Medical Policy

Endothelial Keratoplasty

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Policy Number: 180
BCBSA Reference Number: 9.03.22
NCD/LCD: NA

Related Policies
- Keratoprosthesis, #221

Policy
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity
Medicare HMO BlueSM and Medicare PPO BlueSM Members

Endothelial keratoplasty [Descemet's stripping endothelial keratoplasty (DSEK) Descemet's stripping automated endothelial keratoplasty (DSAEK)], Descemet's membrane endothelial keratoplasty (DMEK), or Descemet's membrane automated endothelial keratoplasty (DMAEK) may be considered MEDICALLY NECESSARY for the treatment of endothelial dysfunction, including but not limited to:
- Ruptures in Descemet's membrane,
- Endothelial dystrophy,
- Aphakic and pseudophakic bullous keratopathy,
- Iridocorneal endothelial (ICE) syndrome,
- Corneal edema attributed to endothelial failure, or
- Failure or rejection of a previous corneal transplant.

Femtosecond laser-assisted corneal endothelial keratoplasty (FLEK) or femtosecond and excimer lasers-assisted endothelial keratoplasty (FELEK) are INVESTIGATIONAL.

Endothelial keratoplasty is NOT MEDICALLY NECESSARY when endothelial dysfunction is not the primary cause of decreased corneal clarity.

Prior Authorization Information
Pre-service approval is required for all inpatient services for all products.
See below for situations where prior authorization may be required or may not be required for outpatient services.
Yes indicates that prior authorization is required.
No indicates that prior authorization is not required.
N/A indicates that this service is primarily performed in an inpatient setting.

<table>
<thead>
<tr>
<th>Outpatient</th>
<th>Commercial Managed Care (HMO and POS)</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial PPO and Indemnity</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Medicare HMO Blue&lt;sup&gt;SM&lt;/sup&gt;</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Medicare PPO Blue&lt;sup&gt;SM&lt;/sup&gt;</td>
<td>No</td>
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</tr>
</tbody>
</table>

**CPT Codes / HCPCS Codes / ICD Codes**

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

**CPT Codes**

<table>
<thead>
<tr>
<th>CPT codes:</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>65756</td>
<td>Keratoplasty (corneal transplant); endothelial</td>
</tr>
<tr>
<td>65757</td>
<td>Backbench preparation of corneal endothelial allograft prior to transplantation (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

The following ICD Diagnosis Codes are considered medically necessary when submitted with the CPT codes above if medical necessity criteria are met:

**ICD-10 Diagnosis Codes**

<table>
<thead>
<tr>
<th>ICD-10-CM Diagnosis codes:</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H18.10</td>
<td>Bullous keratopathy, unspecified eye</td>
</tr>
<tr>
<td>H18.11</td>
<td>Bullous keratopathy, right eye</td>
</tr>
<tr>
<td>H18.12</td>
<td>Bullous keratopathy, left eye</td>
</tr>
<tr>
<td>H18.13</td>
<td>Bullous keratopathy, bilateral</td>
</tr>
<tr>
<td>H18.20</td>
<td>Unspecified corneal edema</td>
</tr>
<tr>
<td>H18.211</td>
<td>Corneal edema secondary to contact lens, right eye</td>
</tr>
<tr>
<td>H18.212</td>
<td>Corneal edema secondary to contact lens, left eye</td>
</tr>
<tr>
<td>H18.213</td>
<td>Corneal edema secondary to contact lens, bilateral</td>
</tr>
<tr>
<td>H18.219</td>
<td>Corneal edema secondary to contact lens, unspecified eye</td>
</tr>
<tr>
<td>H18.221</td>
<td>Idiopathic corneal edema, right eye</td>
</tr>
<tr>
<td>H18.222</td>
<td>Idiopathic corneal edema, left eye</td>
</tr>
<tr>
<td>H18.223</td>
<td>Idiopathic corneal edema, bilateral</td>
</tr>
<tr>
<td>H18.229</td>
<td>Idiopathic corneal edema, unspecified eye</td>
</tr>
<tr>
<td>H18.231</td>
<td>Secondary corneal edema, right eye</td>
</tr>
<tr>
<td>H18.232</td>
<td>Secondary corneal edema, left eye</td>
</tr>
<tr>
<td>H18.233</td>
<td>Secondary corneal edema, bilateral</td>
</tr>
<tr>
<td>H18.239</td>
<td>Secondary corneal edema, unspecified eye</td>
</tr>
</tbody>
</table>
H18.331  Rupture in Descemet's membrane, right eye
H18.332  Rupture in Descemet's membrane, left eye
H18.333  Rupture in Descemet's membrane, bilateral
H18.339  Rupture in Descemet's membrane, unspecified eye
H18.51   Endothelial corneal dystrophy
H18.59   Other hereditary corneal dystrophies
T86.840  Corneal transplant rejection
T86.841  Corneal transplant failure
T85.21XA Breakdown (mechanical) of intraocular lens, initial encounter
T85.22XA Displacement of intraocular lens, initial encounter
T85.29XA Other mechanical complication of intraocular lens, initial encounter

**Description**

**Corneal Disease**

The cornea, a clear, dome-shaped membrane that covers the front of the eye, is a key refractive element for vision. Layers of the cornea consist of the epithelium (outermost layer); Bowman layer; the stroma, which comprises approximately 90% of the cornea; Descemet membrane; and the endothelium. The endothelium removes fluid from and limits fluid into the stroma, thereby maintaining the ordered arrangement of collagen and preserving the cornea's transparency. Diseases that affect the endothelial layer include Fuchs endothelial dystrophy, aphakic and pseudophakic bullous keratopathy (corneal edema following cataract extraction), and failure or rejection of a previous corneal transplant.

**Treatment**

The established surgical treatment for corneal disease is penetrating keratoplasty (PK), which involves the creation of a large central opening through the cornea and then filling the opening with full-thickness donor cornea that is sutured in place. Visual recovery after PK may take 1 year or more due to slow wound healing of the avascular full-thickness incision, and the procedure frequently results in irregular astigmatism due to sutures and the full-thickness vertical corneal wound. PK is associated with an increased risk of wound dehiscence, endophthalmitis, and total visual loss after relatively minor trauma for years after the index procedure. There is also the risk of severe, sight-threatening complications such as expulsive suprachoroidal hemorrhage, in which the ocular contents are expelled during the operative procedure, as well as postoperative catastrophic wound failure.

A number of related techniques have been, or are being, developed to selectively replace the diseased endothelial layer. One of the first endothelial keratoplasty (EK) techniques was termed deep lamellar endothelial keratoplasty, which used a smaller incision than PK, allowed more rapid visual rehabilitation, and reduced postoperative irregular astigmatism and suture complications. Modified EK techniques include endothelial lamellar keratoplasty, endokeratoplasty, posterior corneal grafting, and microkeratome-assisted posterior keratoplasty. Most frequently used at this time are Descemet stripping endothelial keratoplasty, which uses hand-dissected donor tissue, and Descemet stripping automated endothelial keratoplasty, which uses an automated microkeratome to assist in donor tissue dissection. These techniques include donor stroma along with the endothelium and Descemet membrane, which results in a thickened stromal layer after transplantation. If the donor tissue comprises Descemet membrane and endothelium alone, the technique is known as Descemet membrane endothelial keratoplasty (DMEK). By eliminating the stroma on the donor tissue and possibly reducing stromal interface haze, DMEK is considered a potential improvement over Descemet stripping endothelial keratoplasty and Descemet stripping automated endothelial keratoplasty. A variation of DMEK is Descemet membrane automated endothelial keratoplasty. Descemet membrane automated endothelial keratoplasty contains a stromal rim of tissue at the periphery of the DMEK graft to improve adherence and improve handling of the donor tissue. A laser may also be used for stripping in a procedure called femtosecond laser-assisted endothelial keratoplasty and femtosecond and excimer laser-assisted endothelial keratoplasty.
EK involves removal of the diseased host endothelium and Descemet membrane with special instruments after removing the anterior donor corneal stroma by hand (e.g., DSEK) or with the assistance of an automated microkeratome (e.g., Descemet stripping automated endothelial keratoplasty) or laser (femtosecond laser-assisted endothelial keratoplasty or femtosecond and excimer laser-assisted endothelial keratoplasty). Donor tissue preparation may be performed by the surgeon in the operating room or by the eye bank and then transported to the operating room for final punch out of the donor tissue button. For minimal endothelial damage, the donor tissue must be carefully positioned in the anterior chamber. An air bubble is frequently used to center the donor tissue and facilitate adhesion between the stromal side of the donor lenticule and the host posterior corneal stroma. Repositioning of the donor tissue with the application of another air bubble may be required in the first week if the donor tissue dislocates. The small corneal incision is closed with one or more sutures, and steroids or immune-suppressants may be provided topically or orally to reduce the potential for graft rejection. Visual recovery following EK is typically 4 to 8 weeks.

Eye Bank Association of America statistics have shown the number of EK cases in the United States increased from 30,710 in 2015 to 32,221 in 2016. The Eye Bank Association of America estimated that, as of 2016, nearly 40% of corneal transplants performed in the United States were endothelial grafts. As with any new surgical technique, questions have been posed about long-term efficacy and risk of complications. EK-specific complications include graft dislocations, endothelial cell loss, and rate of failed grafts. Long-term complications include increased intraocular pressure, graft rejection, and late endothelial failure.

**Summary**

For individuals who have endothelial disease of the cornea who receive DSEK or DSAEK, the evidence includes a number of cohort studies and a systematic review. Relevant outcomes are change in disease status, morbid events, and functional outcomes. The available literature has indicated that these procedures improve visual outcomes and reduce serious complications associated with PK. Specifically, visual recovery occurs much earlier. Because endothelial keratoplasty maintains an intact globe without a sutured donor cornea, astigmatism or the risk of severe, sight-threatening complications such as expulsive suprachoroidal hemorrhage and postoperative catastrophic wound failure are eliminated. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have endothelial disease of the cornea who receive DMEK or DMAEK, the evidence includes a number of cohort studies and systematic reviews. Relevant outcomes are change in disease status, morbid events, and functional outcomes. Evidence from the cohort studies and meta-analyses has consistently shown that the use of DMEK and DMAEK procedures improve visual acuity. When compared with DSEK and DSAEK, DMEK and DMAEK showed significantly greater improvements in visual acuity, both in the short term and through 1 year of follow-up. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have endothelial disease of the cornea who receive FLEK and femtosecond and excimer laser-assisted endothelial keratoplasty, the evidence includes a multicenter randomized trial that compared FLEK with PK. Relevant outcomes are change in disease status, morbid events, and functional outcomes. Mean best-corrected visual acuity was worse after FLEK than after PK, and endothelial cell loss was higher with FLEK. With the exception of dislocation and need for repositioning of the FLEK, the percentage of complications was similar between groups. Complications in the FLEK group were due to pupillary block, graft failure, epithelial ingrowth, and elevated intraocular pressure, whereas complications in the PK group were related to sutures and elevated intraocular pressure. The evidence is insufficient to determine the effects of the technology on health outcomes.
Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>2/2018</td>
<td>Clarified coding information.</td>
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<tr>
<td>10/2017</td>
<td>New references added from BCBSA National medical policy.</td>
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<tr>
<td>4/2016</td>
<td>New references added from BCBSA National medical policy.</td>
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<tr>
<td>11/2015</td>
<td>Added coding language.</td>
</tr>
<tr>
<td>5/2014</td>
<td>Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.</td>
</tr>
<tr>
<td>1/2014</td>
<td>Clarified coding information.</td>
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</table>

Information Pertaining to All Blue Cross Blue Shield Medical Policies
Click on any of the following terms to access the relevant information:
- Medical Policy Terms of Use
- Managed Care Guidelines
- Indemnity/PPO Guidelines
- Clinical Exception Process
- Medical Technology Assessment Guidelines

References


