Clinical Policy: Prophylaxis of Retinal Detachment
Reference Number: CP.VP.53
Last Review Date: 07/2020

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
This policy describes the medical necessity requirements for surgical prophylaxis of retinal detachment.

Policy/Criteria
I. It is the policy of health plans affiliated with Centene Corporation® that prophylaxis of retinal detachment is medically necessary for the following indications:
   A. Symptomatic retinal breaks, presenting in conjunction with flashes or floaters;
   B. Retinal breaks with persistent vitreous traction at their edge;
   C. Posterior vitreous detachment presenting with pigmented cell or hemorrhage in the vitreous;
   D. Asymptomatic lattice retinal degeneration in the contralateral eye of a patient who has suffered a lattice associated retinal detachment.

II. It is the policy of health plans affiliated with Centene Corporation that prophylactic treatment to prevent retinal detachment is not medically necessary in the following conditions:
   A. Asymptomatic operculated and atrophic round holes without vitreoretinal traction;
   B. Asymptomatic horseshoe tears that may be monitored for spontaneous resolution;
   C. Posterior vitreous detachment without pigmented cell, hemorrhage or visible retinal breaks.

Background
When the retina detaches, it lifts, separating itself from its nourishing blood supply of the underlying choroid. While it is not possible to prevent all retinal detachments, prophylactic treatment of retinal tears, holes, and degenerations has proven to be an effective practice to reduce the risk of vision loss. General risk factors for rhegmatogenous retinal detachments include axial myopia (the magnitude of which is directly proportional to the risk of retinal detachment and which is present in the majority of nontraumatic retinal detachments) cataract surgery (particularly cases with vitreous loss, vitreous prolapse, or surgery in younger patients), ocular trauma and a contralateral rhegmatogenous retinal detachment and certain peripheral retinal degenerations including lattice degeneration. The duly licensed eye care provider secures a potential retinal detachment by freezing (cryotherapy), thus sealing the retinal tissue to the back of the eye, by diathermy (where heat is used for the same purpose), or by laser photocoagulation. Patients will often require multiple sessions for adequate treatment. Only lesions presenting a definite risk of retinal detachment should be treated. Three types of failure should be noted:
   a) Retinal detachment "because of" prophylaxis,
   b) Retinal detachment "in spite of" prophylaxis,
   c) Retinal detachment in cases in which prophylaxis was omitted because of a "false negative diagnosis".
If chorioretinal scarring is deemed inadequate, particularly with respect to completely surrounding the anterior margins of retinal tears, retreatment is indicated. Re-examination at any interval that shows a retinal break or subretinal fluid extending past the area of previous treatment, or entirely new retinal breaks, (approximately 10% of all patients) should also prompt retreatment, or if necessary, surgical
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intervention. Prophylactic treatment of innocuous lesions, based on "false-positive diagnosis", results in expense and stress to the patient and in some cases even in complications of treatment.

Coding Implications

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<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>67141</td>
<td>Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage, 1 or more sessions; cryotherapy, diathermy</td>
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<tr>
<td>67145</td>
<td>Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage, 1 or more sessions; photocoagulation (laser or xenon arc)</td>
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Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Date</th>
<th>Approval Date</th>
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<tbody>
<tr>
<td>Annual review</td>
<td>12/1/2019</td>
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<tr>
<td>Converted to new template</td>
<td>07/2020</td>
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References


Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is
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operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such
health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of
the guidelines used to assist in making coverage decisions and administering benefits. It does not
constitute a contract or guarantee regarding payment or results. Coverage decisions and the
administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage
documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as
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effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements
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This clinical policy does not constitute medical advice, medical treatment or medical care. It is not
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medical advice and treatment of members. This clinical policy is not intended to recommend treatment
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payment for such services.

**Note: For Medicaid members,** when state Medicaid coverage provisions conflict with the coverage
provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the
state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage
Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and
Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical

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