Subject: **Refractive Eye Surgery***

Effective Date: **January 1, 1995**

Department(s): **Utilization Management**

Policy: Refractive eye surgery, including but not limited to laser in situ keratomileusis (LASIK) is not reimbursable under Plans administered by QualCare, Inc. except for specific circumstances delineated in this policy.

Objective: To provide proper and consistent reimbursement and to exclude reimbursement for a category of procedures considered to be not medically necessary.

Procedure: Requests for coverage of surgical procedures on the eye, whose purpose is to correct refractive errors including but not limited to myopia, astigmatism, hyperopia, and presbyopia, will be denied on the basis of the absence of medical necessity.

1. Procedures to be denied under this policy include, but are not limited to, LASIK **(S0800)**, radial keratotomy **(65771)**, photorefractive keratectomy (PRK) **(S0810)**, photoastigmatic keratectomy (PARK) **(65760)**, and intraocular refractive surgery with phakic intraocular lenses.

2. **Surgical procedures on diseased corneas**, such as phototherapeutic keratectomy (PTK) **(S0812)** for corneal scars, superficial corneal dystrophy, and recurrent corneal erosions, **are not excluded from**

coverage by this policy, but will be subject to medical review to determine medical necessity.

3. Correction of surgically-induced astigmatism(post-cataract or post-corneal transplant)(**CPT codes 65772, 65775**) for individuals who are unable to tolerate glasses or contact lenses, are reimbursable under Plans administered by QualCare,Inc.

4. Refractive surgery for keratoconus (ICD-9 371.6) (ICD-10-H18.601H18.602,H18.603, H18.609), including placement of intrastromal corneal ring segments (INTACS) (CPT, 65785) is reimbursable under Plans administered by QualCare, Inc. The INTACS procedure is reimbursable for members ≥ 21 years of age with keratoconus-associated myopia or astigmatism to restore functional vision when this is not possible with contact lenses or spectacles and is in lieu of corneal transplant (also referred to as penetrating keratoplasty or PK). INTACS is **not** considered medically necessary for the treatment of myopia or astigmastism without keratoconus.

5. Conventional, epithelium-off, corneal collagen crosslinking (C-CXL) using a U.S. Food and Drug Administration (FDA) approved drug/device system (e.g., Photrexa® Viscous or Photrexa® with the KXL® System) (**CPT Code 0402T; HCPCS Code J3490**) is considered medically necessary for the treatment of EITHER of the following:

   • progressive keratoconus

   • corneal ectasia following refractive surgery

   When all of the following criteria are met:

   - age 14–65 years

• progressive deterioration in vision, such that adequate functional vision on a daily basis with contact lenses or spectacles can no longer be achieved

• absence of visual disturbance from a significant central corneal opacity or other eye disease (e.g., herpetic keratitis, neurotrophic keratopathy)

6. All other corneal collagen crosslinking procedures (e.g., epithelium-on/transepithelial are considered investigational due to lack of documented efficacy in the medical literature.

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Approved By/Date: QM Committee 10/16/18

*Consistent with Summary Plan Description (SPD). When there is discordance between this policy and the SPD, the provisions of the SPD prevail.