Medical Necessity Guidelines: Laser Vision Correction Surgery

Effective: May 10, 2017


Applies to:
☒ Tufts Health Plan Commercial Plans products; Fax: 617.972.9409
☒ Tufts Health Public Plans products
☐ Tufts Health Direct – Health Connector; Fax: 888.415.9055
☐ Tufts Health Together – A MassHealth Plan; Fax: 888.415.9055
☐ Tufts Health Unify – OneCare Plan; Fax: 781.393.2607
☒ Tufts Health RITogether — A Rhode Island Medicaid Plan; Fax: 857.304.6404
☒ Tufts Health Freedom Plan products; Fax: 617.972.9409

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW
This guideline is for the review of medically necessary laser vision correction surgery. There are several types of this surgery including:

- Laser-in-situ keratomileusis (LASIK): A laser procedure to correct low to high myopia, with or without astigmatism and low to high hyperopia in otherwise healthy eyes, to replace contact lenses or eye glasses.
- Phototherapeutic keratectomy (PTK): An excimer laser procedure to treat corneal conditions usually associated with disease or injury.

COVERAGE GUIDELINES

Phototherapeutic keratectomy (PTK)
Tufts Health Plan may authorize the coverage of phototherapeutic keratectomy when the Member requires the procedure for the treatment of one of the following documented conditions:

- Corneal scars
- Degeneration and dystrophy involving the superficial layer of the cornea
- Anterior basement dystrophy and recurrent epithelial erosion that is recalcitrant to standard therapeutic regimens

Laser-in-situ keratomileusis (LASIK)
Tufts Health Plan may authorize the coverage of Laser-in-situ keratomileusis for Members who have one of the following conditions and are contact lens intolerant:

- Anisometropia resulting in a 2 diopter difference following conventional cataract surgery, anterior segment glaucoma surgery or corneal transplant.
- Astigmatism resulting in a 2 diopter difference following conventional cataract surgery, anterior segment glaucoma surgery or corneal transplant.

LIMITATIONS

- Tufts Health Plan will not cover laser vision correction surgery for cosmetic and/or convenience purposes, i.e., to replace the need to wear eyeglasses or contact lenses.
- Tufts Health Plan will not cover photorefractive keratectomy. Photorefractive keratectomy (PRK) is an excimer laser procedure to correct mild to moderate myopia in otherwise healthy eyes, to replace contact lenses or eye glasses.
- Tufts Health Plan will not cover refractive eye surgery (including radial keratotomy) for conditions which can be corrected by means other than surgery. Radial keratotomy is a surgical procedure designed to correct myopia (nearsightedness) by flattening the cornea with incisions.

CODES
The following HCPCS/CPT codes require prior authorization:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>65772</td>
<td>Corneal relaxing incision for correction of surgically induced astigmatism</td>
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Laser Vision Correction Surgery

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>65775</td>
<td>Corneal wedge resection for correction of surgically induced astigmatism</td>
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<tr>
<td>S0800</td>
<td>Laser in situ keratomileusis (LASIK)</td>
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<tr>
<td>S0812</td>
<td>Phototherapeutic keractectomy (PTK)</td>
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The following HCPCS code will not be covered.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>S0810</td>
<td>Photorefractive keractectomy (PRK)</td>
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REFERENCES

APPROVAL HISTORY
March 5, 2007: Reviewed by the Clinical Coverage Criteria Committee

Subsequent endorsement date(s) and changes made:
- May 28, 2008: Reviewed and renewed without changes
- June 1, 2009: Reviewed and renewed without changes
- November 19, 2009: Administrative process updated
- May 2010: Reviewed at MSPAC, no changes
- November 1, 2011: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC), S0810 has been removed as a limitation and will be covered when meeting criteria for prior authorization
- August 8, 2012: Reviewed by IMPAC, removed photorefractive keractectomy code (S0810) from requiring prior authorization, moved to noncovered
- July 10, 2013: Reviewed by IMPAC, no changes
- February 19, 2014: Reviewed by IMPAC, clarified coverage of laser-in-situ keratomileusis (LASIK)
- June 11, 2014: Reviewed by IMPAC, renewed without changes
- May 13, 2015: Reviewed by IMPAC, renewed without changes
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- May 11, 2016: Reviewed by IMPAC, renewed without changes
- October 24, 2016: Reviewed by IMPAC. For effective date April 1, 2017, laser vision correction surgery for convenience purposes added to limitations.
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- May 10, 2017: Reviewed by IMPAC, renewed without changes

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION
Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member’s health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the our service area who are medical experts in the particular field, FDA and
other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Medical Necessity Guidelines apply to the fully insured Commercial and Medicaid products when Tufts Health Plan conducts utilization review unless otherwise noted in this guideline or in the Member’s benefit document, and may apply to Tufts Health Unify to the same extent as Tufts Health Together. This guideline does not apply to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options or to certain delegated service arrangements. For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates or other requirements will take precedence. For CareLinkSM Members, Cigna conducts utilization review so Cigna’s medical necessity guidelines, rather than these guidelines, will apply.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of these guidelines is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.