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-H18.601 H18.602, H18.603, H18.609), including placement of intrastromal corneal ring segments (INTACS) (CPT 0099T, 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 astigmatism without keratoconus.

5. Riboflavin UVA corneal collagen cross-linking [CPT 0402T] for treatment of keratoconus, or any other condition, is NOT reimbursable as it is considered investigational due to lack of documented efficacy in the medical literature.

References


Weichel ED, Bower KS. Laser refractive surgery. UpToDateOnLine 14.1 at http://www.utdol.com accessed 04/02/06

-----LASIK and its alternatives: An update. The Medical Letter on Drugs and Therapeutics 2004;46(1174):1-3 (Jan 19)


Original Policy (Radial Keratotomy) Effective Date: 01/01/95
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Reviewed without Revision By/Date: BFisher, MD 07/14/2010
Approved By/Date: QM Committee 7/27/10
Reviewed with Revisions By/Date: MMcNeil, MD 07/10/12
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*Consistent with Summary Plan Description (SPD). When there is discordance between this policy and the SPD, the provisions of the SPD prevail.