**Medica Coverage Policy**

**Policy Name:** Laser Surgery for Corneal Pathology  
**Current Policy Effective Date:** 10/1/2016

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**Important Information – Please Read Before Using This Policy**

These services may or may not be covered by all Medica plans. Please refer to the member’s plan document for specific coverage information. If there is a difference between this general information and the member’s plan document, the member’s plan document will be used to determine coverage. With respect to Medicare, Medicaid and MinnesotaCare members, this policy will apply unless these programs require different coverage. Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Medica coverage policy may call the Medica Provider Service Center toll-free at 1-800-458-5512.

Medica coverage policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care and treatment.

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**Coverage Policy**

Corneal laser surgery associated with disease or injury, including but not limited to phototherapeutic keratectomy (PTK), is COVERED. Examples of corneal disease or injury include, but are not limited to:

1. Corneal scars or opacities secondary to trauma, surgery, or infection  
2. Keratoconus nodules  
3. Pathologic opacities  
4. Severe corneal epithelial erosions  
5. Superficial corneal dystrophy  
6. Epithelial basement membrane dystrophy  
7. Salzmann’s degeneration

Refractive eye surgery is excluded from coverage. Corneal laser surgery for the correction of refractive defects in otherwise healthy eyes (e.g., myopia or presbyopia) is NOT COVERED.

**Note:** This policy is not scheduled for routine review of the scientific literature.

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**Description**

The excimer ultraviolet gas laser, with its ability to make extremely small and precise cuts in tissue, is the most commonly used laser for removal of corneal tissue. When used to correct corneal pathologies as a result of disease or illness, the procedure performed is referred to as phototherapeutic keratectomy (PTK).

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**FDA Approval**

There are numerous 510(k) FDA approved eximer lasers. A listing of these approvals is available from the Center for Devices and Radiological Health (CDRH).
Prior Authorization
Prior authorization is not required. However, services with specific coverage criteria may be reviewed retrospectively to determine if criteria are being met. Retrospective denial may result if criteria are not met.

Coding Considerations
Use the current applicable CPT/HCPCS code(s). The following codes are included below for informational purposes only, and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement.

CPT Codes
66999 – unlisted procedure, anterior segment of eye

HCPC Codes
S0810 – photorefractive keratectomy (PRK)
S0812 – phototherapeutic keratectomy (PTK)

Original Effective Date: 8/1/2007
Re-Review Date(s): 7/21/2010
7/17/2013
7/20/2016