Medical Policy
Implantable Miniature Telescope - IMT

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Policy Number: 464
BCBSA Reference Number: N/A
NCD/LCD: Local Coverage Determination (LCD): Implantable Miniature Telescope (IMT) (L33584)

Related Policies
None

Policy
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

An intraocular telescope (Implantable Miniature Telescope [IMT]) may be MEDICALLY NECESSARY for monocular implantation to improve vision in individuals greater than 75 years of age when all of the following criteria are met:
- The individual must:
  - Achieve at least a 5-letter improvement on the Early Treatment Diabetic Retinopathy Study (ETDRS) chart with an external telescope in the eye scheduled for surgery; and
  - Agree to undergo pre-surgery training and assessment (typically 2 to 4 sessions) with low vision specialists (optometrist or occupational therapist) in the use of an external telescope sufficient for assessment and for the individual to make an informed decision; and
  - Agree to participate in postoperative visual training with a low vision specialist; and
  - Have adequate peripheral vision in the eye not scheduled for surgery; and
  - Have retinal findings of geographic atrophy or disciform scar with foveal involvement, as determined by fluorescein angiography; and
  - Have stable, severe to profound vision impairment (best corrected distance visual acuity 20/160 to 20/800) caused by bilateral central scotomas, associated with end-stage age-related macular degeneration (AMD); and
  - Show evidence of visually significant cataract (Grade 2 or more).

An intraocular telescope (Implantable Miniature Telescope [IMT]) is INVESTIGATIONAL and NOT MEDICALLY NECESSARY when all of the above criteria are not met.
Medicare HMO BlueSM and Medicare PPO BlueSM Members

Medical necessity criteria and coding guidance for Medicare Advantage members living in Massachusetts can be found through the link below.

Local Coverage Determination (LCD): Implantable Miniature Telescope (IMT) (L33584)

For medical necessity criteria and coding guidance for Medicare Advantage members living outside of Massachusetts, please see the Centers for Medicare and Medicaid Services website for information regarding your specific jurisdiction at https://www.cms.gov.

Prior Authorization Information

Pre-service approval is required for all inpatient services for all products. See below for situations where prior authorization may be required or may not be required for outpatient services.

Yes indicates that prior authorization is required.

No indicates that prior authorization is not required.

N/A indicates that this service is primarily performed in an inpatient setting.

Outpatient

<table>
<thead>
<tr>
<th>Commercial Managed Care (HMO and POS)</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Commercial PPO and Indemnity</td>
<td>No</td>
</tr>
<tr>
<td>Medicare HMO BlueSM</td>
<td>No</td>
</tr>
<tr>
<td>Medicare PPO BlueSM</td>
<td>No</td>
</tr>
</tbody>
</table>

CPT Codes / HCPCS Codes / ICD Codes

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.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:

CPT Codes

<table>
<thead>
<tr>
<th>CPT codes:</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>C1840</td>
<td>Lens, intraocular (telescopic)</td>
</tr>
<tr>
<td>0308T</td>
<td>Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis</td>
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Description

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 in order to enlarge the retinal image to such a degree that it is visualized outside of vision-impairing central scotomas.

Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>1/2016</td>
<td>Clarified coding information.</td>
</tr>
<tr>
<td>8/2015</td>
<td>Clarified coding language.</td>
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</table>
12/2013 New medically necessary and investigational indications described. Effective 12/1/2013. Added ICD-9 diagnosis code 362.52 as it meets the intent of the policy. Removed LCD: L32275 as it is no longer effective and replaced with LCD: L32454.


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

References
11. NHIC CAC

Endnotes
1 Based on expert opinion