Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Medical Necessity Guidelines:

Laser Vision Correction Surgery

Effective: May 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation (electronically recommended or by fax)	Yes ☒ No ☐
Notification Required	Yes ☐ No ☒

Applies to:

- Tufts Health Plan Commercial products
- Tufts Health Direct
- Tufts Health Together
- Tufts Health RITogether

We recommend submitting prior authorization electronically. If you opt to submit prior authorization requests via fax, please refer to this reference chart for the appropriate fax number (varies by product).
For details on all our products, please visit the Our Plans page on our provider website. For additional Prior Authorization and Notification details on other lines of business not listed on our Medical Necessity Guidelines page, please also reference our Prior Authorization Resources page.

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Overview

This guideline is for the review of medically necessary laser vision correction surgery. There are several types of this surgery including:

- Phototherapeutic keratectomy (PTK): An excimer laser procedure used to treat corneal conditions usually associated with disease or injury. PTK is not intended to decrease the need for glasses and/or contact lenses.
- Corneal relaxing incision and corneal wedge resection: Procedures used to correct surgically induced astigmatism.
- Laser-in-situ keratomileusis (LASIK): A laser procedure performed beneath a very thin flap of the cornea, used to reshape the cornea and correct low to high myopia, with or without astigmatism, and low to high hyperopia in otherwise healthy eyes, replacing the need for contact lenses and/or eyeglasses.
- Photorefractive keratectomy (PRK): Photorefractive keratectomy is an excimer laser procedure performed directly on the corneal surface, used to reshape the cornea and to treat vision problems caused by refractive errors.

Clinical Guideline Coverage Criteria

Phototherapeutic Keratectomy (PTK)

The Plan may authorize the coverage of phototherapeutic keratectomy when the Member requires the procedure for the treatment of **ONE** of the following documented conditions:

1. Corneal scars
2. Degeneration and dystrophy involving the superficial layer of the cornea
3. Anterior basement dystrophy and recurrent epithelial erosion that is recalcitrant to standard therapeutic regimens

Corneal Relaxing Incision and Corneal Wedge Resection

The Plan may authorize the coverage of corneal relaxing incision or corneal wedge resection for Members with documented

intolerance to contact lens when conventional cataract surgery, anterior segment glaucoma surgery or corneal transplant has resulted in surgically induced astigmatism of 2 diopters or greater.

Laser-in-situ Keratomileusis (LASIK) and Photorefractive Keratectomy (PRK)

The Plan may authorize the coverage of Laser-in-situ keratomileusis and photorefractive keratectomy for Members with documented intolerance to contact lens and one of the following conditions:

1. Anisometropia resulting in a 2-diopter difference following conventional cataract surgery, anterior segment glaucoma surgery or corneal transplant.
2. Astigmatism resulting in a 2-diopter difference following conventional cataract surgery, anterior segment glaucoma surgery or corneal transplant.

Limitations

1. The Plan will not cover laser vision correction surgery for cosmetic and/or convenience purposes, i.e., to replace the need to wear eyeglasses and/or contact lenses
2. The Plan will not cover refractive eye surgery for conditions which can be corrected by means other than surgery

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
65772	Corneal relaxing incision for correction of surgically induced astigmatism
65775	Corneal wedge resection for correction of surgically induced astigmatism
S0800	Laser in situ keratomileusis (LASIK)
S0810	Photorefractive keratectomy (PRK)
S0812	Phototherapeutic keratectomy (PTK)

References:

1. Jackson W.B. (2004) Photorefractive Keratectomy: Indications, Surgical Techniques, Complications and Results. In: Bille J.F., Harner C.F.H., Loesel F.F. (eds) Aberration-Free Refractive Surgery. Springer, Berlin, Heidelberg.
2. Watson SL, Leung V. Interventions for recurrent corneal erosions. Cochrane Database Syst Rev. 2018;7(7):CD001861. Published 2018 Jul 9. doi:10.1002/14651858.CD001861.pub4
3. Barsam A, Allan BD. Excimer laser refractive surgery versus phakic intraocular lenses for the correction of moderate to high myopia. Cochrane Database Syst Rev. 2014;(6):CD007679. Published 2014 Jun 17. doi:10.1002/14651858.CD007679.pub4
4. Lake JC, Victor G, Clare G, Porfírio GJ, Kernohan A, Evans JR. Toric intraocular lens versus limbal relaxing incisions for corneal astigmatism after phacoemulsification. Cochrane Database Syst Rev. 2019;12(12):CD012801. Published 2019 Dec 17. doi:10.1002/14651858.CD012801.pub2
5. Ho Wang Yin G, Hoffart L. Post-keratoplasty astigmatism management by relaxing incisions: a systematic review. Eye Vis (Lond). 2017;4:29. Published 2017 Dec 6. doi:10.1186/s40662-0170093-7
6. Song J, Cao H, Chen X, et al. Small Incision Lenticule Extraction (SMILE) Versus Laser Assisted Stromal In Situ Keratomileusis (LASIK) for Astigmatism Corrections: A Systematic Review and Meta-analysis. Am J Ophthalmol. 2023;247:181-199. doi:10.1016/j.ajo.2022.11.013
7. Levy I, Mukhija R, Nanavaty MA. Corneal Allogenic Intrastromal Ring Segments: A Literature Review. J Clin Med. 2025 Feb 18;14(4):1340. doi: 10.3390/jcm14041340. PMID: 40004870; PMCID: PMC11856834.
8. Almutairi MN, Alshehri AM, et. al. Meta-analysis: clinical outcomes of laser-assisted in situ keratomileusis (LASIK) and photorefractive keratectomy (PRK) in hyperopia. BMC Ophthalmol. 2025 Mar 18;25(1):140. doi: 10.1186/s12886-025-03956-6. PMID: 40102791; PMCID: PMC11917003.
9. Torricelli AAM, Giglio VB, Garcia R, Santhiago MR, Bechara SJ, Wilson SE, Monteiro MLR. Photorefractive Keratectomy: Technical Evolution, Refractive Outcomes, Corneal Wound Healing Response, and Complications. J Refract Surg. 2024 Oct;40(10):e754-e767. doi: 10.3928/1081597X-20240826-05. Epub 2024 Oct 1. PMID: 39387384.

Approval And Revision History

March 18, 2020: Reviewed by IMPAC, renewed without changes

Subsequent endorsement date(s) and changes made:

- March 25, 2020: Unify fax number updated
- March 17, 2021: Reviewed by IMPAC, renewed without changes
- May 18, 2022: Reviewed by Medical Policy Approval Committee (MPAC), renewed without changes
- April 19, 2023: Reviewed by MPAC, renewed without changes, effective June 1, 2023
- November 16, 2023: Reviewed at MPAC, Unify removed as an applicable product on this MNG effective January 1, 2024
- November 2023: Rebranded Unify to One Care effective January 1, 2024
- March 20, 2024: Reviewed by MPAC, renewed without changes, effective May 1, 2024
- March 19, 2025: Reviewed by MPAC, renewed without changes, effective April 11, 2025
- March 18, 2026: Reviewed by MPAC, renewed without changes, references updated, effective May 1, 2026.
- March 18, 2026: Administrative update, template updated effective May 1, 2026.

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.