



## MASSACHUSETTS

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# Medical Policy

## Retinal Prosthesis

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### Policy Number: 606

BCBSA Reference Number: 9.03.15

NCD/LCD: Local Coverage Determination (LCD): Category III CPT® Codes (L33392) (A56195)

### Related Policies

Keratoprosthesis, #[221](#)

### Policy

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

Retinal prostheses are [INVESTIGATIONAL](#).

#### Medicare HMO Blue<sup>SM</sup> and Medicare PPO Blue<sup>SM</sup> Members

CPT code 0100T is a covered service.

CPT codes 0472T and 0473T are not covered.

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

[Local Coverage Determinations \(LCDs\) for National Government Services, Inc.](#)

Local Coverage Determination (LCD): Category III CPT® Codes (L33392) (A56195)

**Note:** To review the specific LCD, please remember to click “accept” on the CMS licensing agreement at the bottom of the CMS webpage.

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 at <https://www.cms.gov> for information regarding your specific jurisdiction.

### 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**.

	<b>Outpatient</b>
<b>Commercial Managed Care (HMO and POS)</b>	This is <b>not</b> a covered service.
<b>Commercial PPO and Indemnity</b>	This is <b>not</b> a covered service.
<b>Medicare HMO Blue<sup>SM</sup></b>	Prior authorization is <b>not required</b> .
<b>Medicare PPO Blue<sup>SM</sup></b>	Prior authorization is <b>not required</b> .

**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 following codes are included below for informational purposes only; this is not an all-inclusive list*

**The following CPT and HCPCS codes are considered investigational for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:**

**CPT Codes**

<b>CPT codes:</b>	<b>Code Description</b>
0100T	Placement of a subconjunctival retinal prosthesis receiver and pulse generator, and implantation of intra-ocular retinal electrode array, with vitrectomy
0472T	Device evaluation, interrogation, and initial programming of intra-ocular retinal electrode array (eg, retinal prosthesis), in person, with iterative adjustment of the implantable device to test functionality, select optimal permanent programmed values with analysis, including visual training, with review and report by a qualified health care professional
0473T	Device evaluation and interrogation of intra-ocular retinal electrode array (eg, retinal prosthesis), in person, including reprogramming and visual training, when performed, with review and report by a qualified health care professional

**HCPCS Codes**

<b>HCPCS codes:</b>	<b>Code Description</b>
C1841	Retinal prosthesis, includes all internal and external components
L8608	Miscellaneous external component, supply or accessory for use with the argus ii retinal prosthesis system

**Description**

Two approaches are being explored to develop an artificial retina that could restore sight to patients with blindness secondary to retinal diseases, such as retinitis pigmentosa, hereditary retinal degeneration, and some forms of age-related macular degeneration. The first is implantation of electrode arrays in the epiretinal or subretinal space to stimulate retinal ganglion cells. A second approach is the implantation in the subretinal space of light-sensitive multiphotodiode arrays, which stimulate the remaining photoreceptors in the inner retina. Use of a multiphotodiode array does not require external image

processing. The latter approach is being evaluated for degenerative retinal diseases such as retinitis pigmentosa, in which outer retinal cells deteriorate, but inner retinal cells remain intact for years.

Research in the United States began with a first-generation, 16-electrode device (eg, the Argus 16; Second Sight Medical Products), which permitted the distinction between the presence and absence of light. Three government organizations provided support for the development of the Argus II: The Department of Energy, National Eye Institute at the National Institutes of Health, and National Science Foundation. They collaborated to provide grant funding, support for material design, and other basic research for the project.

Devices in development, none of which are approved or cleared by the U.S. Food and Drug Administration, include the following.

- The Alpha IMS was developed at the University of Tübingen, and has an electronic chip design provided by the Institute for Microelectronics, Stuttgart. The second-generation Alpha IMS device has wireless power and signal transmission and is produced by Retina Implant AG (Germany). The microchip is implanted subretinally and receives input from a multiphotodiode array with 1500 elements that moves with the eye, senses incident light, and applies a constant-voltage signal at the respective 1500 electrodes. The multiphotodiode array transforms visual scenes into corresponding spatial patterns (38°40 pixels) of light-intensity-dependent electric stimulation pulses with a maximum visual field of 15°.
- The Boston Retinal Implant Project uses an external camera mounted on a pair of glasses and a 100-electrode array. The image obtained by the external camera is translated into an electromagnetic signal transmitted from the external primary data coil mounted on a pair of glasses to the implanted secondary data coil attached to the cornea. Most of the volume of the implant lies outside the eye, with transscleral cables connected to a subretinal electrode array. The Boston Retinal Implant Project is a joint effort of the Massachusetts Institute of Technology, the Massachusetts Eye and Ear Infirmary, the Veterans Affairs Boston Healthcare System, and Cornell University.
- EPIRET3 retinal implant (Philipps-University Marburg, Germany) is a wireless system that consists of a semiconductor camera on the frame of a pair of glasses and a transmitter coil outside the eye, which sends electromagnetic signals to a receiver coil in the anterior vitreous (similar to an intraocular lens), which passes them on to a receiver microchip. A stimulator chip then generates the stimulation pulses and activates a selection of 25 electrodes placed on the epiretinal surface via a connecting micro cable.
- Intelligent Retinal Implant System (Pixium Vision, Paris, France) uses an external camera integrated with a pair of glasses and linked by wire to a pocket computer. Receiver electronics connect via a scleral tunnel to an electrode array on the surface of the retina. Pixium Vision is also developing PRIMA, which uses a subretinal implant.
- Learning Retinal Implant (Intelligent Medical Implants, Zug, Switzerland) uses an external camera on the frame of a pair of glasses and wireless data and power transfer. Receiver electronics connect via a scleral tunnel to an epiretinal implant. A retinal encoder with 100 to 1000 tunable spatiotemporal filters simulates the filtering operations performed by the ganglion cell and allows individual calibration to improve each patient's visual perception.
- The Microelectrode-STS (suprachoroidal-transretinal stimulation) system (Osaka University, Japan) places its 9-electrode retinal prosthesis in a scleral pocket with a reference electrode in the vitreous cavity. A video camera is used to detect a visual object. Because the electrodes are at a greater distance from the retina, the resolution of the image may be lower than other devices. A proposed advantage of the STS prosthesis over epi- or subretinal prostheses is the safety of the surgical procedure, because the electrodes do not touch the retina.

## Summary

A retinal prosthesis replaces lost photoreceptor function by transmitting external images to an array of electrodes or via light sensors placed in the epiretinal or subretinal space. The artificial retina could restore sight to patients with blindness secondary to retinal diseases, such as retinitis pigmentosa, hereditary retinal degeneration, and some forms of age-related macular degeneration. Several models of retinal prostheses are in development in the United States, Europe, and Asia. Only the Argus II system has been cleared for use by the U.S. Food and Drug Administration.

For individuals who have blindness secondary to retinal diseases who receive a retinal prosthesis, the evidence includes a prospective single-arm study evaluating the device approved by the U.S. Food and Drug Administration and a systematic review of studies on various devices. Relevant outcomes are functional outcomes, quality of life, and treatment-related morbidity. A 2016 systematic review included studies on the Food and Drug Administration-approved retinal prosthesis as well as devices unavailable in the United States; the overall conclusion was that the evidence on retinal prostheses is insufficient on all outcomes of interest. One study with 30 patients has evaluated the single Food and Drug Administration-approved device (Argus II); numerous articles on this study have been published. Primary outcomes included 3 computer-based visual acuity tests. At 3- and 5-year follow-up visits, patients performed significantly better on the 3 computer tasks with the device on vs off. Performance on the most difficult task (grating discrimination) was still relatively low with the device on. Subgroup studies have tested performance on more practical tasks. These studies have tended to find significantly better performance with the device on but differences between groups may not be clinically meaningful. The same 30 patients have been evaluated multiple times and, as a result of multiple testing, their performance may differ from other individuals with the device. Additional prospective studies and additional evaluations of the ability to perform practical tasks that have a clinically meaningful impact on health outcomes are needed. The evidence is insufficient to determine the effects of the technology on health outcomes.

## Policy History

Date	Action
4/2019	BCBSA National medical policy review. Description, summary and references updated. Policy statements unchanged.
1/2019	Clarified coding information.
7/2017	Clarified coding information.
4/2017	New references added from BCBSA National medical policy.
2/2017	Coverage for Medicare Advantage members clarified based on Local Coverage Determination (LCD): Category III CPT® Codes (L33392).
4/2016	New references added from BCBSA National medical policy.
3/2015	New references added from BCBSA National medical policy.
5/2014	New references added from BCBSA National medical policy.
3/2014	New references added from BCBSA National medical policy.
10/2013	Updated to add new HCPCS code C1841.
4/2013	New references from BCBSA National medical policy.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
5/2011	New policy effective 5/10/2011 describing ongoing non-coverage.

## 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

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