

Laser-assisted In-situ Keratomileusis Radial Keratotomy

Applies to:



**Blue Cross
Blue Shield**
of Michigan

A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

Medicare Plus BlueSM PPO Medicare Plus BlueSM Group PPO Both

Laser-assisted In-situ keratomileusis

LASIK is a procedure that permanently changes the shape of the cornea and is one of several surgical procedures that fall under the generic term of refractive keratoplasty. Refractive keratoplasty includes all corneal surgical procedures to improve vision by changing the refractive index of the corneal surface. Specifically, for the LASIK procedure, a knife, called a microkeratome, is used to cut a flap in the cornea. A hinge is left at one end of this flap. The flap is folded back revealing the stroma, the middle section of the cornea. Pulses from a computer-controlled laser vaporize a portion of the stroma and the flap is replaced.

Radial keratotomy

Radial keratotomy is a surgical correction for myopia (nearsightedness). Using a high-powered microscope, the physician places microincisions (usually eight or fewer) on the surface of the cornea in a pattern much like the spokes of a wheel. The incisions are very precise in terms of depth, length and arrangement. The microincisions allow the central cornea to flatten, thus reducing the convexity of the cornea and improving vision.

Original Medicare

LASIK procedures to treat refractive defects and radial keratotomy are not covered under Original Medicare.

Medicare Plus Blue PPO Enhanced Benefit

Medicare Plus Blue is a Medicare Advantage plan that provides at least the same level of benefit coverage as Original Medicare (Part A and Part B) and may provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows Blue Cross to offer enriched plans by using Original Medicare as the base program and adding benefit options.

Coverage for LASIK and radial keratotomy is provided to members under select individual Medicare Plus Blue PPO and Medicare Plus Blue Group PPO plans. Since Original Medicare does not cover LASIK and radial keratotomy, the scope of the benefit, reimbursement methodology, maximum allowed payment amounts and member cost-sharing are determined by Blue Cross for individual coverage and by the group for those with group based coverage.

Conditions for payment

The table below specifies payment conditions for LASIK and radial keratotomy. Note: Use ICD-9 diagnosis codes for DOS through September 30, 2015. For DOS beginning with October 1, 2015 and later ICD-10 codes must be used.

Conditions for payment	
Eligible providers	M.D., D.O., ophthalmologist or optometrist
Payable location	No restrictions
CPT codes	S0800, 65771, 76514, 92025, 92134
Diagnosis restrictions	ICD-9-CM: 367.0, 367.1, 367.2 ICD-10-CM: H52.0 - 52.03, H52.1 - H52.13, H52.2 - H52.229
Age restrictions	No restrictions

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Reimbursement

Medicare Plus Blue plan's maximum payment amounts for LASIK and radial keratotomy benefits are available on our provider website, bcbsm.com/providers/help/faqs/medicare-advantage/provider-toolkit/enhanced-benefits.html in the MA enhanced benefits fee schedule. The provider will be paid the lesser of the allowed amount or the provider's charge, minus the member's cost-share. This represents payment in full and providers are not allowed to balance bill the member for the difference between the allowed amount and the charge.

Member cost-sharing

- Medicare Plus Blue providers should collect the applicable cost-sharing from the member at the time of the service when possible. Cost-sharing refers to a flat-dollar copayment, a percentage coinsurance or a deductible. Providers can only collect the appropriate Medicare Plus Blue cost-sharing amounts from the member.
- If the member elects to receive a non-covered service, he or she is responsible for the entire charge associated with the non-covered service.

To verify benefits and cost-share amount, providers may utilize web-Denis or call 1-866-309-1719.

Billing instructions

1. Bill services on the CMS 1500 (02/12) claim form or the 837 equivalent claim.
2. Use the Medicare Advantage PPO unique billing requirements.
3. Report CPT/HCPCS codes and diagnosis codes to the highest level of specificity.
4. Report your National Provider Identifier number on all claims.
5. Submit claims to your local BCBS plan.
6. Use electronic billing:
 - a. Michigan providers

Copies of the ANSI ASC X12N 837 and 835 Institutional Health Care Claim and Health Care Claim Payment/Advice (BCBSM Electronic Data Interchange (EDI) Institutional 837/835 Companion Documents) are available on the BCBSM website under the reference library section at: <http://www.bcbsm.com/providers/help/faqs/electronic-connectivity-edi.html>.

- b. Providers outside of Michigan should contact their local BCBS plan.

Additional billing instructions

When billing pre-operative evaluation and management services, use modifier 57. Modifier 57 is the evaluation and management service that resulted in the initial decision to perform surgery, either the day before a major surgery (90-day global) or the day of a major surgery.

Revision History

Policy Number: MAPPO 1014

Revised: 08/14/2015, 10/2013

08/14/2015: Updated formatting and billing instructions, added revision history section, removed reference to CAREN, updated web links.