Clinical Policy: Age-Related Macular Degeneration

Reference Number: CP.VP.02
Last Review Date: 08/2025

Coding Implications
Revision Log

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

Description

Age-related macular degeneration (AMD) is a leading cause of irreversible severe vision impairment in developed countries. Overall, AMD is responsible for an estimated 46% of cases of severe visual loss (acuity 20/200 or worse) in persons over 40 years of age in the United States. This policy describes the medical necessity requirements for macular degeneration assessment.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® (Centene) and Envolve Vision, Inc.® (Envolve) that evaluation for macular degeneration is medically necessary for the following indications:
   A. Cigarette smokers
   B. Increased age
   C. Northern European ancestry
   D. Family history of AMD

II. It is the policy of health plans affiliated with Centene and Envolve that the following therapies are considered investigational, as they are unproven for treatment of the conditions listed below:
   A. Transpupillary thermotherapy for choroidal neovascularization / age-related macular degeneration (AMD), or choroidal tumors;
   B. Conjunctival incision with placement of pharmacologic agent for AMD;
   C. Epiretinal radiation therapy for AMD;
   D. Laser photocoagulation for macular drusen;
   E. Any pharmaceutical or supplemental antioxidant treatment for early AMD.

Background

Nonexudative AMD accounts for approximately 80% of all patients with AMD. The disorder results from a gradual breakdown of the retinal pigment epithelium (RPE), the accumulation of drusen deposits, and loss of function of the overlying photoreceptors. Most patients experience gradual, progressive loss of central visual function. The condition usually affects both eyes, though they will not be at the same stage of disease simultaneously.

Exudative AMD accounts for the remaining approximately 20% of patients with AMD and is a much greater threat to vision loss. The disorder is characterized by the development of neovascularization in the choroid, leading to serous or hemorrhagic leakage and subsequent elevation of the RPE and/or neurosensory retina. Patients with exudative AMD notice a more profound and rapid decrease in central visual function.

Randomized, controlled clinical trials support the use of antioxidant supplementation for slowing the progression to later stages of AMD; intravitreal injection of complement factor inhibitor to

decrease the rate of GA growth; and intravitreal injection of anti-VEGF agents, photodynamic therapy (PDT), and laser photocoagulation surgery to treat neovascular AMD. The use of the combination of antioxidant vitamins and minerals did not reduce the progression of early AMD to the intermediate stage of AMD, and there was insufficient power to determine the effects of the combination treatment on the progression to more advanced AMD. Therefore, there is no evidence to support the use of these supplements for patients who have less than intermediate AMD. See clinical *policy CP.VP.40 Photodynamic and Intravitreal Therapies and Pharmaceuticals* for physician administered pharmaceutical intervention options indicated for AMD.

AMD is characterized by the following fundus changes:

- Presence of at least medium-size drusen (≥ 63 µm in diameter)
- Retinal pigment epithelium (RPE) abnormalities such as hypopigmentation or hyperpigmentation
- Presence of any of the following features: GA of the RPE, choroidal neovascularization ([CNV] exudative, wet), reticular pseudodrusen, or retinal angiomatous proliferation

The classification of AMD from the Age-Related Eye Disease Study (AREDS) is as follows:

- No AMD (AREDS category 1) represented the control group; it is characterized by no or few small drusen, also known as drupelets (small drusen ≤ 63 microns).
- Early AMD (AREDS category 2) is characterized by a combination of multiple small drusen, few intermediate drusen (> 63–124 µm in diameter), or mild RPE abnormalities.
- Intermediate AMD (AREDS category 3) is characterized by either of the following features:
    - Numerous medium drusen
    - At least one large druse (≥ 125 µm in diameter)
- Advanced AMD (AREDS category 4) is characterized by one or more of the following (in the absence of other causes) in one eye:
    - GA of the RPE two subtypes: fovea-involving and not involving fovea6
    - Macular neovascularization (MNV) historically referred to as CNV and includes the following:
        - Type 1 MNV: a neovascular complex located in the sub-RPE space originating from the choroid through a defect in Bruch's membrane
        - Polypoidal choroidal vasculopathy (PCV) lesions, similar to Type 1 MNV, characterized by branching vascular networks with dilated vascular elements (historically referred to as polyps)
        - Type 2 MNV: a neovascular complex located in the subretinal space above the RPE originating from the choroid
        - Type 3 MNV: pathologic angiogenesis originating from the deep retinal capillary plexus and extending to the outer retina (historically referred to as retinal angiomatous proliferation)

AMD clinical evaluation includes:

- thorough patient history including medications and nutritional supplement use, ocular history, medical history, family history and social history;

- assessment of the presence of any visual symptoms (metamorphopsia, decreased vision, scotoma, photopsia, difficulties in dark adaptation);
- dilated funduscopic examination, visual acuity testing and stereoscopic ophthalmoscopy performed as part of a comprehensive eye examination; and
- Amsler grid testing.
- Fluorescein angiography may be completed to confirm "wet" AMD.

Patients are typically aged 50 years or older, with or without visual symptoms. Clinicians should consider the possibility of hereditary macular dystrophies in patients under 50 years of age who have clinical features that resemble AMD. Although AMD is most common for people over 60, it is possible to develop symptoms in one's 40s or 50s. Macular degeneration often runs in families. Symptoms can include:

- Blurry or fuzzy vision
- Distortion of straight lines (appear wavy)
- A dark or empty area appears in the central vision area

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code requiring an additional character

ICD-10-CM Code	Description
H35.3111	Nonexudative age-related macular degeneration, right eye, early dry stage
H35.3112	Nonexudative age-related macular degeneration, right eye, intermediate dry stage
H35.3113	Nonexudative age-related macular degeneration, right eye, advanced atrophic without subfoveal involvement
H35.3114	Nonexudative age-related macular degeneration, right eye, advanced atrophic with subfoveal involvement
H35.3121	Nonexudative age-related macular degeneration, left eye, early dry stage
H35.3122	Nonexudative age-related macular degeneration, left eye, intermediate dry stage
H35.3123	Nonexudative age-related macular degeneration, left eye, advanced atrophic without subfoveal involvement
H35.3124	Nonexudative age-related macular degeneration, left eye, advanced atrophic with subfoveal involvement

ICD-10-CM Code	Description
H35.3131	Nonexudative age-related macular degeneration, bilateral, early dry stage
H35.3132	Nonexudative age-related macular degeneration, bilateral, intermediate dry stage
H35.3133	Nonexudative age-related macular degeneration, bilateral, advanced atrophic without subfoveal involvement
H35.3134	Nonexudative age-related macular degeneration, bilateral, advanced atrophic with subfoveal involvement
H35.3211	Exudative age-related macular degeneration, right eye with active choroidal neovascularization
H35.3212	Exudative age-related macular degeneration, right eye with inactive choroidal neovascularization
H35.3213	Exudative age-related macular degeneration, right eye, with inactive scar
H35.3221	Exudative age-related macular degeneration, left eye, with active choroidal neovascularization
H35.3222	Exudative age-related macular degeneration, left eye, with inactive choroidal neovascularization
H35.3223	Exudative age-related macular degeneration, left eye, with inactive scar
H35.3231	Exudative age-related macular degeneration, bilateral, with active choroidal neovascularization
H35.3232	Exudative age-related macular degeneration, bilateral, with inactive choroidal neovascularization
H35.3233	Exudative age-related macular degeneration, bilateral, with inactive scar
Z83.518	Family history of other specified eye disorder

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date	12/2019	12/2019
Converted to new template	04/2020	06/2020
Annual Review; Updated diagnosis codes to include Z83.518, family history of other specified eye disorder; Relocated macular degeneration screening criteria; Updated indications for screening; Updated references	12/2020	12/2020
Annual Review	12/2021	01/2022
Annual Review	11/2022	12/2022
Annual Review	11/2023	12/2023
Annual Review	11/2024	12/2024
Updated Description, Policy Criteria and Background to include changes to risk factors, outline clinical assessment protocols, disease grading and pharmaceutical management.	06/2025	07/2025
Annual Review	08/2025	10/2025

References

1. American Academy of Ophthalmology Retina Panel. Preferred Practice Pattern® Guidelines. Age-Related Macular Degeneration. San Francisco, CA: American Academy of

Ophthalmology; 2024, https://www.aao.org/preferred-practice-pattern/age-related-macular-degeneration-ppp
2. Gass JDM. Stereoscopic Atlas of Macular Diseases: Diagnosis and Treatment. 4th ed. St. Louis, MO: CV Mosby; 1997.
3. Klein R, Klein BE, Linton KL. Prevalence of age-related maculopathy. The Beaver Dam Eye Study. Ophthalmology. 1992;99(6):933-943.

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 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 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.

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 https://www.cms.gov for additional information.