Overview
Photodynamic therapy is a medical procedure which involves the infusion of a photosensitive (light-activated) drug with a very specific absorption peak. This drug is chemically designed to have a unique affinity for the diseased tissue intended for treatment. Once introduced to the body, the drug accumulates and is retained in diseased tissue to a greater degree than in normal tissue. Infusion is followed by the targeted irradiation of this tissue with a non-thermal laser, calibrated to emit light at a wavelength that corresponds to the drug's absorption peak. The drug then becomes active and locally treats the diseased tissue.

Guidelines
Ocular Photodynamic Therapy (OPT) is used in the treatment of ophthalmologic diseases. OPT is only covered when used in conjunction with verteporfin.

Classic Subfoveal Choroidal Neovascular (CNV) Lesions-OPT is covered with a diagnosis of neovascular age-related macular degeneration (AMD) with predominately classic subfoveal choroidal neovascular (CNV) lesions (where the area of classic CNV occupies ≥50% of the area of the entire lesion) at the initial visit as determined by a fluorescein angiogram (FA). Subsequent follow-up visits will require either an optical coherence tomography or an FA to access treatment response. There are no requirements regarding visual acuity, lesion size, and number of re-treatments.

Occult Subfoveal CNV Lesions-OPT is non-covered for patients with a diagnosis of AMD with occult and no classic CNV lesions.

Other Conditions-Use of OPT with verteporfin for other types of AMD (e.g., patients with minimally classic CNV lesions, atrophic, or dry AMD) is non-covered. OPT with verteporfin for other ocular indications such as pathologic myopia or presumed ocular histoplasmosis syndrome, is eligible for coverage through individual contractor discretion.

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.

Note: See the Medicare Advantage Policy Guidelines titled Ocular Photodynamic Therapy (OPT) (NCD 80.2.1), Photosensitive Drugs (NCD 80.3) and Verteporfin (NCD 80.3.1) for complete coding and coverage guidelines.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>67221</td>
<td>Destruction of localized lesion of choroid (e.g., choroidal neovascularization); photodynamic therapy (includes intravenous infusion)</td>
</tr>
<tr>
<td>67225</td>
<td>Destruction of localized lesion of choroid (e.g., choroidal neovascularization); photodynamic therapy, second eye, at single session (List separately in addition to code for primary eye treatment)</td>
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</table>

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<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
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<tbody>
<tr>
<td>RT</td>
<td>Right side (used to identify procedures perform on the right side of the body)</td>
</tr>
<tr>
<td>LT</td>
<td>Left side (used to identify procedures performed on the left side of the body)</td>
</tr>
<tr>
<td>50</td>
<td>Bilateral Procedure</td>
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</tbody>
</table>

References

CMS National Coverage Determinations (NCDs)

NCD 80.2 Photodynamic Therapy
Reference NCDs: NCD 80.2.1 Ocular Photodynamic Therapy (OPT), NCD 80.3 Photosensitive Drugs, NCD 80.3.1 Verteporfin

CMS Benefit Policy Manual
Chapter 15; § 30.4 Optometrist’s Services

CMS Claims Processing Manual
Chapter 32; § 300-300.3 Billing Requirements for Ocular Photodynamic Therapy (OPT) with Verteporfin

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.

<table>
<thead>
<tr>
<th>Date</th>
<th>Summary of Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/09/2021</td>
<td>• Routine review; no change to guidelines</td>
</tr>
<tr>
<td></td>
<td>• Archived previous policy version MPG245.06</td>
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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.

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*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.