

Refractive Keratoplasty (NCD 80.7)

Guideline Number: MPG266.06
Approval Date: July 8, 2020

[↪ Terms and Conditions](#)

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<p>Related Medicare Advantage Reimbursement Policy</p> <ul style="list-style-type: none"> • Multiple Procedure Payment Reduction (MPPR) on Diagnostic Cardiovascular and Ophthalmology Procedures Policy, Professional
<p>Related Medicare Advantage Coverage Summary</p> <ul style="list-style-type: none"> • Vision Services, Therapy and Rehabilitation

Policy Summary

[↪ See Purpose](#)

Overview

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
- Radial keratotomy, in which spoke-like slits are cut in the cornea to weaken and flatten the normally curved central portion to correct nearsightedness

Guidelines

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.

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.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
65760	Keratomileusis (Non-Covered)
65765	Keratophakia (Non-Covered)
65767	Epikeratoplasty (Non-Covered)
65771	Radial keratotomy (Non-Covered)

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References

CMS National Coverage Determinations (NCDs)

[NCD 80.7 Refractive Keratoplasty](#)

CMS Benefit Policy Manual

[Chapter 15; § 260.2 Ambulatory Surgical Center Services](#)

[Chapter 16; § 10 General Exclusions from Coverage § 180 Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare](#)

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
04/01/2021	Template Update <ul style="list-style-type: none">Reformatted policy; transferred content to new template
07/08/2020	Applicable Codes <ul style="list-style-type: none">Removed list of applicable HCPCS codes: S0800, S0810, and S0812 Supporting Information <ul style="list-style-type: none">Archived previous policy version MPG266.05

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the [References](#) section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage

requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

Medicare Advantage Policy Guidelines are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the [Administrative Guide](#).