<table>
<tr><th colspan="6">PAYMENT POLICY STATEMENT:
MEDICARE ADVANTAGE</th></tr>
<tr><td colspan="2">Original Effective Date</td><td colspan="2">Next Annual Review Date</td><td colspan="2">Last Review / Revision Date</td></tr>
<tr><td colspan="2">05/17/2016</td><td colspan="2">05/17/2017</td><td colspan="2">05/17/2016</td></tr>
<tr><td colspan="3">Policy Name</td><td colspan="3">Policy Number</td></tr>
<tr><td colspan="3">Refractive Keratoplasty</td><td colspan="3">PY-0065</td></tr>
<tr><td colspan="6">Policy Type</td></tr>
<tr><td colspan="2">☐ Medical</td><td colspan="2">☐ Administrative</td><td colspan="2">☒ Payment</td></tr>
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Payment Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Payment Policies.

In addition to this Policy, payment of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

A. SUBJECT
Refractive Keratoplasty

B. BACKGROUND
Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be determined based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment.

C. DEFINITIONS
- Refractive keratoplasty is surgery to reshape the cornea of the eye to correct vision problems such as myopia (nearsightedness) and hyperopia (farsightedness).

- Refractive keratoplasty procedures include keratomileusis, in which the front of the cornea is removed, frozen, reshaped, and stitched back on the eye to correct either near or farsightedness; keratophakia, in which a reshaped donor cornea is inserted in the eye to correct farsightedness; and radial keratotomy, in which spoke-like slits are cut in the cornea to weaken and flatten the normally curved central portion to correct nearsightedness.
- The correction of common refractive errors by eyeglasses, contact lenses or other prosthetic devices is specifically excluded from coverage. The use of radial keratotomy and/or keratoplasty for the purpose of refractive error compensation is considered a substitute or alternative to eye glasses or contact lenses, which are specifically excluded by §1862(a)(7) of the Act (except in certain cases in connection with cataract surgery). In addition, many in the medical community consider such procedures cosmetic surgery, which is excluded by section §1862(a) (10) of the Act. Therefore, radial keratotomy and keratoplasty to treat refractive defects are not covered.
- Keratoplasty that treats specific lesions of the cornea, such as phototherapeutic keratectomy that removes scar tissue from the visual field, deals with an abnormality of the eye and is not cosmetic surgery. Such cases may be covered under §1862(a) (1) (A) of the Act.

Note: The use of lasers to treat ophthalmic disease constitutes ophthalmologic surgery. Coverage is restricted to practitioners who have completed an approved training program in ophthalmologic surgery.

D. POLICY

I. CareSource will reimburse providers for Refractive keratoplasty utilized through Medicare Advantage when approved by CareSource.

II. If required, providers must submit their prior authorization number their claim form, as well as appropriate HCPCS and/or CPT codes along with appropriate modifiers in accordance with CMS.

For Medicare Plan members, reference the Applicable National Coverage Determinations (NCD) and Local Coverage Determinations (LCD). Compliance with NCDs and LCDs is required where applicable.

CONDITIONS OF COVERAGE

Reimbursement is dependent on, but not limited to, submitting CMS approved HCPCS and CPT codes along with appropriate modifiers. Please refer to: https://www.cms.gov/Medicare/Medicare.html

CPT/HCPCS Codes	
Code	Description
65760	Keratomileusis (Not covered by Medicare)
65765	Keratophakia (Not covered by Medicare)
65767	Epikeratoplasty (Not covered by Medicare)
65771	Radial keratotomy (Not Covered by Medicare)
S0800	Laser in situ keratomileusis (lasik) (Not covered by Medicare)
S0810	Photorefractive keratectomy (prk) (Not covered by Medicare)
S0812	Phototherapeutic keratectomy (ptk) (Not covered by Medicare)

AUTHORIZATION PERIOD
If applicable, reimbursement is dependent upon products and services frequency, duration and timeframe set forth by CMS.

E. RELATED POLICIES/RULES

F. REVIEW/REVISION HISTORY

Date Issued: 05/17/2016
Date Reviewed: 05/17/2016
Date Revised:

G. REFERENCES

1. Centers for Medicare & Medicaid. (2016, May). Retrieved May 12, 2016, from https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=72&ncdver=1&DocID=80.7&bc=IAAAABAAAAAA&

The Payment Policy Statement detailed above has received due consideration as defined in the Payment Policy Statement and is approved.