Clinical Policy: Refractive Surgery

Reference Number: CP.VP.52
Last Review Date: 01/2022

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Refractive surgery includes procedures designed to eliminate or reduce the need for glasses or contact lenses. This policy describes the medical necessity requirements for refractive surgery.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® (Centene) that refractive surgery is **not medically necessary**.

Background

Refractive surgery is a method of modifying the refractive status of the eye, and it includes various elective procedures. Procedures that involve altering the cornea are collectively referred to as keratorefractive surgery, refractive keratoplasty, or corneal refractive surgery. Other refractive surgery procedures include placing a phakic intraocular lens (IOL) implant in front of the crystalline lens or replacing the crystalline lens by means of refractive lens exchange. Refractive surgery is more costly, invasive and bears a higher risk of complications than managing refractive error with glasses or contact lenses. Therefore, the selection of refractive surgery over glasses or contact lenses is considered elective and not medically indicated.

The most frequently performed procedures for low to moderate myopia utilize the excimer laser, which was first approved for this purpose by the FDA in 1995. A surface ablation technique, photorefractive keratectomy (PRK), was the first procedure performed; subsequently, LASIK has become the most commonly performed keratorefractive surgery. Other keratorefractive procedures to correct low to moderate myopia include variations of PRK called laser epithelial keratomileusis (LASEK) and epi-LASIK, femtosecond intrastromal lenticular extraction, insertion of intrastromal corneal ring segments, and radial keratotomy (RK).

Photo Refractive Keratectomy (PRK) is used to reduce or correct mild to moderate myopia. PRK utilizes an excimer laser, which produces a highly concentrated beam of light, which flattens the front surface of the cornea by removing micro- thin layers of tissue. Excimer laser-based procedures can have less predictable results when used for correcting high myopia than when used for low to moderate myopia. Alternative procedures to correct high myopia include SMILE, refractive lens exchange, and phakic IOL implantation. Photorefractive keratectomy for hyperopia (H-PRK) reduces hyperopic refractive errors. Lower degrees of hyperopia (0 to +3.50 D) can be corrected with better predictability than higher hyperopic errors

Laser Assisted In Situ Keratomileusis (LASIK) is a procedure that combines two sophisticated techniques of surgery to correct refractive errors. First a microkeratome is used to create a thin flap on the cornea; next an excimer laser is then used to sculpt the underlying cornea into a new shape to correct refractive errors. The laser used in these procedures is a “cool laser.” It does not burn tissue. The laser

vaporizes extremely small amounts of tissue with each pulse of the laser beam. This process allows extremely accurate reshaping or sculpting of the corneal surface.

Laser Epithelial Keratomileusis (LASEK) is a modification of PRK that attempts to preserve the epithelium. After dilute ethanol alcohol is applied to the corneal epithelium, an epithelial trephine and spatula are used sequentially to score, loosen, and roll up the epithelium, which remains attached at a nasal or superior hinge. Photoablation is then performed, and the epithelium is unrolled back over the central corneal stroma. An alternative surface ablation procedure to LASEK is epi-LASIK. Instead of using alcohol to loosen the epithelium, an epikeratome is used to dissect an epithelial sheet from the Bowman membrane. The epikeratome is similar in design to a mechanical microkeratome used for LASIK.

CPT® Codes	Description
65760	Keratomileusis
65765	Keratophakia
65767	Epikeratoplasty
65771	Radial keratotomy
65772	Corneal relaxing incision for correction of surgically induced astigmatism
65775	Corneal wedge resection for correction of surgically induced astigmatism

HCPCS Codes	Description
S0596	Phakic intraocular lens for correction of refractive error
S0800	Laser in situ keratomileusis (LASIK)
S0810	Photorefractive keratectomy (PRK)
S0812	Phototherapeutic keratectomy (PTK)

Reviews, Revisions, and Approvals	Date	Approval Date
Annual Review	12/2019	12/2019
Converted to new template; Added CPT/HCPCS coding; Updated background.	07/2020	10/2020
Annual Review	12/2020	12/2020
Annual Review	12/2021	01/2022

References

1. American Academy of Ophthalmology (AAO) Refractive Management/Intervention Panel. Preferred Practice Pattern® Guidelines. Refractive Errors & Refractive Surgery. San Francisco, CA: American Academy of Ophthalmology 2017, https://www.aao.org/preferred-practice-pattern/refractive-errors-refractive-surgery-ppp-2017.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of

medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.