Geisinger Health Plan

POLICIES AND PROCEDURE MANUAL

Policy: MP124

Section: Medical Benefit Policy

Subject: Transpupillary Thermotherapy

I. Policy: Transpupillary Thermotherapy

II. Purpose/Objective:
To provide a policy of coverage regarding Transpupillary Thermotherapy

III. Responsibility:
A. Medical Directors
B. Medical Management

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

(i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
(ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
(iii) The service or benefit will assist the Member to achieve or maintain maximum functional

capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

DESCRIPTION:
Transpupillary thermotherapy (TTT) involves the use of an infrared laser as a treatment to destroy intraocular tumors or to treat and prevent inappropriate new blood vessel growth in the eye due to age-related macular degeneration.

INDICATIONS: Transpupillary thermotherapy may be considered medically necessary for the treatment of:

- Small (less than 3 mm) choroidal melanoma located posterior to the globe
- Retinoblastoma without evidence of intravitreal or subretinal tumor seeds

EXCLUSIONS: There is insufficient evidence in the published, peer-reviewed medical literature to support the efficacy of this treatment for Exudative (wet) Choroidal neovascularization due to age-related macular degeneration is considered **Experimental, Investigational, or Unproven** and is **NOT COVERED,** except for lines of business for which coverage may be mandated.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

CODING ASSOCIATED WITH: Transpupillary Thermotherapy
The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov ***or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.***

67299 unlisted procedure, posterior segment

LINE OF BUSINESS:
Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

REFERENCES:
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Desjardins L, Lumbroso-Le Rouic L, Levy-Gabriel C et al. Combined proton beam radiotherapy and transpupillary thermotherapy for large uveal melanomas: a randomized study of 151 patients. Ophthalmic Res. 2006;38(5):255-60.

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This policy will be revised as necessary and reviewed no less than annually.

Devised: 2/04

Revised: 6/12 (added indications)

Reviewed: 2/05, 2/06; 2/07; 2/08; 2/09; 2/10; 2/11, 2/12, 6/13, 6/14, 6/15, 6/16, 5/17, 5/18, 5/19