PEHP Health & Benefits

CLINICAL SERVICES POLICY AND PROCEDURES

VISION SURGERY and VISION SCREENING for MEDICAL DISEASES or INJURY

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I. POLICY STATEMENT

A. Post-Cataract Post-Transplant Corneal Surgery

PEHP considers correction of surgically induced astigmatism with a corneal relaxing incision (including limbal relaxing incisions) or corneal wedge resection medically necessary if the member had previous penetrating keratoplasty (corneal transplant) within the past 60 months or cataract surgery within the last 36 months and both of the following criteria are met:

1. The degree of astigmatism must be 3.00 diopters or greater; *and*
2. The member must be intolerant of glasses or contact lenses.

Note: Correction of surgically induced astigmatism with a corneal relaxing incision (including limbal relaxing incisions) or corneal wedge resection is covered when medical necessity criteria are met, even if the member's plan excludes refractive surgery.

B. Phototherapeutic Keratectomy

PEHP considers phototherapeutic keratectomy (PTK) medically necessary for members with *any* of the following corneal conditions:

1. Corneal scars and opacities (including post-traumatic, post-infectious, post-surgical, and secondary to pathology); *or*
2. Epithelial membrane dystrophy; *or*
3. Irregular corneal surfaces due to Salzmann's nodular degeneration or keratoconus nodules; *or*
4. Recurrent corneal erosions when more conservative measures (e.g., lubricants, hypertonic saline, patching, bandage contact lenses, gentle debridement of severely aberrant epithelium) have failed to halt the erosions; *or*
5. Superficial corneal dystrophy (including granular, lattice, and Reis-Bückler's dystrophy).

PEHP considers PTK experimental and investigational for the treatment of infectious keratitis and all other indications because it has not been shown to be safe and effective for these indications.

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, whereas 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.

C. Refractive Surgery

Note: PEHP's standard HMO benefit plan excludes coverage of "radial keratotomy, including related procedures designed to surgically correct refractive errors". Traditional benefit plans generally exclude coverage for services "for or related to any eye surgery mainly to correct refractive errors". These exclusions apply to radial keratotomy (RK), astigmatic keratotomy, PRK, photoastigmatic keratectomy (PARK), laser-in-situ keratomileusis (LASIK), keratomileusis, epikeratophakia, implantation of intrastromal corneal ring segments, and other refractive surgical procedures.

For the U.S. Food and Drug Administration (FDA)-approved indications and indications accepted by the American Academy of Ophthalmology (AAO), refractive surgical procedures are considered not medically necessary, because spectacles or contact lenses have been shown to provide more accurate corrections of refractive errors than refractive surgery.

- **Radial keratotomy (RK)** is not considered medically necessary for the treatment of myopia ranging from -2.00 to -8.00 diopters because this refractive error can be corrected satisfactorily with eyeglasses or contact lenses. Radial keratotomy

is considered investigational for treatment of myopia greater than -8.00 diopters and all other refractive errors because its effectiveness for these indications has not been established.

- **Mnimally invasive radial keratotomy (Mini-RK)** is considered experimental and investigational for the treatment of myopia and other indications.

- **Astigmatic keratotomy (AK)** (arcuate incision, corneal wedge resection) is considered medically necessary when performed for the correction of surgically induced astigmatism following medically indicated cataract removal or corneal transplant surgery. Astigmatic keratotomy is considered investigational for treatment of all other refractive errors because its effectiveness for these indications has not been established.

- **Hexagonal Keratotomy (HK)** is considered experimental and investigational the treatment of hyperopia, or presbyopia following radial keratotomy because its effectiveness for these indications has not been established.

- **Laser-in-situ keratomileusis (LASIK)** is considered not medically necessary for treatment of myopia between -1.0 and -15.0 diopters, with or without astigmatism up to 5.0 diopters, because this can be corrected satisfactorily with eyeglasses or contact lenses. Laser-in-situ keratomileusis is also considered not medically necessary for treatment of hyperopia up to + 6.0 diopters with or without astigmatism up to 5 diopters. Laser-in-situ keratomileusis is considered investigational for treatment of myopia greater than -15.0 diopters or hyperopia greater than + 6.0 diopters, for treatment of persons with astigmatism greater than 5.0 diopters, and for all other refractive errors. This clinical policy is based on the FDA-approved indications for LASIK.

- **Standard keratomileusis (ALK)** is considered investigational for treatment of all refractive errors because its effectiveness for trestment of refractive errors has not been proven.

- **Epikeratoplasty (or epikeratophakia)** is considered medically necessary for the following indications: (i) for the treatment of childhood aphakia since contact lenses are difficult for children to use and intraocular lens implants may result in long-term complications in children; (ii) for the treatment of scarred corneas and corneas affected with endothelial dystrophy; (iii) for the treatment of adult aphakia in circumstances where secondary implantation of an intra-ocular lens is not feasible because reentering the eye could affect outcome (e.g., vitreous in the anterior chamber, history of uveitis, disorganized anterior chamber that cannot support an intraocular lens, significant corneal endothelial disease, or gross corneal irregularity after trauma). This procedure is considered investigational for correction of refractive errors and for all other cases of adult aphakia.

- **Keratophakia** is considered investigational for correction of refractive errors because its effectiveness for the treatment of refractive errors has not been proven.

- **Lamellar keratoplasty (non-penetrating keratoplasty)** is considered medically necessary for treatment of corneal diseases, including scarring, edema, thinning, distortion, dystrophies, degenerations, and keratoconus. It is considered investigational for pterygium and when performed solely to correct astigmatism and other refractive errors because its effectiveness for these indications has not been established.

- **Penetrating keratoplasty (PK) (corneal transplantation, perforating keratoplasty)** is considered medically necessary for treatment of corneal diseases, including: (i) to improve poor visual acuity caused by an opaque cornea; (ii) to remove active corneal disease, such as persistent severe bacterial, fungal, or amebic inflammation of the cornea (keratitis) after appropriate antibiotic therapy; (iii) to restore altered corneal structure or to prevent loss of the globe that has been punctured; and (iv) to treat corneal diseases, including bullous keratopathy, keratoconus, corneal scar with opacity, keratitis, corneal transplant rejection, Fuch's dystrophy, corneal degeneration, other corneal dystrophies, corneal edema, and herpes simplex keratitis. Penetrating keratoplasty is considered investigational when performed solely to correct astigmatism or other refractive errors because its effectiveness for these indications has not been established. Tissue procurement, preservation, storage and transportation associated with medically necessary corneal transplantation are also considered medically necessary. Note: Intralase-Enabled Keratoplasty (IEK) is an accepted method of penetrating keratoplasty; there is no difference in laser versus cold knife outcomes.

- **Photorefractive keratectomy (PRK)** and **Photoastigmatic keratectomy (PARK or PRK-A)** are considered not medically necessary for individuals with hyperopia of up to 6.0 diopters and myopia of up to -10.0 diopters, with or without astigmatism up to 4.0 diopters, because the refractive corrections achieved with PRK and PARK are less precise than that achieved by eyeglasses or contact lenses. Photorefractive keratectomy and PARK are considered investigational for individuals with hyperopia greater than 6.0 diopters, myopia greater than -10.0 diopters, astigmatism greater than 4.0 diopters, and for all other refractive errors. This policy is based on the FDA approved indications for PRK and PARK.

- **Intrastromal corneal ring segments (INTACS)** (Addition Technology, Sunnyvale, CA) are considered not medically necessary for adults with mild myopia (from -1.0 to -3.0 diopters) that have less than 1 diopter of astigmatism. PEHP considers intrastromal corneal ring segments experimental and investigational for children, for persons with moderate-to- severe myopia (greater than -3.0 diopters), for persons with more than 1 diopter of astigmatism, and for hyperopia because their effectiveness for these indications has not been established. Intrastromal corneal ring segments are considered medically necessary for reduction or elimination of myopia or astigmatism in persons with keratoconus or pellucid marginal degeneration who are no longer able to achieve adequate vision using contact lenses or spectacles and for whom corneal transplant is the only remaining option, in persons with a clear central cornea and corneal thickness of 450 microns or greater at the proposed incision site. Intrastromal corneal ring segments are considered experimental and investigational for other indications because their effectiveness for indications other than the ones listed above has not been established. Note: Where indicated for keratoconus or pellucid marginal degeneration, INTACS are not excluded from coverage under plans that exclude coverage of refractive surgery. Please check benefit plan descriptions.

- **Conductive Keratoplasty** is considered not medically necessary for the treatment of individuals who are at least 40 years of age, who have mild-to- moderate hyperopia (0.75 D to 3.25 D), who have 0.75 D or less astigmatism, and whose eyesight has changed very little over the previous 12 months (as demonstrated by a change of less than 0.50 D in refraction). Conductive keratoplasty is considered experimental and investigational for keratoconus and all other indications because its effectiveness for these indications has not been established.

- **Methods of thermokeratoplasty** other than conductive keratoplasty (see above), such as the superficial treatment of Gassett and Kaufman for keratoconus, holmium:YAG laser thermokeratoplasty (laser thermokeratoplasty or LTK), or the hot needle of Fyodorov, are considered experimental and investigational for treatment of refractive errors, keratoconus, and all other indications because their effectiveness for these indications has not been established.

- **Orthokeratology** is considered investigational for correction of refractive errors and all other indications because its effectiveness for these indications has not been established.

- **Scleral Expansion Surgery** is considered experimental and investigational for presbyopia and all other indications because its effectiveness for these indications has not been established.

- **Intraocular lens implants (clear lens extraction)** (aphakic intra-ocular lenses (IOLs)) are considered not medically necessary for correction of presbyopia, hyperopia, and myopia because these refractive errors can be corrected satisfactorily with eyeglasses or contact lenses. Intra-ocular lens implants are considered medically necessary for persons with aphakia

- **Implantable contact lenses (without lens extraction)** (phakic IOLs) (e.g., the Artisan [model 204 and 206] phakic IOL, also known as the Verisye [e.g., VRSM5US and VRSM6US] phakic IOL, and the Collamer lens [e.g., Visian ICL]) is considered not medically necessary for severe myopia because these refractive errors can be corrected satisfactorily with eyeglasses or contact lenses. The Artisan (model 204 and 206) phakic IOL is considered not medically necessary for: (i) the reduction or elimination of myopia in adults with myopia ranging from -5 to -20 diopters with less than or equal to 2.5 diopters of astigmatism at the spectacle plane and whose eyes have an anterior chamber depth (acd) greater than or equal to 3.2 millimeters; and, (ii) individuals with documented stability of refraction for the prior 6 months, as demonstrated by spherical equivalent change of less than or equal to 0.50 diopters. The Visian ICL is considered not medically necessary for adults 21 to 45 years of age to (i) correct myopia ranging from -3.0 diopters to less than or equal to -15.0 diopters with less than or equal to 2.5 diopters of astigmatism at the spectacle plane; (ii) to reduce myopia ranging from greater than -15.0 diopters to -20.0 diopters with less than or equal to 2.5 diopters of astigmatism at the spectacle plane; and (iii) with an anterior chamber depth (acd) 3.00 mm or greater, and a stable refractive history within 0.5 diopter for 1 year prior to implantation. Phakic IOLs are considered experimental and investigational for all other indications because their effectiveness for indications other than the ones listed above has not been established.

D. Contact Lenses for Aphakia

Aphakia is the absence of the lens of the eye, due to surgical removal, a perforating wound or ulcer, or congenital anomaly. It causes a loss of accommodation, hyperopia, and a deep anterior chamber. Complications include detachment of the vitreous or retina, and glaucoma.

Contact lenses may be approved for some members who have had cataract surgery. A cataract is a clouding that develops in the crystalline lens of the eye or in its envelope, varying in degree from slight to complete opacity and obstructing the passage of light. Early in the development of age-related cataract the power of the lens may be increased, causing near-sightedness (myopia) and the gradual yellowing and opacification of the lens may reduce the perception of blue colors. Cataracts typically progress slowly to cause vision loss and may potentially create blindness if untreated.

PEHP covers contact lenses under its medical plan for infants and children who have congenital or acquired aphakia. If cataract removal surgery is performed on one eye, PEHP will cover one contact lens initially following surgery, and will cover three additional replacement lenses each year until the child's fifth birthday. If cataract removal surgery is performed on both eyes, PEHP will cover two lenses initially, and up to six replacement lenses annually until the child reaches his or her fifth birthday.

E. Keratoprosthesis (Artificial Cornea):

The Boston Keratoprosthesis (Boston KPro) may be considered medically necessary for corneal blindness in members who meet the following medical necessity criteria:
The cornea is severely opaque and vascularized, with vision less than 20/400 in the affected eye and lower than optimal vision in the opposite eye; *and*
The member has had 2 or more prior failed penetrating keratoplasties (corneal transplants), with poor prognosis for further grafting; *and*
The member does not have end-stage glaucoma or retinal detachment.

PEHP considers the Boston KPro keratoprostheses experimental and investigational for all other indications because their effectiveness for indications other than the one listed above has not been established.

PEHP considers the AlphaCor keratoprosthesis experimental and investigational because of insufficient evidence of its effectiveness.

F. Endothelial Keratoplasty:

PEHP considers endothelial keratoplasty (Descemet's stripping endothelial keratoplasty (DSEK), Descemet's stripping automated endothelial keratoplasty (DSAEK), and Descemet's membrane endothelial keratoplasty (DLEK) medically necessary for the following indications in persons with endothelial failure and otherwise healthy corneas:

1. Bullous keratopathy;
2. Corneal edema;
3. Endothelial corneal dystrophy and other posterior corneal dystropies;
4. Mechanical complications due to corneal graft or ocular lens prostheses;
5. Rupture of Descemet's membrane.

PEHP considers endothelial keratoplasty procedures experimental and investigational for conditions with concurrent endothelial disease and anterior corneal disease, including anterior corneal dystrophies, anterior corneal scars from trauma or prior infection, ectatic conditions of the cornea such as keratoconus, pellucid marginal degeneration and ectasia after previous laser vision correction surgery, and for all other indications (e.g., iris atrophy) because their effectiveness for these indications has not been established.

G. Collagen Cross-Linking for Keratoconus

PEHP considers epithelium-off photochemical collagen cross-linkage using riboflavin and ultraviolet A medically necessary for keratoconus and keratectasia. Photochemical collagen cross-linkage is considered experimental and investigational for all other indications because its effectiveness for other indications has not been established. Epithelium-on (transepithelial) collagen cross-linkage is considered experimental and investigational for keratoconus, keratectasia, and all other indications. Performance of photochemical collagen cross-llinkage in combination with other procedures (CXL-plus) (e.g., intrastromal corneal ring segments, PRK or phakic intra-ocular lens implantation) is considered experimental and investigational.

H. Routine and Extended Vision Screening for Medical Diseases or Injury

1. Routine Vision Services

a. Routine eye examinations:
Routine eye examinations are covered according to plan/benefit limits when performed by a licensed optometrist or ophthalmologist.

As part of a routine eye exam the provider will typically test:

- Eyelid health and function

- Coordination of eye muscles
- Pupil response to light
- Side, or peripheral vision
- Intraocular pressure, the pressure inside the eye
- Color perception
- Anterior segment of the eye, the area in front of the lens, including the cornea and iris
- The interior and back of the eye, including the retina

Screening of all children for visual or ocular disorders (e.g., pediatric amblyopia and strabismus) at each preventive care visit beginning at birth is considered ***medically necessary.***

Vision screenings conducted by objective, standardized testing (e.g., Snellen letters, Snellen numbers, the tumbling E test, or the HOTV test) at 3, 4, 5, 10, 12, 15, and 18 years of age is considered ***medically necessary.***

Routine screening among the elderly using Snellen acuity testing and Glaucoma testing is considered ***medically necessary.***

Refractive examinations to determine the need for glasses and/or contacts are not considered vision screening.

b. Non-routine eye examination or extended vision testing:

In all instances, extended ophthalmologic tests or screening (92283, 92284) must be medically necessary. To establish medical necessity, a serious ophthalmologic condition must exist, or be suspected, based on routine ophthalmological tests and require further detailed study. Extended vision tests must add information not available for the standard vision examination and/or information that will demonstrably affect the treatment plan. It is not necessary, for example, to confirm information already available by other means. When other routine vision tests have been performed, extended vision testing is not necessary unless there is a reasonable medical expectation that the services might provide additive (non-duplicative) information.

2. Extended Vision Services

a. Fundus Photography

PEHP considers fundus photography medically necessary for any of the following indications:

- Abnormal electro-oculogram (EOG)
- Abnormal oculomotor studies
- Abnormal retinal function studies
- Abnormal visually evoked potential
- Benign neoplasm of choroid, cranial nerves, eyeball, or retina
- Carcinoma in situ of eye
- Chorioretinal inflammation, scars, and other disorders of choroid
- Color vision deficiencies
- Congenital anomalies of posterior segment of eye
- Congenital rubella
- Diabetes mellitus (diabetic retinopathy)
- Disorders of aromatic amino-acid metabolism affecting the fundus
- Disorders of globe
- Disorders of optic nerve and visual pathways
- Endophthalmitis
- Glaucoma and glaucoma suspects
- Hamartoses involving the eye
- Histoplasmosis
- Human immunodeficiency virus (HIV) disease
- Lupus erythematosus
- Malignant neoplasm of eye
- Monitoring of members for toxicity by anti-malarials such as chloroquine (Aralen), hydroxychloroquine (Plaquenil) and drugs acting on other blood protozoa
- Multiple sclerosis
- Penetration of eyeball with magnetic or non-magnetic foreign body
- Peters anomaly

- Pseudotumor cerebri
- Retinal detachment and defects
- Rheumatoid arthritis and other inflammatory polyarthropathies
- Sickle-cell anemia
- Syphilitic retrobulbar neuritis
- Systemic lupus erythematosus
- Toxoplasmosis
- Tuberous sclerosis
- Other retinal disorders where the results of fundus photography will change the treatment of the member.

b. Extended Ophthalmoscopy

PEHP considers extended ophthalmoscopy with a detailed retinal drawing for evaluation of the posterior portion of the eye following routine ophthalmoscopy medically necessary for *any*of the following indications:

- Blunt injury to the eye or periorbital structures; *or*
- Chorioretinitis, chorioretinal scars or choroidal degeneration, dystrophies, hemorrhage and rupture, or detachment; *or*
- Choroidal nevus being evaluated for malignant transformation; *or*
- Degenerative disorders of the globe; *or*
- Diabetic retinopathy (i.e., background retinopathy or proliferative retinopathy retinal vascular occlusion, or separation of the retinal layers); *or*
- Disorders of the vitreous body (i.e., vitreous hemorrhage or posterior vitreous detachment); *or*
- High axial length myopia (-6.00 Diopters or less [toward -10.00 D]); *or*
- High-risk medication for retinopathy or optic neuropathy; *or*
- Macular degeneration; *or*
- Malignant neoplasm of the retina or choroid; *or*
- Metamorphopsia; *or*
- Optic atrophy associated with a progressive and potentially reversible cause (e.g., glaucoma); *or*
- Penetrating wound to the orbit resulting in the retention of a foreign body in the eye; *or*
- Posterior scleritis; *or*
- Retained (old) intra-ocular foreign body, either magnetic or non-magnetic; *or*
- Retinal defects without retinal detachment; *or*
- Retinal detachment, with or without retinal defect; *or*
- Retinal edema; *or*
- Retinal hemorrhage, ischemia, exudates and deposits, hereditary retinal dystrophies or peripheral retinal degeneration; *or*
- Retinopathy of prematurity; *or*
- Retinoschisis and retinal cysts; *or*
- Sudden visual loss or transient visual loss; *or*
- Suspected endophthalmitis as evidenced by severe pain, redness, photophobia, and profound loss of vision; *or*
- Symptoms suggestive of retinal defect; *or*
- Systemic disorders associated with retinal pathology; *or*
- Uncontrolled glaucoma or glaucoma suspect; *or*
- Vogt-Koyanagi syndrome characterized by bilateral uveitis, dysacousia, meningeal irritation, whitening of patches of hair (poliosis), vitiligo, and retinal detachment.

Note: Extended ophthalmoscopy with a detailed retinal drawing for evaluation of the posterior portion of the eye is considered not medically necessary when initial routine ophthalmoscopy showed normal clinical findings.

PEHP considers repeat extended ophthalmoscopy medically necessary when there is a change in signs, symptoms or condition for indications (listed in the afore-mentioned policy section) that may progress.

PEHP considers extended ophthalmoscopy with a detailed retinal drawing experimental and investigational for the following indications because its effectiveness for these indications has not been established (not an all-inclusive list):

a. Congenital hypertrophy of the retinal pigment epithelium
b. Monitoring of fingolimod (Gilenya) therapy

c. Monitoring methotrexate or tamoxifen therapy
d. Neurodegenerative disorders/diseases (e.g., Alzheimer's disease, amyotrophic lateral sclerosis, Friedreich's ataxia, Huntington's disease, Lewy body disease, multiple-system atrophy, Parkinson's disease, and spinal muscular atrophy)
e. Noonan's syndrome
f. Ophthalmic artery aneurysm
g. Optic neuritis
h. Pseudotumor cerebri (orbital pseudotumor)
i. Retinal angioma
j. Screening for retinoblastoma
k. Sickle cell disease
l. Staphyloma posticum (posterior staphyloma)

II. CODES

CPT Codes / HCPCS Codes	
Post-Cataract Post-Transplant Corneal Surgery:	
CPT codes covered if selection criteria are met:	
65772	Corneal relaxing incision for correction of surgically induced astigmatism
65775	Corneal wedge resection for correction of surgically induced astigmatism
Other CPT codes related to the policy:	
65750 - 65755	Keratoplasty (corneal transplant); penetrating (in aphakia or pseudoaphakia)
65770	Keratoprosthesis
Phototherapeutic Keratectomy:	
Other CPT codes related to the policy:	
65760	Keratomileusis
HCPCS codes covered if selection criteria are met:	
S0812	Phototherapeutic keratectomy (PTK)
Refractive Surgery:	
Radial keratotomy:	
CPT codes covered if selection criteria are met:	
65771	Radial keratotomy
Minimally invasive radial keratotomy **no specific code**:	
Astigmatic keratotomy (AK):	
CPT codes covered if selection criteria are met:	
65772	Corneal relaxing incision for correction of surgically induced astigmatism
65775	Corneal wedge resection for correction of surgically induced astigmatism
Other CPT codes related to the policy:	
65400 - 65600	Cornea excision, removal or destruction, or cryotherapy of lesion on cornea
Hexagonal keratotomy:	
No specific code	
Laser in-situ keratomileusis:	
CPT codes covered if selection criteria are met:	
65760	Keratomileusis
HCPCS codes covered if selection criteria are met:	
S0800	Laser in situ keratomileusis (LASIK)
Standard keratomileusis (ALK):	

CPT codes not covered for indications listed in the policy:	
65760	Keratomileusis
Epikeratoplasty (or epikeratophakia):	
CPT codes covered if selection criteria are met:	
65767	Epikeratoplasty
Other HCPCS codes related to the policy:	
V2500 - V2599	Contact lens
Keratophakia:	
CPT codes not covered for indications listed in the policy:	
65765	Keratophakia
Other HCPCS codes related to the policy:	
V2785	Processing, preserving, and transporting corneal tissue
Lamellar keratoplasty (non-penetrating keratoplasty):	
CPT codes covered if selection criteria are met:	
65710	Keratoplasty (corneal transplant); anterior lamellar
0289T	Corneal incisions in the donor cornea created using a laser, in preparation for penetrating or lamellar keratoplasty (List separately in addition to code for primary procedure)
0290T	Corneal incisions in the recipient cornea created using a laser, in preparation for penetrating or lamellar keratoplasty (List separately in addition to code for primary procedure)
Other HCPCS codes related to the policy:	
V2785	Processing, preserving, and transporting corneal tissue
Penetrating keratoplasty (PK) (corneal transplantation, perforating keratoplasty):	
CPT codes covered if selection criteria are met:	
65730	Keratoplasty (corneal transplant); penetrating (except in aphakia or pseudoaphakia)
0289T	Corneal incisions in the donor cornea created using a laser, in preparation for penetrating or lamellar keratoplasty (List separately in addition to code for primary procedure)
0290T	Corneal incisions in the recipient cornea created using a laser, in preparation for penetrating or lamellar keratoplasty (List separately in addition to code for primary procedure)
HCPCS codes covered for indications listed in the policy:	
V2785	Processing, preserving, and transporting corneal tissue
Photorefractive keratectomy (PRK) and Photoastigmatic keratectomy (PARK or PRK-A):	
CPT codes covered if selection criteria are met:	
65760	Keratomileusis
HCPCS codes covered if selection criteria are met:	
S0810	Photorefractive keratectomy (PRK)
HCPCS codes not covered for indications listed in the policy:	
S0596	Phakic intraocular lens for correction of refractive error
Intrastromal corneal ring (INTACS):	
CPT codes covered if selection criteria are met:	
65785	Implantation of intrastromal corneal ring segments
Conductive Keratoplasty (no specific codes):	
Other CPT codes related to the policy:	
65771	Radial keratotomy
Methods of thermokeratoplasty other than conductive keratoplasty (no specific codes):	
Orthokeratology (no specific codes):	

Other CPT codes related to the policy:	
92070	Fitting of contact lens for treatment of disease, including supply of lens
92310 - 92326	Contact lens services
Other HCPCS codes related to the policy:	
V2500 - V2599	Contact lens
Scleral Expansion Surgery (no specific codes):	
Intraocular lens implants (clear lens extraction) (aphakic intraocular lenses (IOLS)):	
CPT codes not covered for indications listed in the policy:	
66840	Removal of lens material; aspiration technique, 1 or more stages
66940	extracapsular (other than 66840, 66850, 66852)
66985	Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal
HCPCS codes not covered for indications listed in the policy:	
C1780	Lens, intraocular (new technology)
Q1004	New technology intraocular lens category 4 as defined in Federal Register notice
Q1005	New technology intraocular lens category 5 as defined in Federal Register notice
V2630	Anterior chamber intraocular lens
V2631	Iris supported intraocular lens
V2632	Posterior chamber intraocular lens
V2788	Presbyopia correcting function of intraocular lens
Keratoprosthesis (artificial cornea):	
CPT codes covered if selection criteria are met:	
65770	Keratoprosthesis [AlphaCor keratoprosthesis not covered]
HCPCS codes covered if selection criteria are met:	
C1818	Integrated keratoprosthesis
L8609	Artificial cornea
Other HCPCS codes related to the policy:	
V2630	Anterior chamber intraocular lens
V2631	Iris supported intraocular lens
V2632	Posterior chamber intraocular lens
Endothelial keratoplasty (DSEK, DSAEK, and DLEK):	
CPT codes covered if selection criteria are met:	
65756	Keratoplasty (Corneal Transplant); endothelial
65757	Backbench preparation of corneal endothelial allograft prior to transplantation (List separately in addition to code for primary procedure)
Collagen crosslinking by combined riboflavin/ultraviolet-A (UVA) treatment Epithelium-off photochemical (CXL) :	
No specific code	
CPT codes covered if selection criteria are met:	
0402T	Collagen cross-linking of cornea (including removal of the corneal epithelium and intraoperative pachymetry when performed)
Collagen crosslinking, Epithelium-on (transepithelial) collagen cross-linkage (CXL plus) :	
No specific code	

CPT codes covered if selection criteria are met:	
92250	Fundus photography with interpretation and report [includes Optomap]

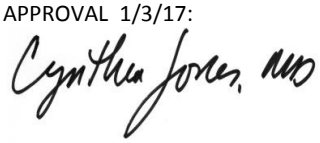
CPT codes not covered if selection criteria are met:	
0380T	Computer-aided animation and analysis of time series retinal images for the monitoring of disease progression, unilateral or bilateral, with interpretation and report

CPT codes covered if selection criteria are met:	
92225	Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report, initial
92226	subsequent

III. REFERENCES

Aetna Clinical Policy Bulletin, Corneal Remodeling, Rev. 10/18/16
Aetna Clinical Policy Bulletin, Fundus Photography, Rev. 9/1/16
Aetna, Clinical Policy Bulletin, Extended Ophthalmoscopy, Rev. 11/3/16

APPROVAL 1/3/17:



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Dr. Cynthia Jones, PEHP Chief Medical Officer