Ocular Telescope

Guideline Number: MPG222.06
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➲ Terms and Conditions

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Policy Summary

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Overview

The Implantable Miniature Telescope (IMT) is a telescope prosthetic device that replaces the natural lens in one eye of patients with bilateral, advanced age-related macular degeneration (AMD) in order to enlarge the retinal image to such a degree that it is visualized outside of vision-impairing central scotomas.

Guidelines

The intraocular telescope is indicated for monocular implantation to improve vision in patients greater than or equal to 65 years of age with stable severe to profound vision impairment (best corrected distance visual acuity 20/160 to 20/800) caused by bilateral central scotoma associated with untreatable end-stage age-related macular degeneration.

Patients must:

- Have retinal findings of geographic atrophy or disciform scar with foveal involvement, as determined by fluorescein angiography
- Have untreatable end-stage, non-exudative, age-related macular degeneration
- Have evidence of visually significant cataract (= Grade 2)
- Agree to undergo pre-surgery training and assessment (typically 2 to 4 sessions) with low vision specialists in the use of an external telescope sufficient for patient assessment and for the patient to make an informed decision regarding the potential risks and benefits of the IMT
- Achieve at least 5-letter improvement on the Early Treatment Diabetic Retinopathy Study (ETDRS) chart with an external telescope during the pre-implant evaluation
- Complete and agree to the "Acceptance of risk and informed consent agreement" provided in the device labeling documentation
- Agree to participate in post-implant visual training with a low vision specialist

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws

that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
0308T	Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis

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HCPCS Code	Description
C1840	Lens, intraocular (telescopic)

Modifier	Description
LT	Left side (used to identify procedures performed on the left side of the body)
RT	Right side (used to identify procedures performed on the right side of the body)

Diagnosis Code	Description
H35.3110	Nonexudative age-related macular degeneration, right eye, stage unspecified
H35.3111	Nonexudative age-related macular degeneration, right eye, early dry stage
H35.3112	Nonexudative age-related macular degeneration, right eye, intermediate dry stage
H35.3113	Nonexudative age-related macular degeneration, right eye, advanced atrophic without subfoveal involvement
H35.3114	Nonexudative age-related macular degeneration, right eye, advanced atrophic with subfoveal involvement
H35.3120	Nonexudative age-related macular degeneration, left eye, stage unspecified
H35.3121	Nonexudative age-related macular degeneration, left eye, early dry stage
H35.3122	Nonexudative age-related macular degeneration, left eye, intermediate dry stage
H35.3123	Nonexudative age-related macular degeneration, left eye, advanced atrophic without subfoveal involvement
H35.3124	Nonexudative age-related macular degeneration, left eye, advanced atrophic with subfoveal involvement
H35.3130	Nonexudative age-related macular degeneration, bilateral, stage unspecified
H35.3131	Nonexudative age-related macular degeneration, bilateral, early dry stage
H35.3132	Nonexudative age-related macular degeneration, bilateral, intermediate dry stage
H35.3133	Nonexudative age-related macular degeneration, bilateral, advanced atrophic without subfoveal involvement
H35.3134	Nonexudative age-related macular degeneration, bilateral, advanced atrophic with subfoveal involvement

References

CMS Local Coverage Determinations (LCDs) and Articles

LCD	Article	Contractor	Medicare Part A	Medicare Part B
L35490 Category III Codes	A56902 Billing and Coding: Category III Codes	WPS	AK, AL, AR, AZ, CA, CO, CT, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH,	IA, IN, KS, MI, MO, NE

LCD	Article	Contractor	Medicare Part A	Medicare Part B
			OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	
L35094 Services That Are Not Reasonable and Necessary	A56967 Billing and Coding: Services That Are Not Reasonable and Necessary	Novitas	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
L33584 Implantable Miniature Telescope (IMT)	A57411 Billing and Coding: Implantable Miniature Telescope (IMT)	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
N/A	A53501 Implantable Miniature Telescope (IMT) for Macular Degeneration	Palmetto		AL, GA, NC, SC, TN, VA, WV
L34370 Category III CPT® Codes Retired 06/19/2020	A57230 A57230 - Billing and Coding: Category III CPT® Codes Retired 06/19/2020	CGS	KY, OH	KY, OH
N/A	A52375 Category III CPT® Code Coverage Retired 09/26/2019	CGS	KY, OH	KY, OH

UnitedHealthcare Commercial Policies

Macular Degeneration Treatment Procedures

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
04/01/2021	Template Update • Reformatted policy; transferred content to new template
07/08/2020	Supporting Information • Updated *References* section to reflect the most current information • Archived previous policy version MPG222.05

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.