Clinical Policy: Laser Iridotomy and Iridectomy

Reference Number: OC.UM.CP.0037
Last Review Date: 11/2022

Coding Implications
Revision Log

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

Description

Laser peripheral iridotomy (LPI) is the preferred procedure for treating angle-closure glaucoma caused by relative or absolute pupillary block. This policy describes the medical indications for performing iridotomy or iridectomy.

Policy/Criteria

I. It is the policy of health plans affiliated with Envolve Vision, Inc.® (Envolve) that laser peripheral iridotomy is **medically necessary** for the following indications:
   A. Acute or chronic angle-closure glaucoma.

II. It is the policy of health plans affiliated with Envolve that laser iridectomy is **medically necessary** for the following indications:
   A. Acute or chronic angle closure glaucoma in the presence of corneal haze or opacification rendering the cornea not clear enough for visualization of the iris in spite of the use of topical glycerin.

III. It is the policy of health plans affiliated with Envolve that incisional iridectomy is **medically necessary** for the following indications:
   A. Acute or chronic angle closure glaucoma in an uncooperative patient.

Background

LPI should be performed after intraocular pressure (IOP) and intraocular inflammation are controlled. The aim is to prevent another attack of acute angle-closure glaucoma or progression to chronic angle-closure glaucoma. In patients with chronic angle-closure glaucoma, IOP may remain the same or be lowered after LPI, depending on the extent of peripheral anterior synechiae.

LPI eliminates pupillary block by allowing the aqueous to pass directly from the posterior chamber into the anterior chamber, bypassing the pupil. LPI can be performed with an argon laser, with a neodymium:yttrium-aluminum-garnet (Nd:YAG) laser, or, in certain circumstances, with both. The fellow eye in a patient with acute angle-closure glaucoma or chronic angle-closure glaucoma has a 50% chance of developing acute angle-closure glaucoma. Alternative procedures include laser iridoplasty (66762) and incisional iridotomy/iridectomy (66500, 66625, 66630).

Method of Treatment

Involves:

- Topical anesthesia;
- Use of special lens, e.g., Wise, Abraham;
- Iridotomy /iridectomy (one or multiple) with:

- Argon laser photocoagulation;
- Application of stretch burns around the peripheral iridotomy site;
- Application of penetrating burns (25-100);
- Enlarging the iridotomy by chipping away at the edges to create an opening at least 0.2 mm in diameter.

Or:

- YAG laser photocoagulation (less likely to close than Argon iridectomy).
- Verification of patency by direct examination of the anterior lens capsule through the iridotomy site.

The Nd:YAG laser creates iridotomies by a different mechanical principal than the argon laser. The laser medium contains yttrium, aluminum, and garnet crystal with suspended neodymium atoms. It has a wavelength of 1064 nm, which is invisible to the naked eye and is in the infrared range, but it is paired with a low-powered continuous-wave helium neon aiming beam that produces a red light, which is used for focusing. Most Nd:YAG lasers are of the fundamental q-switched type and work by producing photodisruption of tissue. The photodisruption process releases shock waves that mechanically cause tissue disruption. Iris color and the presence of melanin pigment, which is important in argon laser iridectomy technique, is not a significant factor with the Nd:YAG laser. Some Nd:YAG lasers are capable of producing thermal effects using continuous-wave or pulsed action.

During the late 1980s the Nd:YAG laser became the laser of initial choice for performing iridectomies. This is because of the relative ease of performance, the reduced rate of closure of the iridectomies, and less postoperative inflammation.

Coding Implications

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CPT® Codes	Description
66500	Iridotomy by stab incision (separate procedure); except transfixion
66505	Iridotomy by stab incision (separate procedure); with transfixion as for iris bombe
66625	Iridectomy, with corneoscleral or corneal section; peripheral for glaucoma (separate procedure)
66630	Iridectomy, with corneoscleral or corneal section; sector for glaucoma (separate procedure)
66635	Iridectomy, with corneoscleral or corneal section; optical (separate procedure)
66761	Iridotomy/iridectomy by laser surgery (e.g., for glaucoma) (per session)

CPT® Codes	Description
66762	Iridoplasty by photocoagulation (1 or more sessions) (eg, for improvement of vision, for widening of anterior chamber angle)

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code requiring an additional character

ICD-10-CM Code	Description
H40.031	Anatomical narrow angle, right eye
H40.032	Anatomical narrow angle, left eye
H40.033	Anatomical narrow angle, bilateral
H40.061	Primary angle closure without glaucoma damage, right eye
H40.062	Primary angle closure without glaucoma damage, left eye
H40.063	Primary angle closure without glaucoma damage, bilateral
H40.1311	Pigmentary glaucoma, right eye, mild stage
H40.1312	Pigmentary glaucoma, right eye, moderate stage
H40.1313	Pigmentary glaucoma, right eye, severe stage
H40.1321	Pigmentary glaucoma, left eye, mild stage
H40.1322	Pigmentary glaucoma, left eye, moderate stage
H40.1323	Pigmentary glaucoma, left eye, severe stage
H40.1331	Pigmentary glaucoma, bilateral, mild stage
H40.1332	Pigmentary glaucoma, bilateral, moderate stage
H40.1333	Pigmentary glaucoma, bilateral, severe stage
H40.211	Acute angle-closure glaucoma, right eye
H40.212	Acute angle-closure glaucoma, left eye
H40.213	Acute angle-closure glaucoma, bilateral
H40.2211	Chronic angle-closure glaucoma, right eye, mild stage
H40.2212	Chronic angle-closure glaucoma, right eye, moderate stage
H40.2213	Chronic angle-closure glaucoma, right eye, severe stage
H40.2221	Chronic angle-closure glaucoma, left eye, mild stage
H40.2222	Chronic angle-closure glaucoma, left eye, moderate stage
H40.2223	Chronic angle-closure glaucoma, left eye, severe stage
H40.2231	Chronic angle-closure glaucoma, bilateral, mild stage
H40.2232	Chronic angle-closure glaucoma, bilateral, moderate stage
H40.2233	Chronic angle-closure glaucoma, bilateral, severe stage
H40.231	Intermittent angle-closure glaucoma, right eye
H40.232	Intermittent angle-closure glaucoma, left eye
H40.233	Intermittent angle-closure glaucoma, bilateral
H40.241	Residual stage of angle-closure glaucoma, right eye
H40.242	Residual stage of angle-closure glaucoma, left eye
H40.243	Residual stage of angle-closure glaucoma, bilateral
H40.831	Aqueous misdirection, right eye
H40.832	Aqueous misdirection, left eye
H40.833	Aqueous misdirection, bilateral

Reviews, Revisions, and Approvals	Date	Approval Date
Annual Review	12/2019	12/2019
Converted to new template	05/2020	06/2020
Annual Review; Added CPT codes	12/2020	12/2020
Annual Review; Added CPT codes for Iridectomy; Updated References	12/2021	12/2021
Annual Review	11/2022	11/2022

References

1. American Academy of Ophthalmology Glaucoma Panel, Preferred Practice Pattern Guidelines, Primary Angle-Closure Disease, San Francisco, CA, American Academy of Ophthalmology 2020, https://www.aao.org/preferred-practice-pattern/primary-angle-closure-disease-ppp
2. Laser Iridectomy, History, Volume 6, Chapter 19 Laser Surgery in Glaucoma, Arthur L. Schwartz, Howard S. Weiss, http://www.oculist.net/downaton502/prof/ebook/duanes/pages/v6/v6c019.html

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 operated or administered, in whole or in part, by Envolve Vision, Inc., 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 well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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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 policy. Refer to the CMS website at http://www.cms.gov for additional information.