ND

Medical Policies

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Policy Number:	S-41		
Policy Name:	Corneal Surgery to Correct Refractive Errors and Phototherapeutic Keratectomy, and Corneal Collagen Cross-Linking		
Policy Type:	Medical	**Policy Subtype:**	Surgery
Effective Date:	09-15-2025	**End Date:**	11-02-2025

Description

Corneal surgery is performed to change the shape of the cornea which will correct vision problems such as myopia (nearsightedness), hyperopia (farsightedness), and astigmatism. Corneal surgeries performed for this purpose may include radial keratotomy, photorefractive keratectomy (PRK), laser-assisted in-situ keratomileusis (LASIK), keratomileusis, keratophakia, and epikeratoplasty.

Phototherapeutic keratectomy (PTK) involves the use of the excimer laser to treat visual impairment or irritative symptoms relating to diseases of the anterior cornea. PTK functions by removing anterior stromal opacities or eliminating elevated cornea lesions while maintaining a smooth corneal surface.

Intrastromal corneal ring segments (i.e., INTACS) when provided in accordance with the Humanitarian Device Exemption (HDE) specifications of the United States Food and Drug Administration (U.S. FDA), consist of micro-thin methylmethacrylate inserts of variable thickness that are implanted on the perimeter of the cornea. They are used in refractive surgery to correct mild myopia (see above), and as a treatment of keratoconus. The inserts help restore vision in keratoconus individuals by flattening and repositioning the cornea.

Corneal collagen cross-linking (CXL) is a photochemical procedure for the treatment of progressive keratoconus and corneal ectasia. Keratoconus is a dystrophy of the cornea characterized by progressive deformation (steepening) of the cornea while corneal ectasia is keratoconus that occurs after refractive surgery. Both lead to functional loss of vision and the need for corneal transplantation.

Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of processing, regardless of service date; **or**

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of service.

Corneal Refractive Surgery

Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of processing, regardless of service date.

Corneal refractive surgery may be considered medically necessary when ANY ONE of the following is met:

- Correction of astigmatism resulting from trauma or from a previous eligible surgery (i.e., cataract surgery); or
- Correction of aphakia.

Corneal refractive surgery not meeting the criteria as indicated in this policy is considered not medically necessary.

NOTE: These procedures should not be confused with corneal transplants (also called keratoplasties).

Procedure Codes

65760	65765	65767	65771	65772	65775	66999
S0800	S0810					

Phototherapeutic Keratectomy (PTK)

Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of processing, regardless of service date.

PTK may be considered medically necessary for ANYONE (1) of the following conditions:

- Corneal scarring and opacities (including post-traumatic, post-infectious, post-surgical, and secondary to pathology); or
- Superficial corneal dystrophy (including granular, lattice and Reis-Bückler's dystrophy); or
- Epithelial membrane dystrophy; or
- Irregular corneal surfaces due to Salzmann's nodular degeneration or keratoconus nodule; or
- Recurrent corneal erosions when more conservative measures (i.e., lubricants, hypertonic saline, patching, bandage contact lenses, gentle debridement of severely aberrant epithelium) have failed to halt the erosions.

NOTE: PTK should not be confused with photorefractive keratectomy (PRK). Although technically the same procedure, PTK is used for the correction of particular corneal diseases whereas PRK involves the use of the excimer laser for correction of refractive errors (i.e., myopia, hyperopia, astigmatism, and presbyopia) in persons with otherwise non-diseased corneas.

PTK not meeting the criteria as indicated in this policy is considered not medically necessary.

Procedure Code

S0812

Intrastromal Corneal Ring Segments

Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of service.

Implantation of intrastromal corneal ring segments may be considered medically necessary for the treatment of keratoconus in individuals 21 years of age or older who meet ALL the following criteria:

- Who have experienced a progressive deterioration in their vision, such that they can no longer achieve adequate functional vision on a daily basis with their contact lenses or spectacles; and
- Who have clear central corneas with a corneal thickness of 450 microns or greater at the proposed incision site; and
- Who have corneal transplantation as the only option remaining to improve their functional vision.

Insertion of intrastromal cornea ring segments not meeting the criteria as indicated in this policy is considered not medically necessary.

Any pre- and post-operative evaluations and measurements, not an all-inclusive list (i.e., ophthalmic echography, keratometry, pachymetry) performed in conjunction with services identified with ineligible procedures are non-covered.

Procedure Codes

65785	76510	76511	76512	76513	76514	76516
76519						

Contact Lenses for Keratoconus

When a covered individual or group customer benefit, contact lenses are covered for the treatment of keratoconus.

Corneal Collagen Cross-Linking

Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of service

Corneal CXL using riboflavin and ultraviolet A may be considered medically necessary in individuals who have failed conservative treatment (i.e., spectacle correction, rigid contact lens) when used for EITHER of the following conditions:

- Progressive keratoconus; or
- Corneal ectasia after refractive surgery.

Corneal CXL using riboflavin and ultraviolet A not meeting the criteria as indicated in this policy is considered experimental/investigational and therefore non-covered because the safety and/or effectiveness of this service cannot be established by the available published peer-reviewed literature.

Procedure Code

0402T

Diagnosis Codes

Covered Diagnosis Codes for Procedure Code S0812

A18.59	E50.6	H17.00	H17.01	H17.02	H17.03	H17.10
H17.11	H17.12	H17.13	H17.811	H17.812	H17.813	H17.819
H17.821	H17.822	H17.823	H17.829	H17.89	H17.9	H18.451
H18.452	H18.453	H18.459	H18.501	H18.502	H18.503	H18.511
H18.512	H18.513	H18.521	H18.522	H18.523	H18.531	H18.532
H18.533	H18.541	H18.542	H18.543	H18.551	H18.552	H18.553
H18.601	H18.602	H18.603	H18.609	H18.611	H18.612	H18.613
H18.619	H18.621	H18.622	H18.623	H18.629	H18.831	H18.832
H18.833	H18.839	H18.891	H18.892	H18.893	H18.9	Q13.3

Covered Diagnosis Codes for Procedure Code 65785

H18.601	H18.602	H18.603	H18.609	H18.611	H18.612	H18.613
H18.619	H18.621	H18.622	H18.623	H18.629		

Covered Diagnosis Codes for Procedure Code 65772, 65775, 66999

H18.10	H18.11	H18.12	H18.13	H27.00	H27.01	H27.02
H27.03	Q12.3					

CURRENT CODING

CPT:

0402T	COLLAGEN CROSS-LINKING CORNEA&PACHYMTRY	Medicaid Expansion
65760	KERATOMILEUSIS	Medicaid Expansion
65765	KERATOPHAKIA	Medicaid Expansion
65767	EPIKERATOPLASTY	Medicaid Expansion
65771	RADIAL KERATOTOMY	Medicaid Expansion
65772	CRNL RELAXING INC CORRJ INDUCED ASTIGMATISM	Medicaid Expansion

65775	CRNL WEDGE RESCJ CORRJ INDUCED ASTIGMATISM	Medicaid Expansion
65785	IMPLANTATION INTRASTROMAL CORNEAL RING SEGMENTS	Medicaid Expansion
66999	UNLISTED PROCEDURE ANTERIOR SEGMENT EYE	Medicaid Expansion
76510	OPHTHALMIC US DX B-SCAN&QUAN A-SCAN SM PT ENCTR	Medicaid Expansion
76511	OPHTHALMIC US DX QUANTITATIVE A-SCAN ONLY	Medicaid Expansion
76512	OPHTHALMIC US DX B-SCAN W/WO NON-QUAN A-SCAN	Medicaid Expansion
76513	DX OPHTHALMIC US ANT SEGMENT IMMERSION UNI/BI	Medicaid Expansion
76514	OPHTHALMIC US DX CORNEAL PACHYMETRY UNI/BI	Medicaid Expansion
76516	OPHTHALMIC BIOMETRY US ECHOGRAPY A-SCAN	Medicaid Expansion
76519	OPH BMTRY US ECHOGRAPY A-SCAN IO LENS PWR CAL	Medicaid Expansion
0402T	COLLAGEN CROSS-LINKING CORNEA&PACHYMTRY	Commercial
65760	KERATOMILEUSIS	Commercial
65765	KERATOPHAKIA	Commercial
65767	EPIKERATOPLASTY	Commercial
65771	RADIAL KERATOTOMY	Commercial
65772	CRNL RELAXING INC CORRJ INDUCED ASTIGMATISM	Commercial
65775	CRNL WEDGE RESCJ CORRJ INDUCED ASTIGMATISM	Commercial
65785	IMPLANTATION INTRASTROMAL CORNEAL RING SEGMENTS	Commercial
66999	UNLISTED PROCEDURE ANTERIOR SEGMENT EYE	Commercial
76510	OPHTHALMIC US DX B-SCAN&QUAN A-SCAN SM PT ENCTR	Commercial
76511	OPHTHALMIC US DX QUANTITATIVE A-SCAN ONLY	Commercial
76512	OPHTHALMIC US DX B-SCAN W/WO NON-QUAN A-SCAN	Commercial

76513	DX OPHTHALMIC US ANT SEGMENT IMMERSION UNI/BI	Commercial
76514	OPHTHALMIC US DX CORNEAL PACHYMETRY UNI/BI	Commercial
76516	OPHTHALMIC BIOMETRY US ECHOGRAPY A-SCAN	Commercial
76519	OPH BMTRY US ECHOGRAPY A-SCAN IO LENS PWR CAL	Commercial

HCPCS:

S0800	Laser in situ keratomileusis	Medicaid Expansion
S0810	Photorefractive keratectomy	Medicaid Expansion
S0812	Phototherap keratect	Medicaid Expansion
S0800	Laser in situ keratomileusis	Commercial
S0810	Photorefractive keratectomy	Commercial
S0812	Phototherap keratect	Commercial

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ND Committee Review

Internal Medical Policy Committee 11-19-2020 Coding update- *Effective January 4, 2021*

- *Removed* covered Diagnosis Codes for procedure code S0812: H18.50; H18.51; H18.52; H18.53; H18.54; H18.55; H18.59

Internal Medical Policy Committee 5-20-2021 *Effective July 5, 2021*

- *Changed* Title, and
- *Updated* policy criteria to include language from S-250, and
- *Added* Professional Statement, and
- *Updated* Diagnosis Code section, and
- *Updated* coding

Internal Medical Policy Committee 3-23-2022 Coding update: *Effective May 2, 2022*

- *Removed* Covered Diagnosis Codes for Procedure Code 0402T
- *Removed* Diagnosis Codes H18.601; H18.602; H18.603; H18.611; H18.612; H18.613; H18.621; H18.622; H18.623; H18.711; H18.712; H18.713

Internal Medical Policy Committee 7-21-2022 Coding update - *Effective September 21, 2022*

- *Removed* Diagnosis Code: H18.999
- *Added* Diagnosis Codes: H18.501; H18.502; H18.503; H18.511; H18.512; H18.513; H18.521; H18.522; H18.523; H18.531; H18.532; H18.533; H18.541; H18.542; H18.543; H18.551; H18.552 and H18.553.

Internal Medical Policy Committee 7-26-2023 Annual Review-no change in criteria

Internal Medical Policy Committee 7-16-2024 Annual Review-no change in criteria

- *Added* Policy Application

Disclaimer

Current medical policy is to be used in determining a Member's contract benefits on the date that services are rendered. Contract language, including definitions and specific inclusions/exclusions, as well as state and federal law, must be considered in determining eligibility for coverage. Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information. Likewise, medical policy, which addresses the issue(s) in any specific case, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and the Company reserves the right to review and update medical policy periodically.