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 Blue℠ PPO ☐ Medicare Plus Blue℠ 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 aren't covered under Original Medicare.

Medicare Plus Blue℠ PPO enhanced benefit

Medicare Plus Blue ia 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 doesn't 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.

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	H52.0 – 52.03, H52.1 – H52.13, H52.2 – H52.229
Age restrictions	No restrictions

Reimbursement

Medicare Plus Blue plan's maximum payment amounts for LASIK and radial keratotomy benefits are available on our provider website, **www.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 aren't 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 noncovered service, he or she is responsible for the entire charge associated with that service.
- Providers may not have members sign an ABN to accept financial responsibility for noncovered items or services. If there is any question about whether an item or service is covered, seek a coverage determination from Blue Cross before providing the item or service to the member. If a provider provides a noncovered item/service to a member without first obtaining a coverage determination, the member must be held harmless for all charges except for any applicable cost share.
- Cost-share amounts incurred by the member under this benefit don't count toward either the plan deductible or the combined maximum out-of-pocket limit as listed in the Evidence of Coverage document (applies to members with individual coverage).

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 form.
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 Blue Cross 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 (Blue Cross Electronic Data Interchange (EDI) Institutional 837/835 Companion Documents) are available on the Blue Cross 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 Blue Cross 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

Reviewed: 11/20/2020, 10/07/2019, 07/19/2018

Revised: 08/22/2016, 08/14/2015, 10/2013

08/22/2016: Removed ICD-9 references and codes, added bullet indicating for individual members cost shares for this benefit do not apply to the combined maximum out of pocket amount.

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