basic or standard lens or premium intraocular lenses or Intraocular lens implant (i.e., monofocal IOL, multifocal IOL, or accommodating IOL) for the correction of refractive error including but not limited to:
    - Accommodating posterior chamber IOLs (e.g., Crystalens)
    - Multi-focal posterior chamber IOLs (Array Model SA40, ReZoom, AcrySof ReSTOR, Tecnis ZM900 and ZMAOO, AcrySof ReSTOR, Acrysof Restor SA60D3 multifocal, Acrysof Natural ReSTOR SN60D3, AcrySof ReSTOR Aspheric IOL model SN6AD1, AcrySof ReSTOR Aspheric IOL model SN6AD3
    - Astigmatism-correcting (toric) posterior chamber IOLs-- Staar Toric IOL, Staar Elastic Toric Lens Model AA4203TL, AcrySof Toric IOL, AcrySof Aspheric Toric IOL SN6AT3, SN6AT4 and SN6AT5, AcrySof Toric Models SA60T3, SA60T4 and SA60T5, AcrySof Toric Model SA60T, and Acrysof IQ Toric Model SN6ATT)., Tecnis Toric intraocular lens

Corneal Cross-Linking New Drug Applications (NDA) (J3490) are considered not medically necessary and not clinically superior for any use, to include but not limited to:

- Epioxa™ HD / Epioxa™ New Drug Application (NDA) for Epi - ON procedure

Transpupillary thermotherapy (TTT) 67299 is considered not medically necessary for any use other than those indicated in clinical criteria, to include but not limited to:

- Choroidal neovascularization
    - Macular degeneration

Document History:

Revised Dates:

- 2026: February – Implementation date of June 1, 2026. Annual review. Coding/auth removal. Merge with Keratoconus Lenses and Interventions-Piggyback Contact Lenses Medical 03 (Archived). Add Corneal Cross-Linking criteria and new guidance for Unclassified medication code.
- 2025: October – Coding updated. Implementation date of February 1, 2026.
- 2025: February - Added criteria for Transpupillary Thermotherapy. Removed criteria for Dextenza. Updated policy to new format.
- 2024: February
- 2022: March, July, September
- 2021: February, June
- 2020: June, October
- 2016: February
- 2015: January, April, September, October, November
- 2014: January, March, July, August, November
- 2013: January, February, April, November
- 2012: January, May
- 2011: November
- 2010: June, September
- 2009: May
- 2008: May

Reviewed Dates:

- 2023: February
- 2019: August
- 2017: March, November
- 2016: March, September
- 2011: May
- 2010: May
- 2007: October
- 2001: December
- 2000: December
- 1999: November
- 1998: November
- 1996: August

Origination Date: February 1994

Coding:

Medically necessary with criteria:

Coding	Description
0308T	Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis
0402T	Collagen cross-linking of cornea (including removal of the corneal epithelium and intraoperative pachymetry when performed)
0449T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device
0450T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; each additional device (List separately in addition to code for primary procedure)
65785	Implantation of intrastromal corneal ring segments
66710	Ciliary body destruction; cyclophotocoagulation, transscleral

66711	Ciliary body destruction; cyclophotocoagulation, endoscopic, without concomitant removal of crystalline lens
67299	Unlisted procedure, posterior segment
92072	Fitting of contact lens for management of keratoconus, initial fitting
92325	MODIFICAJ CONTACT LENX SPX SUPVJ ADAPTATION
92499	Unlisted ophthalmological service or procedure
J2787	Riboflavin 5'- Phosphate, ophthalmic solution, up to 3ml
V2510	Contact lens, gas permeable, spherical, per lens
V2511	Contact lens, gas permeable, toric, prism ballast, per lens
V2512	Contact lens, gas permeable, bifocal, per lens
V2513	Contact lens, gas permeable, extended wear, per lens
V2530	Contact lens, scleral, gas impermeable, per lens (for contact lens modification, see CPT Level I code 92325)
V2531	Contact lens, scleral, gas permeable, per lens (for contact lens modification, see CPT Level I code 92325)
Below codes are used only for piggy-back lenses and should be used in conjunction with one of above codes:	
V2520	Contact lens, hydrophilic, spherical, per lens
V2521	Contact lens, hydrophilic, toric, or prism ballast, per lens
V2522	Contact lens, hydrophilic, bifocal, per lens
V2523	Contact lens, hydrophilic, extended wear, per lens

Considered Not Medically Necessary:

Coding	Description
0100T	Placement of a subconjunctival retinal prosthesis receiver and pulse generator, and implantation of intra-ocular retinal electrode array, with vitrectomy
0198T	Measurement of ocular blood flow by repetitive intraocular pressure sampling, with interpretation and report
0207T	Evacuation of meibomian glands, automated, using heat and intermittent pressure, unilateral
0253T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the suprachoroidal space
0329T	Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral, with interpretation and report
0330T	Tear film imaging, unilateral or bilateral, with interpretation and report
0465T	Suprachoroidal injection of a pharmacologic agent (does not include supply of medication)
0472T	Device evaluation, interrogation, and initial programming of intraocular retinal electrode array (eg, retinal prosthesis), in person, with iterative adjustment of the implantable device to test functionality, select optimal permanent programmed values with analysis, including visual training, with review and report by a qualified health care professional
0473T	Device evaluation and interrogation of intraocular retinal electrode array (eg, retinal prosthesis), in person, including reprogramming and visual training, when performed, with review and report by a qualified health care professional
0474T	Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space
0507T	Near-infrared dual imaging (ie, simultaneous reflective and trans-illuminated light) of meibomian glands, unilateral or bilateral, with interpretation and report
0563T	Evacuation of meibomian glands, using heat delivered through wearable, open-eye eyelid treatment devices and manual gland expression, bilateral
66683	Implantation of iris prosthesis, including suture fixation and repair or removal of iris, when performed
0621T	Trabeculostomy ab interno by laser
0622T	Trabeculostomy ab interno by laser; with use of ophthalmic endoscope
66999	Unlisted procedure, anterior segment of eye
J3490	Unclassified drugs

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device-code(s) does not constitute or imply member coverage or provider reimbursement.

Policy Approach and Special Notes: *

- Coverage:
  - See the appropriate benefit document for specific coverage determination. Individual specific benefits take precedence over medical policy.

    - For Dextenza (Dexamethasone Intracanalicular Ophthalmic Insert) refer to pharmacy Prior Authorization
- Application to products:
    - Policy is applicable to Sentara Health Plan Virginia Medicaid products.
- Authorization requirements:
    - Pre-certification by the Plan is required.
    - See MCG Cataract Removal, with or without Intraocular Lens Implant (A-0190)
    - See MCG Capsulotomy, Laser (A-0191)
    - See MCG Iridectomy, Incisional or Laser (A-0198)
    - See MCG Trabeculoplasty and Trabeculectomy, Laser (A-0196)
    - See MCG Iridotomy, Laser (A-0197)
    - See MCG Evoked Potentials: SEP, MEP, BAEP, VEP (A-0143)
- 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. EPSDT Supplement B (updated 5.19.22)_Final.pdf
    - Service authorization requests must be accompanied by sufficient clinical records to support the request. Clinical records must be signed and dated by the requesting provider withing 60 days of the date of service requested.

References:

References used include but are not limited to the following: 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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Keywords:

Cataract Procedures, SHP Surgical 60, cataract, ophthalmic, ocular, implant, intracapsular, extracapsular, lens, laser, SHP Glaucoma Procedures, Ophthalmic Procedures, Aqueous shunt, aqueous drainage devices, Microstent Bypass, Canaloplasty, Endoscopic Cyclophotocoagulation, Transscleral Cyclophotocoagulation, open-angle glaucoma, glaucoma, trabeculectomy, tube shunt procedures, intra-ocular pressure, Xen, Ahmed glaucoma implant, Baerveldt seton, Glaucoma pressure regulator, Ex-PRESS Mini Glaucoma Shunt, Krupin-Denver valve implant, Molteno implant, Schocket shunt, Laser trabeculotomy, ab interno, add diode laser hyperthermia, thermal therapy