Medical Policy

Healthcare Services Department

Policy Name	Policy Number	Scope
Refractive Keratoplasty/Cornea Transplant	MP-CT-FP-05-23	☒ MMM MA ☐ MMM Multihealth

Service Category

☐ Anesthesia
☐ Surgery
☐ Radiology Procedures
☐ Pathology and Laboratory Procedures
☐ Medicine Services and Procedures
☐ Evaluation and Management Services
☐ DME/Prosthetics or Supplies
☒ Other Transplant
Refractive Keratoplasty/ Cornea Transplant

Service Description

NCD 80.7
Refractive Keratoplasty 80.7

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.

Please note that all services described in this policy require prior authorization.

- Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.
- Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.
- Providers must submit all required and requested documentation for case evaluation and determination.
- The plan may request additional documentation and information not received and or provided initially related to condition and diagnosis for case evaluation and determination.
- Any additional documentation submitted specifying medical necessity criteria and considered important for case evaluation and determination will be reviewed by Clinical Team utilizing guidelines and regulation criteria.

Medical Necessity Guidelines

NCD 80.7
Refractive Keratoplasty 80.7

Benefit Category
No Benefit Category

Please Note: This may not be an exhaustive list of all applicable Medicare benefit categories for this item or service.
Item/Service Description

Indications of Coverage

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.

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 opthalmalogic surgery. Coverage is restricted to practitioners who have completed an approved training program in ophthalmologic surgery.

Limits or Restrictions

Radial keratotomy and keratoplasty to treat refractive defects are not covered.

Reference Information

NCD 80.7
Refractive Keratoplasty/Cornea Transplant

Medicare Coverage Database (MCD)
Link: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx

Policy History

Date	Version	Comments
12/07/2023	Draft	New Medical Policy
12/15/2023	Final	Approved by Medical Policy Committee