ND

Medical Policies

Print

Policy Number:	S-140		
Policy Name:	Ocular Photodynamic Therapy (PDT)		
Policy Type:	Medical	**Policy Subtype:**	Surgery
Effective Date:	09-15-2025	**End Date:**	11-02-2025

Description

Ocular photodynamic therapy (PDT) is a form of treatment for certain types of ophthalmic diseases characterized by neovascularization (i.e., age-related wet macular degeneration) that uses a combination of a photosensitizing drug and non-thermal laser light to treat diseased tissue. The treatment takes approximately 20 minutes and can be performed in a doctor's office.

Transpupillary thermotherapy (TTT) is a technique in which low level heat is delivered through the pupil using a modified diode laser. TTT is designed to gently heat subfoveal choroidal lesions while limiting damage to the overlying retinal pigment epithelium.

Policy Application

All claims submitted for this policy will be processed according to the policy effective date and associated revision effective dates in effect on the date of processing, regardless of service date. and/or

All claims submitted for this policy will be processed according to the policy effective date and associated revision effective dates in effect on the date of service.

*See below to determine whether the policy rules apply to initial and adjustment claims based on date of processing (DOP) or Date of Service (DOS).

Criteria

Coverage is subject to the specific terms of the member's benefit plan.

Verteporfin PDT

Verteporfin PDT as monotherapy may be considered **medically necessary** as a treatment of choroidal neovascularization (CNV) associated with **ANY** of the following conditions:

- Age-related macular degeneration with **EITHER**:
  - Classic subfoveal CNV; **or**
  - Predominantly classic subfoveal CNV; **or**
- Chronic central serous chorioretinopathy; **or**
- Choroidal hemangioma; **or**
- Occult neurovascularization; **or**
- Pathologic myopia; **or**
- Presumed ocular histoplasmosis.

If CNV leakage is detected on fluorescein angiography, subsequent verteporfin PDT may be considered medically necessary.

Verteporfin PDT as monotherapy for other ophthalmic disorders not meeting the criteria indicated in this policy is considered experimental/investigational and therefore, non-covered because the safety and/ or effectiveness of this service cannot be established by the available published peer-reviewed literature.

Verteporfin PDT when used in combination with one (1) or more anti-vascular endothelial growth factor therapies is considered experimental/investigational as a treatment of CNV and, therefore, is non-covered because the safety and/or effectiveness of this service cannot be established by the available published peer-reviewed literature when associated with **ANY** of the following conditions:

- Age-related macular degeneration; **or**
- Pathologic myopia; **or**
- Presumed ocular histoplasmosis; **or**
- Central serous chorioretinopathy; **or**
- Choroidal hemangioma; **or**
- Other ophthalmologic disorders.

Procedure Codes

67221	67225	J3396

Transpupillary Thermotherapy (TTT)

TTT may be considered medically necessary for **EITHER** of the following indications:

- Retinoblastoma involving less than half (50%) of the retina, and without associated vitreal or subretinal seeds at the time of thermotherapy; **or**
- Small two (2) to three (3) mm chorodial melanomas located posterior in the globe.

TTT not meeting the criteria as indicated in this policy is considered experimental/investigational and, therefore, non-covered because the safety and/or effectiveness of this service cannot be established by the available published peer reviewed literature.

Procedure Codes

67299

Other Drugs and Procedures

All claims submitted for this policy will be processed according to the policy effective date and associated revision effective dates in effect on the date of processing, regardless of service date.

Other drugs for ocular PDT and other procedures, such as photocoagulation (feeder vessel technique) are considered experimental/investigational and, therefore, non-covered because the safety and/or effectiveness of this service cannot be established by the available published peer-reviewed literature.

Procedure Codes

G0186

NOTE: In addition to the above criteria, product specific dosage and/or frequency limits may apply in accordance with the U.S. Food and Drug Administration (U.S. FDA)-approved product prescribing information, national compendia, Centers for Medicare and Medicaid Services (CMS) and other peer reviewed resources or evidence-based guidelines. BCBSND may deny, in full or in part, reimbursement for utilization that does not fall within the applicable dosage and/or frequency limits.

Professional Statements and Societal Positions Guidelines

National Institute of Health and Excellence – 2018

In 2018, the National Institute for Health and Care Excellence updated its 2003 guidance on the use of photodynamic therapy for age-related macular degeneration. The Institute made the following recommendations:

- Recommends against use of photodynamic therapy as monotherapy for late (wet) age-related macular degeneration and against use of photodynamic therapy as first-line adjunctive therapy to antivascular endothelial growth factor therapies for late (wet) age-related macular degeneration
- Recommends for photodynamic therapy as second-line adjunctive therapy to antivascular endothelial growth factor therapies for late (wet) age-related macular degeneration in a trial setting.

American Academy of Ophthalmology – 2019

In 2019, the American Academy of Ophthalmology updated its 2015 preferred practice pattern guideline on age-related macular degeneration. The 2019 update states that verteporfin photodynamic therapy has approval by the U.S. Food and Drug Administration for the treatment of age-related macular degeneration-related, predominantly classic, subfoveal choroidal neovascularization.

The 2019 update stated that antivascular endothelial growth factor therapies have become first-line therapy for treating and stabilizing most cases of age-related macular degeneration and suggests that verteporfin photodynamic therapy is rarely needed.

National Comprehensive Cancer Network – 2021

Ocular Photodynamic Therapy

- There is no recommendation to treat uveal melanoma with ocular PDT mentioned in the NCCN guidelines.

Transpupillary Thermotherapy

- Consider additional treatment with resection, laser ablation, transpupillary thermotherapy, or cryotherapy if concerned that adequate response was not achieved from initial radiation.
- For small recurrences in [individuals] who cannot undergo radiation therapy or surgery, transpupillary thermotherapy is recommended.

Diagnosis Codes

Covered Diagnosis Codes for Procedure Codes 67221; 67225 and J3396

B39.4	B39.5	B39.9	D18.09	H32	H35.051	H35.052
H35.053	H35.059	H35.30	H35.3210	H35.3211	H35.3212	H35.3213
H35.3220	H35.3221	H35.3222	H35.3223	H35.3230	H35.3231	H35.3232
H35.3233	H35.3290	H35.3291	H35.3292	H35.3293	H35.711	H35.712
H35.713	H35.719	H44.20	H44.21	H44.22	H44.23	H44.2A1
H44.2A2	H44.2A3	H44.2B1	H44.2B2	H44.2B3	H44.2C1	H44.2C2
H44.2C3	H44.2D1	H44.2D2	H44.2D3	H44.2E1	H44.2E2	H44.2E3

CURRENT CODING

CPT:

67221	DSTRJ LESION CHOROID PHOTODYNAMIC THERAPY	Commercial
67225	DSTRJ LESION CHOROID PDT 2ND EYE 1 SESSION	Commercial
67299	UNLISTED PROCEDURE POSTERIOR SEGMENT	Commercial
67221	DSTRJ LESION CHOROID PHOTODYNAMIC THERAPY	Medicaid Expansion

67225	DSTRJ LESION CHOROID PDT 2ND EYE 1 SESSION	Medicaid Expansion
67299	UNLISTED PROCEDURE POSTERIOR SEGMENT	Medicaid Expansion

HCPCS:

G0186	Dstry eye lesn,fdr vssl tech	Commercial
J3396	Verteporfin injection	Commercial
G0186	Dstry eye lesn,fdr vssl tech	Medicaid Expansion
J3396	Verteporfin injection	Medicaid Expansion

References

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ND Committee Review

Internal Medical Policy Committee 3-17-2021 Revision- ***Effective May 3, 2021***

- ***Changed*** Title, and
- ***Updated*** language throughout policy

Internal Medical Policy Committee 11-23-2021 Revision ***Effective January 3, 2022***

- Updated Professional statements and administrative changes.

Internal Medical Policy Committee 5-24-2022 Annual Review-no changes in criteria ***Effective July 4, 2022***

Internal Medical Policy Committee 5-23-2023 Annual Review-no changes in criteria ***Effective July 3, 2023***

Internal Medical Policy Committee 5-14-2024 Annual Review-no changes in criteria ***Effective July 1, 2024***

- ***Added*** Policy Application

Disclaimer

Current medical policy is to be used in determining a Member's contract benefits on the date that services are rendered. Contract language, including definitions and specific inclusions/exclusions, as well as state and federal law, must be considered in determining eligibility for coverage. Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information. Likewise, medical policy, which addresses the issue(s) in any specific case, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and the Company reserves the right to review and update medical policy periodically.