KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington

Clinical Review Criteria

Corneal Procedures for Correction of Refractive Errors

- LASIK (Laser Assisted In-situ Keratomileusis)
- PTK (Phototherapeutic Keratectomy)

Criteria

For Medicare Members

Source	Policy
CMS Coverage Manuals	None
National Coverage Determinations (NCD)	Refractive Keratoplasty (80.7)
Local Coverage Determinations (LCD)	None
Local Coverage Article	None

For Non-Medicare Members

Corneal Procedures for the correction of refractive errors (including but not limited to LASIK) are covered when **All of the following** conditions are met:

1. Astigmatism and/or anisometropia have been surgically induced.
2. Patient is unable to wear glasses or contact lenses after surgery due to anisometropia (eyes having unequal refractive power) and/or high astigmatism.
3. Documented attempts to correct the surgical error with historical means of refraction and/or contact lens fitting.
4. There must be 2.5 diopter or more increase in astigmatism and/or anisometropia from the pre to the postoperative state.
5. Patient must express some functional disability due to the increased astigmatism and the surgeon must have a reasonable expectation that the laser will improve the patient's function.
6. The patient's primary problem is not corneal graft rejection or multiple failures when comfort may be the goal, not vision improvement.
7. The equipment used is FDA approved and the procedure is performed by an ophthalmologist trained to use the equipment.
   Relative contraindications include:
   a. Poorly controlled autoimmune disease
   b. Immunosuppressive medications
   c. Keratoconus and other corneal ectasias
   d. History of keloid formation
   e. Coexisting ocular disease
   f. Unstable refractive error
   g. Underlying systemic disease affecting wound healing

Corneal Procedures for the correction of corneal lesions (including but not limited to Phototherapeutic Keratectomy (PTK)) are covered when the **ALL of the following** criteria are met:

1. It is being used to remove damaged and/or diseased tissue from the anterior surface of the cornea.
2. **ONE of the following** is true:
   a) The proposed treatment area is up to 300 microns thick or the cornea is at least 250 microns thick after ablation and other less invasive treatments are not possible or have failed (such as stromal puncture)

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b) The treatment of anterior corneal dystrophies, removal of scars and other opacities in the anterior third of the cornea and smoothing of irregular corneal surfaces to improve visual acuity and reduce pain associated with the corneal condition or improve the patient's ability to wear or tolerate spectacles or contact lenses.

3. And **None of the following** conditions exist:
   a) Active infections of the cornea
   b) Bullous keratopathy
   c) Deep pathology extending beyond the anterior third of the cornea
   d) Depressed scars
   e) Unstable keratometry
   f) Existing hyperopia

Photorefractive keratectomy (PRK) is considered cosmetic and is not covered.

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

The following information was used in the development of this document and is provided as background only. It is provided for historical purposes and does not necessarily reflect the most current published literature. When significant new articles are published that impact treatment option, Kaiser Permanente will review as needed. This information is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

Background

In 1995 the FDA approved the use of Excimer 193nm laser as an effective tool for performing phototherapeutic (PTK=correcting corneal pathology) and photorefractive (PRK=correcting visual abnormalities) keratectomy of PRK and PTK. In early 1996 Kaiser Permanente evaluated the use of this technology and its efficacy. Following that evaluation, it was recommended that Kaiser Permanente would provide PRK/LASIK as a non-covered service. However, in a few cases where traditional treatment options, including surgery, have failed and the only option available is PRK/LASIK.

Evidence and Source Documents

On March 13, 1996, The GHC Committee on Medically Emerging Technology (COMET) reviewed key articles and concluded that the recent FDA approved Excimer 193nm laser is an effective tool for performing phototherapeutic (PTK=correcting corneal pathology) and photorefractive (PRK=correcting visual abnormalities) keratectomy. In the case of photorefractive keratectomy, its use should be restricted to patients with low to moderate myopia (1 to 8 diopters of visual correction) until efficacy data becomes available for PRK in high myopes. For GHC patients, it was recommended that PTK for corneal pathology should be a covered service and that PRK for refractive errors should be a non-covered service.

Applicable Codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT® or HCPC Codes	Description
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
65760	Keratomileusis
S0800	Laser in situ keratomileusis (LASIK) ***S codes not covered by Medicare***
S0812	Phototherapeutic keratectomy (PTK) ***S codes not covered by Medicare***

Considered Cosmetic & Not Medically Necessary:

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CPT® or HCPC Codes	Description
S0810	Photorefractive keratectomy (PRK) ***S codes not covered by Medicare***

***Note:** Codes may not be all-inclusive. Deleted codes and codes not in effect at the time of service may not be covered.

****To verify authorization requirements for a specific code by plan type, please use the **Pre-authorization Code Check**.

Creation Date	Revision Dates	Date Last Revised
02/26/1998	08/03/2010[MDCRPC],06/7/2011[MDCRPC],04/03/2012[MDCRPC],05/01/2012[MDCRPC], 03/05/2013[MDCRPC],01/07/2014[MDCRPC], 11/04/2014[MPC], 09/01/2015[MPC], 07/05/2016[MPC], 05/02/2017[MPC], 03/06/2018[MPC], 02/05/2019[MPC], 02/04/2020[MPC], 02/02/2021[MPC], 02/07/2023[MPC] , 08/06/2024[MPC]	01/16/2025

[MDCRPC] Medical Director Clinical Review and Policy Committee
[MPC] Medical Policy Committee

Revision History	Description
02/16/2016	Added additional keratoplasty codes
02/16/2022	Updated applicable codes
1/16/2025	Updated name of policy.

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