



## MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an independent licensee of the Blue Cross and Blue Shield Association

# Medical Policy Vision Services

## Table of Contents

- [Policy: Commercial](#)
- [Coding Information](#)
- [Information Pertaining to All Policies](#)
- [Policy: Medicare](#)
- [Description](#)
- [References](#)
- [Authorization Information](#)
- [Policy History](#)

## Policy Number: 675

BCBSA Reference Number: 9.03.02A

NCD/LCD: NA

## Related Policies

- Endothelial Keratoplasty, #[180](#)
- Epiretinal Radiation Therapy for Age-Related Macular Degeneration, #[610](#)
- Gas Permeable Scleral Contact Lens, #[371](#)
- Implantation of Intrastromal Corneal Ring Segments, #[235](#)
- Intravitreal Angiogenesis Inhibitors for Choroidal Vascular Conditions, #[343](#)
- Keratoprosthesis, #[221](#)
- Orthoptic Training for the Treatment of Vision or Learning Disabilities, #[611](#)
- Transpupillary Thermotherapy for Treatment of Choroidal Neovascularization, #[600](#)
- Photocoagulation of Macular Drusen, #[607](#)
- Photodynamic Therapy for Choroidal Neovascularization, #[599](#)
- Phototherapeutic Keratectomy, #[597](#)

## Policy

### Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity Medicare HMO Blue<sup>SM</sup> and Medicare PPO Blue<sup>SM</sup> Members

Radial keratotomy is **NOT MEDICALLY NECESSARY** for the treatment of any medical condition.

Epikeratophakia may be **MEDICALLY NECESSARY** in the treatment of aphakia.

The following procedures are **INVESTIGATIONAL**:

- Keratomileusis
- Keratophakia.

The following procedures to correct disorders of refraction or accommodation, even with vision care rider are considered **NOT MEDICALLY NECESSARY**:

- Automated lamellar keratoplasty
- LASIK® for vision correction

- Mini-radial keratotomy
- Tectonic or optic keratoplasty
- Photorefractive keratectomy
- Conductive keratoplasty, **AND**
- Hexagonal keratoplasty.

Lamellar keratoplasty and tectonic or optic keratoplasty may be **MEDICALLY NECESSARY** for medical conditions such as corneal ulcers or trauma resulting in the formation of scar tissue.

All other refractive keratoplasty procedures listed under the Description section of the policy are **INVESTIGATIONAL**.

### 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.

#### Outpatient

<b>Commercial Managed Care (HMO and POS)</b>	No
<b>Commercial PPO and Indemnity</b>	No
<b>Medicare HMO Blue<sup>SM</sup></b>	No
<b>Medicare PPO Blue<sup>SM</sup></b>	No

### 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

CPT codes:	Code Description
65767	Epikeratoplasty

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

#### ICD-10 Diagnosis Codes

ICD-10-CM diagnosis codes:	Code Description
H27.00	Aphakia, unspecified eye
H27.01	Aphakia, right eye
H27.02	Aphakia, left eye

H27.03	Aphakia, bilateral
Q12.3	Congenital aphakia

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

CPT codes:	Code Description
65710	Keratoplasty (corneal transplant); anterior lamellar

The following CPT codes are considered investigational for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

### CPT Codes

CPT codes:	Code Description
65760	Keratomileusis
65765	Keratophakia
65771	Radial keratotomy

### Description

- Refractive keratoplasty is a generic term that includes all surgical procedures on the cornea to improve vision by changing the refractive index of the corneal surface. Refractive keratoplasties include the following surgeries:
- Radial Keratotomy (RK) is a surgical correction for myopia (nearsightedness). Using a high-powered microscope, the physician places microincisions (usually eight or fewer) on the surface of the cornea in a pattern much like the spokes of a wheel. The incisions are very precise in terms of depth, length, and arrangement. The microincisions allow the central cornea to flatten, thus reducing the convexity of the cornea, which produces an improvement in vision.
- Photorefractive Keratectomy (PRK) uses a computerized laser to correct myopia (nearsightedness). The excimer laser is well-suited for cornea reshaping, because the removal of just tiny amounts of tissue can produce the results needed to correct nearsightedness. The excimer laser produces a beam of ultraviolet light in pulses that last only a few billionths of a second. Each pulse removes a microscopic amount of tissue by evaporating it, producing very little heat and usually leaving underlying tissue almost untouched. Overall, the surgery takes approximately 10–20 minutes; however, the use of the laser beam lasts only 15–40 seconds.
- Automated Lamellar Keratoplasty (ALK) can correct hyperopia. For the treatment of moderate farsightedness, the cornea is opened across the top to form a type of “cap,” using an automated instrument. When the “cap” is positioned back into its original location on top of the eye, microscopic scar tissue is formed, causing the “cap” to bulge out, thus correcting the overly flattened cornea that is associated with hyperopia. Almost like Velcro, the cornea and “cap” adhere to each other, eliminating the need for sutures. Normally, one eye is treated at a time, with about 3 to 4 weeks allowed between each eye surgery. To ease any discomfort, the eye is anesthetized with special drops, and the patient is given a mild sedative to remain relaxed and aware throughout the procedure.
- Minimally Invasive Radial Keratotomy (mini-RK) is intended in cases of myopia, to alter the cornea's shape and consequently the refraction by reducing the millimeters of cornea that are incised.

- Hexagonal Keratotomy is a form of refractive corneal surgery used to treat naturally occurring hyperopia (far-sightedness) and presbyopia (loss of accommodation in the eyes in advancing age) following radial keratotomy. A hexagonal pattern of intersecting incisions in the cornea is used in performing this procedure.

All of the above procedures can be used alone or in combination to produce the optimal result for a given patient.

- Keratomileusis involves removing, freezing, and lathing the patient's cornea, followed by its replacement onto the corneal bed. This surgery has been proposed for myopia and aphakic hyperopia (aphakia is the absence of the lens of the eye).
- Keratophakia involves removing the patient's cornea followed by placement of a lathed donor cornea beneath the recipient's cornea, which is then reattached. This surgery has been proposed for aphakic hyperopia.
- Epikeratophakia (lamellar keratoplasty) involves suturing a prelathed donor cornea onto the surface of the recipient's cornea. This surgery has been proposed as a means of correcting adult and pediatric aphakia, keratoconus (a conical protrusion of the cornea, caused by thinning of the stroma, and resulting in major changes in the refractive power of the eye), and myopia.

## **Policy History**

Date	Action
12/2015	Added coding language.
8/2014	New medically necessary indications described. Coding information clarified. Effective 8/1/2014.
4/2014	Medical policy ICD10 remediation: Formatting, editing and coding updates. No changes to policy statements.

## **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**

1. TEC Assessment 1988
2. TEC Assessment 1986