



Policy Key: Ophthalmology Services

TriWest Clinical Operations – TRICARE West

SCOPE

This Policy Key provides criteria to use during medical necessity review for services, supplies and procedures related to diagnosis and/or treatment of a medical condition of the eye.

This Policy Key does not include routine or well child examinations.

NOT COVERED

- Orthoptics, also known as vision training, vision therapy, eye exercises, eye therapy [1, 2]
- Refractive corneal surgery except to relieve astigmatism after corneal transplant. [2]
- Eyeglasses, and contact lenses **except as noted in Chapter 7, Section 6.2**, refer to Lenses, Intraocular or Contact below [2]
- Adjustments, cleaning, or repairs of glasses are not covered [3]
- Orthokeratology [2]
- Epikeratophakia for treatment of aphakia and myopia [2]
- Transpupillary thermotherapy as primary treatment (without chemotherapy) of choroidal melanoma [2]
- Autologous serum eye drops for the treatment of dry eye syndrome, keratitis, or ocular hypertension [2]
- Astigmatism-Correcting Intraocular Lenses along with any adjustment, subsequent treatment, services or supplies required to examine and monitor the lenses [3]
- Presbyopia-Correcting Intraocular Lenses along with any adjustment, subsequent treatment, services or supplies required to examine and monitor the lenses [3]
- When the prescription remains unchanged, replacement for lenses that are lost, have deteriorated or that have become unusable due to physical growth are not covered [3]
- Amniotic membrane in strabismus surgery unproven [4]
- Ologen biodegradable collagen matrix implant unproven for reducing adhesions in restrictive strabismus [4]

COVERAGE CRITERIA

Services and Procedures

- **Initial Level of Review** may approve the following:
 - Phototherapeutic Keratectomy (PTK) for corneal dystrophies.[2]
 - Strabismus surgical treatment and correction when meets **Either** of the following conditions: [2,4]
 - Age 17 or younger with diagnosis of strabismus **or**

- Age 18 or older with documented diplopia or impairment of peripheral vision due to esotropia **and** restoration of alignment will restore ability to maintain binocular fusion
- Corneal Transplant [2]
- Transpupillary thermotherapy (laser hyperthermia, CPT codes 77600-77615) with Plaque Radiotherapy (Brachytherapy) with chemotherapy for retinoblastoma treatment. [2]
- Transpupillary thermotherapy (CPT code 67299) with Plaque Radiotherapy (Brachytherapy) for choroidal melanoma treatment [2]
- Relaxing keratotomy to relieve astigmatism following a corneal transplant [2]
- Transpupillary thermotherapy (laser hyperthermia, with chemotherapy, for retinoblastoma treatment. [2]
- Ex-PRESS Mini Glaucoma Shunt and other FDA approved aqueous shunts or stents when they are used to reduce Intraocular Pressure (IOP) in glaucoma treatment that cannot be controlled effectively with medications. [2]
- Photodynamic Therapy, including off-label use (CPT code 66183), for the treatment of Central Serous Chorioretinopathy, retinal astrocytic hamartoma in tuberous sclerosis (with Visudyne, HCPCS code 13396), or a rare disease, on a case-by-case basis for the treatment of a rare disease. [2]
- Implantable Miniature Telescope (IMT) is covered for FDA approved indications for beneficiaries with end-stage-related macular degeneration.
- Canaloplasty for primary open angle glaucoma treatment [2]
- Insertion of aqueous drainage device (iStent®, CyPass®) during cataract surgery to reduce IOP in the treatment of glaucoma, initial insertion, and each additional insertion [2]
- **Medical Director** may approve for **ANY** of the following
 - Intrastromal Corneal Ring Segments (Intacs®) is covered for United States (US) Food and Drug Administration (FDA) approved indications when **BOTH** the following conditions are met: [2]
 - Unable to achieve adequate vision using lenses or glasses
 - Corneal transplant is the only remaining option
 - Collagen Cross-linking for corneal ectasia treatment due to the rare disease Keratoconus [2]
 - Insertion, programming, evaluation, and interrogation of retinal prosthesis (CPT codes 66174 and 66175) is covered for use with Argus® II Retinal Prosthesis System (in accordance with the humanitarian device policy) [2]

Lenses, Intraocular or Contact

Note: Benefits are limited to one set of lenses related to one of the qualifying eye conditions listed below. A set may also include a combination of both lenses and eyeglasses when a combination is necessary and related to one of the qualifying eye conditions. Lenses must be either approved for marketing by the FDA or subject to an Investigational Device Exemption (IDE). [3]



- **Initial Level of Review** may approve for the **initial** set of lenses for **ANY** of the following conditions:
 - Contact lenses for treatment of infantile glaucoma [3]
 - Corneal or scleral lenses for treatment of keratoconus. [3]
 - Scleral lenses to retain moisture when normal tearing is not present or is inadequate. [3]
 - Corneal or scleral lenses are prescribed to reduce corneal irregularity other than astigmatism. [3]
 - Intraocular lenses (IOL), contact lenses, or eyeglasses to perform the function of the human lens, lost as the result of intraocular surgery or ocular injury or congenital absence. Benefits for the IOL for this condition are limited to the standard fixed non-accommodating monofocal IOL, (V2630, V2631, V2632). [3]

Eyeglasses

- **Initial Level of Review** may approve the **initial** set of eyeglasses for the following:
 - Eyeglasses to perform the function of the human lens lost as the result of intraocular surgery, ocular injury, or congenital absence. [3]

Replacement

- **Initial Level of Review may** approve replacement lenses or eyeglasses if there has been a prescription change that is still related to a qualifying eye condition. [3]

DEFINITIONS

NA

CODES

CPT - 0100T, 0191T, 0253T, 0308T, 0376T, 0402T, 0472T - 0474T, 65091 - 65755, 65772 - 66175, 66179 - 68899, 77600 – 77615

HCPS - C1783, L8612

REFERENCES

[1] TRICARE Policy Manual 6010.63-M, April 2021, Change 17, (September 20, 2024), Chapter 7, Section 6.1, Ophthalmological Services, https://manuals.health.mil/pages/DisplayManualHtmlFile/2024-09-20/AsOf/TPT5/C7S6_1.html

[2] TRICARE Policy Manual 6010.63-M, April 2021, Change 17, (September 20, 2024), Chapter 4, Section 21.1, Eye and Ocular Adnexa, https://manuals.health.mil/pages/DisplayManualHtmlFile/2024-09-20/AsOf/TPT5/C4S21_1.html

[3] TRICARE Policy Manual 6010.63-M, April 2021, Change 17, (September 20, 2024), Chapter 7, Section 6.2, Lenses (Intraocular or Contact) and Eyeglasses, https://manuals.health.mil/pages/DisplayManualHtmlFile/2024-09-20/AsOf/TPT5/C7S6_2.html



[4] Aetna. (n.d.). Clinical policy bulletin: Strabismus repair. Retrieved July 23, 2025, from https://www.aetna.com/cpb/medical/data/500_599/0566.html

On a Mission to Serve®