Clinical Policy: Optic Nerve Decompression Surgery

Description
Optic nerve (ON) sheath decompression involves direct decompression (fenestration) of the ON sheaths just behind the globe. The approach and technique for an ON sheath fenestration varies. This policy describes the medical necessity requirements for ON decompression surgery.

Policy/Criteria
I. It is the policy of health plans affiliated with Centene Corporation® that ON sheath decompression surgery is medically necessary for treatment of the following conditions:
   A. Papilledema accompanying idiopathic intracranial hypertension (IIH) with either of the following:
      1. Visual function that is severely impaired or continues to deteriorate, despite aggressive medical management (e.g., Diamox, furosemide, and corticosteroids);
      2. Incapacitating headaches;
   B. Traumatic optic neuropathy (TON) with radiologic evidence of any of the following:
      1. Optic canal fracture with impingement of the ON by a fracture fragment;
      2. Intraneural edema;
      3. Sheath hematoma;
   C. Facial fibrous dysplasia, and either of the following:
      1. Cystic degenerations and optic canal narrowing. If intent is prophylactic, risk of ON damage is clearly explained;

II. It is the policy of health plans affiliated with Centene Corporation that there is insufficient evidence in the published peer-reviewed literature to support the use of ON sheath decompression surgery for the treatment of nonarteritic anterior ischemic optic neuropathy (NAION).

Background
ON sheath decompression surgery is typically performed in instances of papilledema due to idiopathic intracranial hypertension (IIH), in which the main symptom is rapid and/or progressive vision loss rather than headache. The effect is normally limited to the ipsilateral ON, although occasionally the procedure appears to have a filtration effect, resulting in improvements in headaches and contralateral disc edema as well.

Idiopathic Intracranial Hypertension
Idiopathic intracranial hypertension (IIH), also known as pseudotumor cerebri, is a disorder defined by clinical criteria that include symptoms and signs isolated to those produced by increased intracranial pressure (e.g., headache, papilledema, vision loss), elevated intracranial pressure with normal cerebrospinal fluid composition, and no other cause of intracranial hypertension evident on neuroimaging or other evaluations. The incidence of IIH in the general population is estimated to be 1-2 per 10,000 individuals. The disease is more common in women and tends to occur in young to middle-aged adults. Risk factors for IIH include obesity, high blood pressure, and use of certain medications. The condition is often characterized by a slow, steady increase in intracranial pressure, leading to a buildup of pressure within the cranial vault. As pressure increases, it can cause compression of the optic nerves and surrounding structures, leading to visual symptoms such as blurry vision, vision loss, and papilledema.

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population is thought to be about 1-2 per 100,000. In obese, young females between the ages of
15-44, the incidence of IIH is higher (4-21 per 100,000). IIH occurs in men and children as well,
but with substantially lower frequency. Weight is a risk factor for men but is less prevalent than
in women and is not usually a factor in prepubertal children.20 Many individuals suffer from
intractable, disabling headaches, and there is a risk of severe, permanent vision loss.
Recommendations for the treatment of IIH are limited due to a lack of randomized controlled
trials. In addition, the natural history of untreated IIH is uncertain.

The goals of treatment are to detect and prevent vision loss, reduce intracranial pressure, and
relieve headache. Medical treatment consists of first line treatment with Diamox
(acetazolamide), which inhibits choroid plexus carbonic anhydrase and reduces cerebrospinal
fluid production by 50 to 60%. Furosemide (Lasix®) and corticosteroids can be added. Surgery is
reserved for patients whose visual function is severely impaired or continues to deteriorate
despite aggressive medical management. Those who suffer incapacitating headaches may also be
candidates for surgery.

Two main surgical options include ON sheath decompression and cerebrospinal fluid (CSF)
shunting. The overall rate of visual improvement seems to be equivalent across both surgical
treatment modalities and an individualized approach is recommended when choosing a surgical
procedure.20 In one of the largest case studies, ON sheath decompression stabilized or improved
visual acuity in 94% of patients and visual fields in 88% of patients. Visual function is greatly
improved in patients with acute rather than chronic papilledema. Thus, in patients with
significant visual loss, waiting a prolonged period for a response to medical therapy may not be
warranted. ON sheath decompression also may improve visual function in patients with
progressive visual loss despite a functioning shunt.

Traumatic Optic Neuropathy

Traumatic optic neuropathy (TON) is an important cause of severe visual loss following blunt or
penetrating head trauma. Following the initial insult, ON swelling within the ON canal or
compression by bone fragments are thought to result in secondary retinal ganglion cell loss. ON
decompression with steroids or surgical interventions, or both, have been advocated to improve
visual prognosis in TON.

A 2013 Cochrane Review of surgical treatment for TON concluded there is not enough evidence
that surgical decompression of the ON provides any additional benefit beyond conservative
management, citing a lack of randomized controlled trials (RCTs), and a wide range of surgical
techniques that make comparisons difficult.10 Given that it would be quite difficult to conduct an
adequately powered RCT of surgical ON decompression for TON, the authors’ state ON
decompression for TON should be assessed on a case by case basis, taking risks of surgery into
consideration.10 A 2015 review of TON investigation and management included 14 articles
regarding treatment for TON.1 The authors noted that studies investigating ON decompression
for TON are largely small and retrospective, with one larger study- the International Optic Nerve
Trauma Study- comprised of 133 patients. Across the studies reviewed, improvement after ON
decompression ranged from 27 to 82%, potentially reflecting the poorly defined indications for
surgery. The authors argue that surgery should be reserved for instances in which “there is
Facial Fibrous Dysplasia
Fibrous dysplasia (FD) is a rare condition involving non-malignant overgrowth of bone; approximately 20% of FD cases involve craniofacial bones. Surgery has been the primary form of management of compression of the optic nerve due to FD, although there is no clear agreement on timing of surgery or in which circumstances the surgery is most beneficial. McCune-Albright syndrome (MAS) is a very rare condition that accounts for about 3% of all FD cases and presents as polyostotic FD (involving multiple bones/foci of disease), café-au-lait skin macules, and precocious puberty. Studies have shown that narrowing of the optic canal in MAS is not directly correlated with vision loss, and that acute visual loss is related to aneurysmal bone cysts and mucoceles. However, ideal operative management of craniofacial dysplasia in MAS has not been established due to its rarity. Due to the risks of postoperative complications, which occur in 50% of patients, prophylactic surgery to prevent vision loss is only indicated in cases with aneurysmal bone cysts and mucoceles. Otherwise, surgery to decompress the ON is reserved for cases of FD with established vision loss.

Nonarteritic Anterior Ischemic Optic Neuropathy
NAION is the most common form of ischemic optic neuropathy. It is an idiopathic, ischemic insult of the ON head characterized by acute, monocular, painless visual loss with optic disc swelling. Visual function can be impaired through decreased central visual acuity or peripheral field loss, or both. The typical presentation is sudden onset of painless monocular vision loss, often upon awakening.

ON sheath decompression surgery was reported in 1989 to be of benefit to patients with NAION. The presumed mechanism of action in ON decompression surgery revolved around restoration of impaired blood flow to the ON through reduction of the pressure around the nerve. Initial results of uncontrolled studies suggested that ON sheath decompression was a promising treatment of progressive visual loss in patients with NAION. Other investigators who evaluated this surgical procedure reported varying degrees of success. To resolve the controversy over the effectiveness of ON decompression for NAION, the National Eye Institute sponsored the Ischemic Optic Neuropathy Decompression Trial, a multicenter, randomized controlled clinical trial of ON decompression surgery for patients with NAION. The study found no benefit from surgery in NAION patients with progressive visual loss; in fact, significantly more patients in the surgery group had progressive loss of vision than patients who received only careful follow-up. The investigators concluded that ON decompression surgery is not an effective treatment for NAION and, in fact, may increase the risk of progressive visual loss in NAION patients. The trial was stopped early because the surgery was not helping the participants more than careful follow-up alone. Pain and double vision were harms experienced by some participants in the surgery group at one week after the surgery. The trial investigators reported that continued enrollment would be unlikely to produce results in favor of surgery.

Coding Implications
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2020, 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.

### CPT® Codes

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<th>CPT® Codes</th>
<th>Description</th>
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<tr>
<td>67570</td>
<td>Optic nerve decompression (eg, incision or fenestration of optic nerve sheath)</td>
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### ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code requiring an additional character

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<thead>
<tr>
<th>ICD 10 CM Code</th>
<th>Description</th>
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<tr>
<td>G93.2</td>
<td>Benign intracranial hypertension</td>
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<tr>
<td>H47.021</td>
<td>Hemorrhage in optic nerve sheath, right eye</td>
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<tr>
<td>H47.022</td>
<td>Hemorrhage in optic nerve sheath, left eye</td>
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<tr>
<td>H47.11</td>
<td>Papilledema associated with increased intracranial pressure</td>
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<tr>
<td>M85.08</td>
<td>Fibrous dysplasia (monostotic), other site</td>
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<tr>
<td>M85.09</td>
<td>Fibrous dysplasia (monostotic), multiple sites</td>
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<tr>
<td>Q78.1</td>
<td>Polyostotic fibrous dysplasia</td>
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<tr>
<td>S04.011+ through S04.019+</td>
<td>Injury of optic nerve</td>
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### Reviews, Revisions, and Approvals

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<tr>
<th>Description</th>
<th>Revision Date</th>
<th>Approval Date</th>
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<tr>
<td>Policy adopted from Health Net NMP353 ON Decompression Surgery</td>
<td>08/16</td>
<td>09/16</td>
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<tr>
<td>Reclassified TON as medically necessary with certain criteria; added facial fibrous dysplasia as a medically necessary indication, and updated related background information and codes.</td>
<td>09/17</td>
<td>09/17</td>
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<tr>
<td>References reviewed and updated.</td>
<td>08/18</td>
<td>08/18</td>
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<tr>
<td>References reviewed and updated. Specialist review.</td>
<td>07/19</td>
<td>08/19</td>
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<tr>
<td>References reviewed and updated.</td>
<td>07/20</td>
<td>08/20</td>
</tr>
<tr>
<td>Revised language in II from “investigational” to “insufficient evidence to support…” References reviewed, updated and reformatted. Changed “review date” in the header to “date of last revision” and “date” in the revision log header to “revision date.” Replaced member with member/enrollee.</td>
<td>08/21</td>
<td>08/21</td>
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<tr>
<td>Annual review. References reviewed and updated. Specialist review. Background updated with no clinical significance.</td>
<td>07/22</td>
<td>07/22</td>
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### References


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**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.

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Note: For Medicaid member/enrollees, 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 member/enrollees, 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.

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