

Policy: MP289

Section: Medical Benefit Policy

Subject: Treatment of Dry Eye Syndrome

Applicable Lines of Business

Commercial	X	CHIP	X
Medicare	X	ACA	X
Medicaid	X		

I. Policy: Treatment of Dry Eye Syndrome

II. Purpose/Objective:

To provide a policy of coverage regarding Treatment of Dry Eye Syndrome

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

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

- 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:

Dry eye disease is a multifactorial disease of the tears and ocular surface that can result in ocular discomfort and visual impairment. Dry eye is also known as keratoconjunctivitis sicca, dry eye syndrome, and dysfunctional tear syndrome.

INDICATIONS:

Punctal Plugs and Punctoplasty

The Plan considers punctal plugs, standard punctoplasty by electrodesiccation or electrocautery medically necessary when **the following** criteria are met:

- Medical record documentation of a diagnosis of severe dry eyes (also known as dry eye syndrome, keratoconjunctivitis sicca, xerophthalmia, xerosis, or sicca syndrome) with either documented objective evidence of lacrimal gland deficiency (e.g., Schirmer test or the tear break-up time test) or evidence of corneal decompensation on slit-lamp exam (i.e., an ocular surface dye staining pattern (rose bengal, fluorescein, or lissamine green) characteristic of dry eye syndrome); **and**
 - Therapeutic failure or inadequate response to conservative interventions including a 2 or more week trial of artificial tears; **and**
 - Adjustment to medications that may contribute to dry eye syndrome if applicable.

Repeat punctal plug procedures are considered medically necessary for **ANY of the following** indications:

- Replacement of temporary dissolvable punctal plugs with long-lasting semi-permanent punctal plugs; **OR**
- Use of shorter-acting punctal plugs composed of resorbable materials when dry eye syndrome is due to temporary or seasonal conditions; **OR**
- Replacement with flow controller punctal plugs for persons who experience epiphoria with standard punctal plugs; **OR**
- An isolated procedure for occlusion of upper puncta for persons with inadequate relief from occlusion of lower puncta

Tarsorrhaphy (surgical eyelid closure) is considered medically necessary after failure or contraindication to conservative treatment.

Tear osmolarity testing is considered medically necessary for the diagnosis and monitoring of Dry Eye Syndrome if slit lamp, as well as two other tests, fail to establish the suspected diagnosis of dry eye syndrome

Autologous Serum Tears (NOT COVERED FOR MEDICARE BUSINESS SEGMENT) for the treatment of severe dry eye syndrome is considered to be medically necessary when

- The condition is refractory to non-prescription artificial tears; and
- A documented failure, intolerance or contraindication to commercially available pharmacologic therapies

LIMITATIONS:

- Replacement of silicone punctal plugs or other long-lasting plugs is not medically necessary more frequently than every 6 months.

For information regarding amniotic membrane transplant, see: MP267

For information regarding contact lens, see: MP83

EXCLUSIONS:

The Plan considers the use of any of the following for the treatment of dry eyes **unproven** and therefore **NOT COVERED:**

- Intense Pulsed Light therapy

- Laser occlusion of the tear duct opening
- Tear film imaging (e.g., the Tear Stability Analysis System)
- Tear film biomarkers (e.g., goblet cell-specific MUC5AC and interleukin-8)
- Acupuncture
- Mechanical eyelid cleaning devices
- Eyelid thermal pulsation (e.g., MiBo Thermoflo; iLux, Systane iLux2, LipiFlow® Thermal Pulsation System)
- Intranasal Neurostimulation (e.g., TrueTear, iTEAR100)

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.

Medicaid Business Segment:

Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis

CODING ASSOCIATED WITH: Treatment of Dry Eye Syndrome

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.

- 67875 Closure of eyelid by suture
- 67880 Revision of eyelid
- 67882 Revision of eyelid
- 68760 Closure of lacrimal punctum; by thermocauterization, ligation or laser surgery
- 68761 by plug, each
- 68801 Dilation of lacrimal punctum, with or without irrigation
- 83861 Tear osmolarity
- 92499 Unlisted ophthalmological service or procedure [*may be utilized for TrueTear, iTEAR100, iLux Thermal Pulsation System or Systane iLux2 Thermal Pulsation System*]
- 0207T Evacuation of meibomian glands, automated, using heat and intermittent pressure, unilateral [*may be utilized for LipiFlow*]
- 0330T Tear film imaging, unilateral or bilateral, with interpretation and report [*may be utilized for LipiView*]
- 0507T Near-infrared dual imaging (ie, simultaneous reflective and trans-illuminated light) of meibomian glands, unilateral or bilateral, with interpretation and report [*This service may be used in conjunction with the LipiScan Thermal Pulsation System*]
- 0563T Evacuation of meibomian glands, automated, using heat and intermittent pressure, bilateral [*may be utilized for TearCare*]
- J9999 Unlisted
- J3490 Unlisted
- C9399 Unlisted

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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.

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

Devised: 4/14

Revised: 4/16 (add exclusion); 4/17 (add coverage); 4/19 (add exclusion), 4/21 (add biomarker exclusion); 4/22 (add IPL and mechanical device exclusion); 4/24 (add exclusion for intranasal neurostimulation); 7/24 (revise serum tear exclusion for Medicare)

Reviewed: 4/15, 4/18, 4/20, 4/23

CMS UM Oversight Committee Approval: 12/23, 7/24

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.

Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at <https://www.geisinger.org/health-plan/providers/ghp-clinical-policies>

Please be advised that the use of the logos, service marks or names of Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company on a marketing, press releases or any communication piece regarding the contents of this medical policy is strictly prohibited without the prior written consent of Geisinger Health Plan. Additionally, the above medical policy does not confer any endorsement by Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company regarding the medical service, medical device or medical lab test described under this medical policy.