

Vision Services

Policy Number: MCS104.06

Approval Date: January 18, 2024

Effective Date: March 1, 2024

 [Instructions for Use](#)

Table of Contents	Page
Coverage Guidelines	1
• Eye Examination	2
• Services of an Optometrist and/or Ophthalmologist	2
• Frames and Lenses	2
• Vision Therapy	4
• Annual Diabetic Retinal Examination	4
• Corneal Collagen Cross-Linking	4
• Photocoagulation, Focal Laser	4
• Glaucoma Screening	5
• Rehabilitation Services for Members with Vision Impairment	5
• Intraocular Photography	5
• Vitrectomy	5
• Visual Tests Prior to and General Anesthesia During Cataract Surgery	6
• Computer Enhanced Perimetry	6
• Glaucoma Surgical Treatments	6
• Avastin®	6
• Lucentis®	6
• Implantable Miniature Telescope	6
• Home Visual Field Monitoring	6
• Placement of Intraocular Radiation Source Applicator	7
• Retinal Prosthesis	7
• Corneal Hysteresis Measurement	7
Definitions	7
Supporting Information	8
Policy History/Revision Information	9
Instructions for Use	10

Related Medicare Advantage Policy Guidelines

- [Corneal Topography](#)
- [Ocular Telescope](#)

Coverage Guidelines

Vision services, therapy and rehabilitation are covered in accordance with Medicare coverage criteria.

Note: The guidelines in this Coverage Summary are for specific procedures/medications only. For procedures/medications not addressed in this Coverage Summary, refer to the [Medicare Coverage Database](#) to search for applicable coverage policies (National Coverage Determinations, Local Coverage Determinations and Local Coverage Articles).

Eye Examination

Eye examination by the member's physician for the treatment or diagnosis for a specific illness, symptom, complaint or injury is covered.

Refer to the [Medicare Benefit Policy Manual, Chapter 16, §90 – Routine Services and Appliances](#).

For visual acuity screening, refer to the [Medicare Claims Processing Manual, Chapter 18, §80 – Initial Preventive Physical Examination \(IPPE\)](#).

(Accessed August 1, 2023)

Services of an Optometrist and/or Ophthalmologist

Services of an optometrist and/or ophthalmologist are covered when medically reasonable and necessary for the diagnosis and treatment of an eye disease or injury.

Where more than one practitioner furnishes concurrent care, services furnished to a member by both an ophthalmologist and another physician (including an optometrist) may be recognized for payment if it is determined that each practitioner's services were reasonable and necessary.

Refer to the [Medicare Benefit Policy Manual, Chapter 15, §30.4 – Optometrist's Services](#). (Accessed May 8, 2023)

Frames and Lenses

Routine Corrective Refractive Frames and Lenses

Eye examinations for the purpose of prescribing, fitting, or changing eyeglasses; eye refractions by whatever practitioner and for whatever purpose performed are not covered by Medicare, however, some members may have this benefit, including the frames and lenses through their UnitedHealthcare Medicare Advantage plan.

Refer to the member's Schedule of Benefit (SOB) to determine eligibility for this benefit and the applicable copayment/coinsurance will apply, if any. In some cases, vision services may be provided by the medical group or by another vision services provider. Contact the customer services department for assistance in determining the member's assigned vision services provider.

Refer to the [Medicare Benefit Policy Manual, Chapter 16, §90 – Routine Services and Appliances](#).

(Accessed May 8, 2023)

Post Cataract Surgery Frames and Lenses

One pair of eyeglasses or contact lenses are covered after each cataract surgery, with the insertion of a conventional intraocular lens (IOL).

Refer to the:

- [NCD for Intraocular Lenses \(IOLs\) \(80.12\)](#).
- [NCD for Refractive Keratoplasty \(80.7\)](#).

(Accessed May 8, 2023)

There is no specific time frame after the cataract surgery when a member must receive the post-cataract lenses. However, to ensure that the lenses are still medically necessary, the lenses should be dispensed within 3 months of being ordered.

For members who are aphakic and do not have an IOL, either because of surgery or congenital absence, the following lenses or combination of lenses are covered when determined to be medically necessary:

- Prosthetic bifocal lenses in frames (prescription eyeglasses);
- Prosthetic lenses in frames (prescription eyeglasses) for far vision and lenses in frames for near vision (prescription eyeglasses); or
- When contact lenses for far vision are prescribed, coverage includes: contact lenses and prosthetic lenses in frames (prescription eyeglasses) for near vision, and prosthetic lenses in frames (prescription eyeglasses) for when the contacts

are removed (i.e., coverage for contacts for far vision, eyeglasses for near vision to be worn with the contacts, and eyeglasses for far vision for when the contacts are removed).

Note: Prosthetic lenses (prescription eyeglasses) that have ultraviolet absorbing or reflecting properties may be covered in lieu of the regular (untinted) prosthetic lenses mentioned in (a), (b) and (c) above if it has been determined that such lenses are medically reasonable and necessary for the individual patient.

Refer to the:

- [Medicare Benefit Policy Manual, Chapter 15, §120 – Prosthetic Devices.](#)
- [NCD for Intraocular Lenses \(IOLs\) \(80.12\).](#)

(Accessed May 8, 2023)

Hydrophilic Contact Lenses for Corneal Bandage

FDA-approved hydrophilic contact lens used as moist corneal bandages for the treatment of acute or chronic corneal pathology are covered:

- Bullous keratopathy
- Dry eyes
- Corneal ulcers and erosion
- Keratitis
- Corneal edema
- Descemetocoele
- Corneal ectasis
- Mooren's ulcer
- Anterior corneal dystrophy
- Neurotrophic keratoconjunctivitis

Hydrophilic contact lenses are not covered when used in the treatment of non-diseased eyes with spherical ametropia, refractive astigmatism and/or corneal astigmatism.

Refer to the:

- [NCD for Hydrophilic Contact Lens For Corneal Bandage \(80.1\).](#)
- [NCD for Hydrophilic Contact Lenses \(80.4\).](#)

(Accessed May 8, 2023)

Hard/Rigid Contact Lenses for the Treatment of Keratoconus

Hard/rigid contact lenses for the treatment of keratoconus are covered.

Note: Routine physical checkups; eyeglasses, contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses; eye refractions by whatever practitioner and for whatever purpose performed; hearing aids and examinations for hearing aids; and immunizations are not covered.

The routine physical checkup exclusion applies to (a) examinations performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury; and (b) examinations required by third parties such as insurance companies, business establishments, or Government agencies.

The exclusions apply to eyeglasses or contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive errors.

The exclusions do not apply to physician services (and services incident to a physician's service) performed in conjunction with an eye disease, as for example, glaucoma or cataracts, or to post-surgical prosthetic lenses which are customarily used during convalescence from eye surgery in which the lens of the eye was removed, or to permanent prosthetic lenses required by an individual lacking the organic lens of the eye, whether by surgical removal or congenital disease. Refer to the [Medicare Benefit Policy Manual, Chapter 16, §90 – Routine Services and Appliances](#). (Accessed May 8, 2023)

Non-Covered

Frames, lenses, contact lenses or plano lenses (non-prescription) are not covered except as described above. Refer to the [Medicare Benefit Policy Manual, Chapter 16, §90 – Routine Services and Appliances](#).

Low vision aids, progressive lenses, scratch coating for lenses, contact lens cleaner or solutions are not covered. Refer to the DME MAC [LCD for Refractive Lenses \(L33793\)](#) and the [Medicare Benefit Policy Manual, Chapter 16, §90 – Routine Services and Appliances](#).

Local Coverage Determinations (LCD) for refractive lenses exists and compliance with these policies is required where applicable. Refer to the DME MAC [LCD for Refractive Lenses \(L33793\)](#).
(Accessed December 7, 2023)

Vision Therapy (e.g., Ocular Exercises, Visual Training, Vision Training, Orthoptics, and any Associated Supplemental Testing) (CPT Code 92065)

Medicare does not have a National Coverage Determination (NCD) for vision therapy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled [Visual Information Processing Evaluation and Orthoptic and Vision Therapy](#).

Note: After searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

For rehabilitation services for vision impairment, refer to Coverage Summary titled [Skilled Nursing Facility, Rehabilitation, and Long-Term Acute Care and Hospital](#).

Annual Diabetic Retinal Examination

Annual diabetic retinal examination is covered for members with diabetes. Refer to the [Medicare Benefit Policy Manual, Chapter 16, §90 – Routine Services and Appliances](#). (Accessed May 8, 2023)

Corneal Collagen Cross-Linking (CPT Code 0402T and HCPCS J2787)

Medicare does not have a National Coverage Determination (NCD) for corneal collagen cross-linking. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.

For coverage guidelines, refer to the UnitedHealthcare Medical Policy titled [Corneal Collagen Cross-Linking](#).

Note: After searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

Photocoagulation, Focal Laser (CPT Codes 67105, 67107, 67145, 67210, 67220, and 67228)

Medicare does not have a National Coverage Determination (NCD) for photocoagulation, focal laser. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the InterQual® CP: Procedures, Photocoagulation, Focal Laser.

Click [here](#) to view the InterQual® criteria.

Note: After searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use InterQual® criteria referenced above for coverage guidelines.
(Accessed January 10, 2024)

Glaucoma Screening

Screening for glaucoma is defined to include (1) a dilated eye examination with an intraocular pressure measurement; and (2) a direct ophthalmoscopy examination, or a slit lamp biomicroscopic examination.

Annual (once every 12 months) glaucoma screening is covered for members with diabetes mellitus or a family history of glaucoma, or African Americans age 50 and over, or Hispanic-Americans age 65 and older.

Note: Optometrist may perform a Medicare covered glaucoma screening, if the service is within the scope of practice permitted by state licensure.

Refer to the [Medicare Benefit Policy Manual, Chapter 15, §280.1 – Glaucoma Screening](#).
(Accessed August 1, 2023)

Rehabilitation Services for Members with Vision Impairment

For coverage guidelines, refer to the Coverage Summary titled [Skilled Nursing Facility, Rehabilitation, and Long-Term Acute Care and Hospital](#).

Intraocular Photography (also known as Fundus Photography)

Intraocular Photography to Diagnose Conditions Listed Below (CPT Code 92250)

Intraocular photography when used by an ophthalmologist is covered for the diagnosis of such conditions as macular degeneration, retinal neoplasms, choroid disturbances and diabetic retinopathy, or to identify glaucoma, multiple sclerosis and other central nervous system abnormalities.

Note: Optometrists may be allowed to perform intraocular photography and other services, if the services are within the scope of practice permitted by state licensure. Refer to the [Definition](#) section for Optometrist Services.

Refer to the [NCD for Intraocular Photography \(80.6\)](#). (Accessed May 8, 2023)

Vitrectomy

Vitrectomy is covered for the following conditions: vitreous loss incident to cataract surgery, vitreous opacities due to vitreous hemorrhage or other causes, retinal detachments secondary to vitreous strands, proliferative retinopathy, and vitreous retraction. Refer to the [NCD for Vitrectomy \(80.11\)](#). (Accessed May 8, 2023)

Bladeless, Computer Controlled Laser Cataract Surgery (Femtosecond Laser System, e.g., LenSx® Laser)

CMS Rulings 05-01 and 1536-R allow facilities and physicians to charge patients only for the non-covered portion of a service that is furnished at the same time as a covered service.

Services that are part of cataract surgery with a conventional lens, including but not necessarily limited to the incision by whatever method, capsulotomy by whatever method, and lens fragmentation by whatever method, may not be charged to the patient. The patient may only be charged for those non-covered services specified above. (refer to the [Post Cataract Surgery Frames and Lenses](#) section.)

Medicare coverage and payment for cataract surgery is the same irrespective of whether the surgery is performed using conventional surgical techniques or a bladeless, computer controlled laser. Under either method, Medicare will cover and pay for the cataract removal and insertion of a conventional intraocular lens.

If the bladeless, computer controlled laser cataract surgery includes implantation of a presbyopia intraocular lens (PC-IOL) or astigmatism correcting intraocular lens (AC-IOL), only charges for those non-covered services specified above) may be charged to the patient. (refer to the [Post Cataract Surgery Frames and Lenses](#) section.)

These charges could possibly include charges for additional services, such as imaging, necessary to implant a PC-IOL or an AC-IOL but that are not performed when a conventional IOL is implanted. Performance of such additional services by a physician on a limited and non-routine basis in conventional IOL cataract surgery would not disqualify such services as non-covered services.

This guidance does not apply to the use of technology for refractive keratoplasty.

Refer to the [CMS Publication \(November 16, 2012\) – Laser-Assisted Cataract Surgery and CMS Ruling 05-01 and CMS Ruling 1536-R](#). (Accessed May 8, 2023)

Visual Tests Prior to and General Anesthesia During Cataract Surgery

Pre-Surgery Evaluations

Where the only diagnosis is cataract(s), Medicare does not routinely cover testing other than one comprehensive eye examination (or a combination of a brief/intermediate examination not to exceed the charge of a comprehensive examination) and an A-scan or, if medically justified, a B-scan.

General Anesthesia

The use of general anesthesia in cataract surgery may be considered reasonable and necessary if, for particular medical indications, it is the accepted procedure among ophthalmologists in the local community to use general anesthesia.

Refer to the [NCD for Use of Visual Test Prior to and General Anesthesia during Cataract Surgery \(10.1\)](#).

(Accessed May 8, 2023)

Computer Enhanced Perimetry

Computer enhanced perimetry is covered when used in assessing visual fields in patients with glaucoma or other neuropathologic defects. Refer to the [NCD for Computer Enhanced Perimetry \(80.9\)](#). (Accessed February 7, 2023)

Glaucoma Surgical Treatments

Refer to the Coverage Summary titled [Glaucoma Surgical Treatments](#).

Avastin® (Bevacizumab)

Refer to the Coverage Summary titled [Medications/Drugs \(Outpatient/Part B\)](#).

Lucentis® (Ranibizumab)

Refer to the Coverage Summary titled [Medications/Drugs \(Outpatient/Part B\)](#).

Implantable Miniature Telescope (IMT) (CPT Codes 0308T, 0378T, 0379T, 67036, and 67299 and HCPCS Code C1840)

Medicare does not have a National Coverage Determination (NCD) for Implantable Miniature Telescope (IMT). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable.

For specific LCDs/LCAs, refer to the table for [Implantable Miniature Telescope \(IMT\)](#).

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Medical Policy titled [Macular Degeneration Treatment Procedures](#).

Note: After checking the [Implantable Miniature Telescope \(IMT\)](#) table and searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

Home Visual Field Monitoring (CPT Codes 0378T and 0379T)

Medicare does not have a National Coverage Determination (NCD) for home visual field monitoring. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Medical Policy titled [Macular Degeneration Treatment Procedures](#).

Note: After searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

Placement of Intraocular Radiation Source Applicator (CPT Codes 63036, 67299, and 92499)

Medicare does not have a National Coverage Determination (NCD) for placement of intraocular radiation source applicator. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Medical Policy titled [Macular Degeneration Treatment Procedures](#).

Note: After searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

Retinal Prosthesis (CPT Code 0100T)

Medicare does not have a National Coverage Determination (NCD) for retinal prosthesis. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for [Retinal Prosthesis](#).

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled [Omnibus Codes](#).

Note: After searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

Corneal Hysteresis Measurement

Medicare does not have a National Coverage Determination (NCD) for corneal hysteresis measurement. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for [Corneal Hysteresis Measurement](#).

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled [Corneal Hysteresis and Intraocular Pressure Measurement](#).

Note: After checking the [Corneal Hysteresis Measurement](#) table and searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

Definitions

Humanitarian Device Exemption (HDE): Is the application process. An HDE is similar in both form and content to a pre-market approval (PMA) application; however, the HDE is “exempt” from the effectiveness requirements of a PMA.

An HDE application **does not require** the explanation of scientific results of a valid clinical investigation which demonstrates the device is effective for its intended purpose.

An HDE must contain sufficient information for the Food and Drug Administration (FDA) to determine that the probable benefit to health outweighs the risk of injury or illness taking into account the probable risks and benefits of currently available devices or alternative forms of treatment. (Refer to section 520(m) (2) (C)). An FDA approved HDE authorizes marketing of a Humanitarian Use Device (HUD). [FDA – Medical Devices, HDE Approvals](#).

Optometrist Services: Effective April 1, 1987, a doctor of optometry is considered a physician with respect to all services the optometrist is authorized to perform under State law or regulation. To be covered under Medicare, the services must be

medically reasonable and necessary for the diagnosis or treatment of illness or injury, and must meet all applicable coverage requirements. Refer to the [Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, §70.5 – Optometrist](#).

Presbyopia: Age associated type of refractive error that results in a progressive loss of ability to focus on objects at near distance or close-up. [CMS Ruling 05-01 \(May 3, 2005\) – Requirements for Determining Coverage of Presbyopia-Correcting Intraocular Lenses](#).

Vision Impairment Rehabilitation: Designed to improve the performance of activities of daily living in patients with vision impairment or vision loss whose vision cannot be corrected to normal or near normal by standard restorative processes. Vision impairment ranging from low vision to total blindness may result from primary eye disorders, such as macular degeneration, retinitis pigmentosa, or glaucoma, or as a condition secondary to another primary diagnosis, such as diabetes mellitus, acquired immune deficiency syndrome (AIDS), infection, etc. Vision rehabilitation in these patients is intended to maximize the use of residual vision and to provide practical adaptations and training to increase functional ability, personal safety, and independence. [Medicare Program Memorandum AB-02-078 – Rehabilitation Services for Visually Impaired, Change Request 2083, May 29, 2002](#).

(Accessed May 8, 2023)

Supporting Information

Implantable Miniature Telescope (IMT)				
Accessed January 12, 2024				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L33584 (A57411)	Implantable Miniature Telescope (IMT)	Part A and B MAC	National Government Services, Inc.	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
A53501	Billing and Coding: Implantable Miniature Telescope (IMT) for Macular Degeneration	Part A and B MAC	Palmetto GBA	AL, GA, NC, SC, TN, VA, WV
L35490 (A56902)	Category III Codes	Part A and B MAC	Wisconsin Physicians Service Insurance Corporation	IA, IN, KS, MI, MO, NE
Back to Guidelines				

Corneal Hysteresis Measurement				
Accessed January 18, 2024				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L38014 (A56248)	Corneal Hysteresis	Part A and B MAC	National Government Services, Inc.	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
L38026 (A56968)	Corneal Hysteresis	Part A and B MAC	Palmetto GBA	AL, GA, NC, SC, TN, VA, WV
L38211 (A56910)	Corneal Hysteresis	Part A and B MAC	Wisconsin Physicians Service Insurance Corporation	IA, IN, KS, MI, MO, NE
Back to Guidelines				

Retinal Prosthesis (CPT code 0100T)

Accessed January 12, 2024

LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
A54327	Billing and Coding: ArgusM II Retinal Prosthesis System	Part A and B MAC	CGS Administrators, LLC	KY, OH
Back to Guidelines				

Policy History/Revision Information

Date	Summary of Changes
01/18/2024	<p>Title Change</p> <ul style="list-style-type: none"> Previously titled <i>Vision Services, Therapy, and Rehabilitation</i> <p>Coverage Guidelines</p> <ul style="list-style-type: none"> Removed content/language addressing: <ul style="list-style-type: none"> Scanning computerized ophthalmic diagnostic imaging (SCODI)/scanning laser glaucoma tests (SLGT)/optical coherence test (OCT)/scanning laser polarimetry (CPT codes 92132, 92133, and 92134) Remote imaging to detect retinal disease (e.g., retinopathy in patients with diabetes) (CPT code 92227) Remote imaging to manage active retinal disease (e.g., diabetic retinopathy) (CPT code 92228) Computerized corneal topography (CPT code 92025) Corneal pachymetry (ophthalmic ultrasound) (CPT code 76514) <p>Corneal Collagen Cross-Linking (CPT Code 0402T and HCPCS Code J2787) (new to policy)</p> <ul style="list-style-type: none"> Added language to indicate: <ul style="list-style-type: none"> Medicare does not have a National Coverage Determination (NCD) for corneal collagen cross-linking; Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled <i>Corneal Collagen Cross-Linking</i> <p>Photocoagulation, Focal Laser (CPT Codes 67105, 67107, 67145, 67210, 67220, and 67228) (new to policy)</p> <ul style="list-style-type: none"> Added language to indicate: <ul style="list-style-type: none"> Medicare does not have a NCD for photocoagulation, focal laser; LCDs/LCAs do not exist For coverage guidelines, refer to the InterQual® CP: Procedures, Photocoagulation, Focal Laser After searching the Medicare Coverage Database, if no LCD/LCA is found, then use InterQual® referenced above for coverage guidelines <p>Implantable Miniature Telescope (IMT) (CPT Codes 0308T, 0378T, 0379T, 67036, 67299 and HCPCS Code C1840)</p> <ul style="list-style-type: none"> Updated list of applicable CPT codes; added 0378T, 0379T, 67036, and 67299 <p>Home Visual Field Monitoring (CPT Codes 0378T and 0379T) (new to policy)</p> <ul style="list-style-type: none"> Added language to indicate: <ul style="list-style-type: none"> Medicare does not have a NCD for home visual field monitoring; LCDs/LCAs do not exist at this time For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled <i>Macular Degeneration Treatment Procedures</i> <p>Placement of Intraocular Radiation Source Applicator (CPT Codes 63036, 67299, and 92499) (new to policy)</p> <ul style="list-style-type: none"> Added language to indicate: <ul style="list-style-type: none"> Medicare does not have a NCD for placement of intraocular radiation source applicator; LCDs/LCAs do not exist at this time

Date	Summary of Changes
	<ul style="list-style-type: none">○ For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled <i>Macular Degeneration Treatment Procedures</i> <p>Supporting Information</p> <ul style="list-style-type: none">● Archived previous policy version MCS104.05

Instructions for Use

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member’s Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member’s EOC/SB, the member’s EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing the items or services in this coverage summary have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, UnitedHealthcare applies internal coverage criteria in the UnitedHealthcare commercial policies referenced in this coverage summary. The coverage criteria in these commercial policies was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

CPT® is a registered trademark of the American Medical Association.