



MASSACHUSETTS

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Medical Policy Photocoagulation of Macular Drusen

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Policy Number: 607

BCBSA Reference Number: 9.03.11A (For Plan internal use only)

LCD/NCD: N/A

Related Policies

- Transpupillary Thermotherapy for Treatment of Choroidal Neovascularization, #[600](#)
- Photodynamic Therapy for Choroidal Neovascularization, #[599](#)

Policy

**Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity
Medicare HMO BlueSM and Medicare PPO BlueSM Members**

Destruction of macular drusen with laser therapy is considered **NOT MEDICALLY NECESSARY**.

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	This is not a covered service.
Commercial PPO and Indemnity	This is not a covered service.
Medicare HMO BlueSM	This is not a covered service.
Medicare PPO BlueSM	This is not a covered service.

CPT Codes / HCPCS Codes / ICD Codes

The following codes are included below for informational purposes. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

There is no specific CPT code for this procedure.

Description

Photocoagulation describes the use of focused laser energy to treat disease. Laser photocoagulation of macular drusen has been evaluated as a method of slowing progression to advanced age-related macular degeneration (AMD).

AMD is a painless, insidious process. In its earliest stages, it is characterized by minimal visual impairment and the presence of large or "soft" drusen, ie, subretinal accumulations of cellular debris adjacent to the basement membrane of the retinal pigment epithelium.

Large drusen appear as large, pale yellow or pale gray domed elevations and result in thickening of the space between the retinal pigment epithelium and its blood supply, the choriocapillaris. Clinical and epidemiologic studies have shown that the presence of large and/or numerous soft drusen is associated with an increased risk of the development of choroidal neovascularization (CNV) in eyes with AMD. For example, in patients with bilateral drusen, the 3-year risk of developing CNV is estimated to be 13%, rising to 18% for those older than age of 65 years. The emergence of CNV greatly increases the risk of subsequent irreversible loss of vision.

Two different kinds of low energy laser therapies, argon and infrared laser, have been investigated as techniques to eliminate drusen by photocoagulation in an effort to prevent the evolution to CNV, ultimately leading to improved preservation of vision. The lasers used are those that are widely used for standard photocoagulation of extrafoveal CNV. Therefore, the treatment of macular drusen represents an additional indication for an existing laser approved by the U.S. Food and Drug Administration (FDA). Photocoagulation describes the use of focused laser energy to treat disease. Laser photocoagulation of macular drusen has been evaluated as a method of slowing progression to advanced age-related macular degeneration (AMD).

Summary

Evidence from multiple trials indicates that drusen ablation does not prevent visual loss, CNV, or AMD. Furthermore, the evidence from trials indicates that drusen ablation may be accompanied by harm. The literature indicates that photocoagulation of macular drusen procedure is not clinically appropriate; this approach is considered not medically necessary.

Policy History

Date	Action
11/2022	Annual policy review. Policy updated with literature review through October 2022. No references added. Policy statements unchanged.
2/2020	Policy updated with literature review through February 1, 2020, references added. Policy statements unchanged.
7/2016	Annual policy review. Not medically necessary statement clarified.
8/2014	Medical policy ICD10 remediation: Formatting, editing and coding updates. No changes to policy statements.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

[Medical Policy Terms of Use](#)

[Managed Care Guidelines](#)

[Indemnity/PPO Guidelines](#)

[Clinical Exception Process](#)

[Medical Technology Assessment Guidelines](#)

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