



**Subject:** *Phototherapeutic Keratectomy*

**Number:** *200308-0008*

Effective date: 09/05/2003

Revision date(s): 03/2001, 10/2001, 08/28/2003

**Important note**

Even though this policy may indicate that a particular service or supply is considered covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the *Evidence of Coverage* to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans. With respect to Medicare and Medicaid members, this policy will apply unless Medicare and Medicaid policies extend coverage beyond this Medical Policy and Criteria Statement. Medicare and Medicaid policies will only apply to benefits paid for under Medicare or Medicaid rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the following Web site: <http://www.cms.hhs.gov/manuals/pub06pdf/pub06pdf.asp>

**Overview**

**Phototherapeutic keratectomy (PTK)** is a surgery that uses a laser to treat visual impairment or irritative symptoms relating to diseases of the cornea by removing thin layers of the corneal tissue. PTK should not be confused with *photorefractive keratectomy (PRK)*. PRK is a surgery to improve near-sightedness (vision correction) where a laser removes tiny amounts of tissue to flatten the cornea.

Although technically the same procedure, PTK is used for the correction of particular corneal diseases, whereas PRK is used for correction of refractive errors (e.g., myopia, hyperopia, astigmatism, and presbyopia) in patients with otherwise non-diseased corneas.

**Policy and criteria**

**NOTE:** These services require prior authorization by the plan medical director.

**When services are covered:**

We cover **phototherapeutic keratectomy (PTK)** as treatment for ANY of the following conditions:

- Superficial corneal dystrophy (including granular, lattice, and Reis-Bückler's dystrophy)
- Epithelial membrane dystrophy
- Irregular corneal surfaces due to Salzmann's nodular degeneration or keratoconus nodules
- Corneal scars and opacities (including post-traumatic, post-infectious, post-surgical, and secondary to pathology); or
- 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.

We cover **Lamellar (non-penetrating) Keratoplasty (LK)** as an alternative to PTK. Lamellar keratoplasty is a corneal transplant procedure in which a partial thickness of the cornea is removed and the diseased tissue is replaced with a partial-thickness donor cornea. Please refer to the **Cornea Transplant Policy** for additional information regarding LK.

**NOTE:** LK may be indicated for a number of corneal diseases, including scarring, edema, thinning, distortion, dystrophies, degenerations, and keratoconus. It is considered investigational and not medically necessary when performed solely to correct astigmatism and other refractive errors.

In addition, **both** of the following **patient selection criteria** must be met:

- Patient must be 18 years of age or older, AND
- There is documented failure of non-surgical management.

***When services are not covered:***

We **do not cover** services when the above criteria are not met.

We **do not cover** the following procedures because they are not scientifically proven:

- Keratoprosthesis
- Keratomileusis
- Keratophakia
- Epikeratoplasty
- Vision therapy or orthoptic services

We **do not cover the following when done to correct disorders of refraction or accommodation** but we do cover these procedures for certain medical conditions such as corneal ulcer or trauma resulting in the formation of scar tissue:

- Lamellar keratoplasty
- Tectonic or optic keratoplasty

We **do not cover phototherapeutic keratectomy (PTK)** for:

- Recurrent corneal erosions until other surgical treatments (such as mechanical superficial keratectomy or anterior stromal micropuncture) have been shown to be unsuccessful.
- Treatment of infections keratitis as it has not been shown to be safe and effective for this indication.

We do not cover the following **procedures to correct disorders of refraction or accommodation:**

- Radial keratotomy, mini-radial keratotomy, or LASIK for vision correction
- Photorefractive keratectomy
- Automated lamellar keratoplasty
- Conductive keratoplasty (CK)
- Hexagonal keratoplasty

**FCHP products to which this policy applies:**

- ⊕ FCHP Direct and FCHP Select Care (HMO)
- ⊕ FCHP Flex Care Direct and Select (POS)
- ⊕ Fallon Preferred Care (PPO)
- ⊕ FCHP MassHealth
- ⊕ Non-Group: FCHP Independent Care, Direct enrollment and Bill-at-home
- ⊘ Medicare plan – *reminder* to refer to CMS for policy and criteria

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**Committee review dates:**

**Technology Assessment Committee: 11/2003**

Approved by:

*Signature on file*

9/04/2003

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