I. Policy: Amniotic Membrane Transplant for Ocular Surface Defects and Amniotic Injections

II. Purpose/Objective:

To provide a policy of coverage regarding Amniotic Membrane Transplant for Ocular Surface Defects and Amniotic Injections

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:
Amniotic membrane transplantation (AMT) is a procedure that utilizes amniotic membrane tissue to reconstruct damaged ocular surfaces and promote healing of corneal, conjunctival, and eyelid tissues after injury due to trauma, disease, or surgery. Human amniotic membrane grafts may also be used to treat lower extremity diabetic skin ulcers.

INDICATIONS:
Preserved human amniotic membrane transplantation may be considered medically necessary for the treatment of ocular surface defects including, but not limited to:

- Bullous keratopathy
- Chemical or thermal burns to ocular surface
- Corneal ulcerations
- Pterygium (either primary and/or recurrent)
- Stevens-Johnson syndrome
- Limbal cell deficiency
- Persistent epithelial defects
- Conjunctival surface reconstruction
- Herpes zoster ophthalmicus

Human amniotic membrane grafts will be considered medically necessary for the treatment of non-healing lower-extremity diabetic skin ulcers. (See also: MP075) Examples of these human amniotic membrane products include, but are not limited to:

- AmnioBand® Membrane
- Biovance®
- Epifix®
- GrafixCore™
- GrafixPrime™

EXCLUSIONS: Injection of human amniotic fluid is considered investigational for all indications including, but not limited to osteoarthritis and plantar fasciitis. There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this service on health outcomes when compared to established treatments or technologies, and therefore are considered to be NOT COVERED.

CODING ASSOCIATED WITH: Amniotic Membrane Transplant for Ocular Surface Defects and Amniotic Injections

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.

- 65778 – Placement of amniotic membrane on the ocular surface; without sutures
- 65779 - single layer, sutured
- 65780 – Ocular surface reconstruction; amniotic membrane transplantation, multiple layers
- 65781 limbal stem cell allograft (e.g., cadaveric or living donor)
- 65782 limbal conjunctival autograft (includes obtaining graft)
- V2790 Amniotic membrane for surgical reconstruction, per procedure
- Q4132 Grafix Core, per sq cm
- Q4133 Grafix prime, grafixpl prime, stravix and stravixpl, per square centimeter
- Q4151 AmnioBand or Guardian, per sq cm
- Q4154 Biovance, per sq cm
- Q4168 AmnioBand, 1 mg
- Q4186 Epifix, per square centimeter
- Q4187 Epicord, per square centimeter
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 supersede this policy. For PA Medicaid Business segment, this policy applies as written.

REFERENCES:
Geisinger Technology Assessment Committee Triage review July 2012


Dighiero, PL, Mercié, M, and Gicquel, J. Early use of amniotic membrane transplantation combined with topical steroids in severe bacterial keratitis. IOVS. 2005;45ARVO-abstract. Cochrane Library


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

Devised: 7/12
Revised: 7/19 (add indications and exclusions)
Reviewed: 8/13, 8/14; 8/15; 7/16, 7/17, 6/18, 7/20

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.