Medical Necessity Guidelines: Laser Vision Correction Surgery

Effective: March 18, 2020

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☒ No ☐**

Applies to:

COMMERCIAL Products

☒Tufts Health Plan Commercial products; Fax: 617.972.9409

☒Tufts Health Freedom Plan products; Fax: 617.972.9409

- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products

☒Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055

☒Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055

☒Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404

☒Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304

*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products

- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

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 performed beneath a very thin flap of the cornea, used to reshape the cornea and correct low to high myopia, with or without astigmatism, and low to high hyperopia in otherwise healthy eyes, replacing the need for contact lenses and/or eyeglasses.
- Photorefractive keratectomy (PRK): Photorefractive keratectomy is an excimer laser procedure performed directly on the corneal surface, used to reshape the cornea and to treat vision problems caused by refractive errors.
- Phototherapeutic keratectomy (PTK): An excimer laser procedure used to treat corneal conditions usually associated with disease or injury. PTK is not intended to decrease the need for glasses and/or contact lenses.
- Corneal relaxing incision and corneal wedge resection: Procedures used to correct surgically induced astigmatism.

CLINICAL COVERAGE CRITERIA

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

Corneal relaxing incision and corneal wedge resection

Tufts Health Plan may authorize the coverage of corneal relaxing incision or corneal wedge resection for Members with documented intolerance to contact lens when conventional cataract surgery, anterior

segment glaucoma surgery or corneal transplant has resulted in surgically induced astigmatism of 2 diopters or greater.

Laser-in-situ keratomileusis (LASIK) and Photorefractive keratectomy (PRK)
Tufts Health Plan may authorize the coverage of Laser-in-situ keratomileusis and photorefractive keratectomy for Members with documented intolerance to contact lens **and** one of the following conditions:

- 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 and/or contact lenses.
- Tufts Health Plan will not cover refractive eye surgery for conditions which can be corrected by means other than surgery.

CODES

The following HCPCS/CPT codes require prior authorization:

Code	Description
65772	Corneal relaxing incision for correction of surgically induced astigmatism
65775	Corneal wedge resection for correction of surgically induced astigmatism
S0800	Laser in situ keratomileusis (LASIK)
S0810	Photorefractive keratectomy (PRK)
S0812	Phototherapeutic keratectomy (PTK)

REFERENCES

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2. Eye Surgery Education Council. Glossary. Retrieved on March 2, 2007 from eyesurgeryeducation.org/Glossary.html
3. Hayes, Inc. Crystalens® accommodating intraocular lens (eyeoinics, inc.) for correction of post-cataract aphakia. Hayes Search and Summary. August 23, 2005.
4. Hayes, Inc. Intacs™ (Addition Technology Inc.) for keratoconus and vision correction. Hayes Health Technology Brief. July 17, 2005.
5. Hayes, Inc. Intrastromal corneal ring segments (ICRS) for vision correction. Hayes Alert. 2005: 8(7).
6. Siganos, C.S., Kymionis, G.D., Kartakis, N., et al. Management of keratoconus with Intacs. American Journal of Ophthalmology. 2003; 135(1):64-70.
7. Hersh, P.S., Brint, S.F., et. al. Photorefractive keratectomy versus laser in situ keratomileusis for moderate to high myopia. Ophthalmology. 1998; 105 (8): 1512–1523.
8. Lee, J.B., Kim J.S., et. al. Comparison of Two Procedures: Photorefractive Keratectomy Versus Laser In Situ Keratomileusis for Low to Moderate Myopia. J Ophthalmol 2001; 45:487–491.
9. Jackson W.B. (2004) Photorefractive Keratectomy: Indications, Surgical Techniques, Complications and Results. In: Bille J.F., Harner C.F.H., Loesel F.F. (eds) Aberration-Free Refractive Surgery. Springer, Berlin, Heidelberg.

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 , 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 keratectomy 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
- April 11, 2018: Reviewed by IMPAC, renewed without changes
- June 13, 2018: Reviewed at IMPAC. For effective date August 1, 2018, PRK removed from limitations section and may be covered with prior authorization. Criteria added for corneal relaxing incision and corneal wedge resection.
- October 2018: Template and disclaimer updated
- March 20, 2019: Reviewed by IMPAC, renewed without changes
- March 18, 2020: Reviewed by IMPAC, renewed without changes
- March 25, 2020: Unify fax number updated

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 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.

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.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline 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