Geisinger

# Geisinger Health Plan Policies and Procedure Manual

**Policy: MP289**

**Section: Medical Benefit Policy**

**Subject: Treatment of Dry Eye Syndrome**

**Applicable line of business:**

| | | | |
|---|---|---|---|
| **Commercial** | **x** | **Medicaid** | **x** |
| **Medicare** | **x** | **ACA** | **x** |
| **CHIP** | **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.

Commercial

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.

Medicare

Geisinger Gold Medicare Advantage HMO, PPO, and HMO D-SNP plans are offered by Geisinger Health Plan/Geisinger Indemnity Insurance Company, health plans with a Medicare contract. Continued enrollment in Geisinger Gold depends on contract renewal. Geisinger Health Plan/Geisinger Indemnity Insurance Company are part of Geisinger, an integrated health care delivery and coverage organization.

CHIP

Geisinger Health Plan Kids (GHP Kids) is a Children's Health Insurance Program (CHIP) offered by Geisinger Health Plan in conjunction with the Pennsylvania Department of Human Services (DHS). Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Medicaid

Geisinger Health Plan Family (GHP Family) is a Medical Assistance (Medicaid) insurance program offered by Geisinger Health Plan in conjunction with the Pennsylvania Department of Human Services (DHS). Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization

**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 electrodessication 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, lactoferrin and/or IgE)
- 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); 7/25 (add biomarker exclusion)

**Reviewed:** 4/15**,** 4/18, 4/20, 4/23, 7/26

**CMS UM Oversight Committee Approval:** 12/23, 7/24, 10/25, 9/26

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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

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