Ophthalmology Services

Reimbursement Policy ID: RPC.0110.DEDS

Recent review date: 12/2025

Next review date: 12/2026

AmeriHealth Caritas VIP Care reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas VIP Care may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT®); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy addresses reimbursement for certain ophthalmology procedures. The scope of this policy includes corneal procedures, cataract procedures, vitrectomy, and placement of stents.

Exceptions

N/A

Reimbursement Guidelines

Corneal Refractive Procedures
Refractive surgery is performed to correct vision refraction conditions like nearsightedness, farsightedness, astigmatism, or presbyopia. As a condition for reimbursement, the corneal refractive procedures listed below require a diagnosis of the applicable refractive disorder as well as an additional diagnosis that supports the need for the procedure, such as keratoconus, Fuchs dystrophy, corneal scarring or corneal ulcer.

65760 – Keratomileusis
65765 – Keratophakia
65767 – Epikeratoplasty
65770 – Keratoprothesis
65771 – Radial keratotomy
S0800 – Laser in situ keratomileusis (LASIK)
S0810 – Photo refractive keratectomy (PRK)
S0812 – Phototherapeutic keratectomy (PTK)

Corneal Cross-linking
This procedure is used to treat a weakened or warped cornea. Disease or surgery can harm collagen, the substance that holds the cornea together. Corneal cross-linking uses riboflavin 5′-phosphate ophthalmic solution and ultraviolet A radiation to treat either progressive keratoconus or corneal ectasia following refractive surgery. This procedure may be reimbursable after refractive procedures and conservative interventions have failed.

Intraocular lens
Intraocular lenses are artificial lenses that are surgically implanted in the eye to replace the natural lens, and are used to correct vision issues, most commonly, cataracts. Cataracts are generally part of the normal aging process. They form when the proteins in the lens of the eye clump together, making the lens cloudy. Cataract procedures are reimbursable except for treatment of astigmatism and presbyopia with intraocular lenses (V2787 or V2788).

Vitrectomy
Vitrectomy is a type of eye surgery used to treat problems of the eye's retina and vitreous. In this surgery, an ophthalmologist may remove blood or other substance keeping light from focusing properly on the retina; remove scar tissue that is wrinkling or tearing the retina and causing poor vision; help repair a retina that has detached (pulled away) from the eye wall; or remove a foreign object stuck inside the eye from an injury. During vitrectomy, the ophthalmologist removes some or all of the vitreous from the middle of the eye. This vitreous is replaced with either a salt water (saline) solution or a bubble made of gas or oil.

Vitrectomy procedures may not be reimbursed when billed without a diagnosis justifying the procedure.

XEN Gel Stent
The XEN gel stent may be reimbursable for medically necessary management of refractory glaucoma with a prior failure of surgical management or unresponsiveness to maximum tolerated medical therapy. Refer to the clinical policy, CCP.1510 XEN Gel Stent for Glaucoma, for additional details. This procedure requires prior authorization.

Modifiers
Modifiers are required to identify the eye on which the procedure was performed.

LT - left eye

RT – right eye
50 – bilateral procedure

Definitions

N/A

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI).
VI. Corresponding AmeriHealth Caritas VIP Care Clinical Policies.
VII. Medicare Fee Schedule(s).

Attachments

N/A

Associated Policies

CCP.1510 XEN Gel Stent for Glaucoma
CCP.1415 Corneal Cross-Linking

Policy History

12/2025	Reimbursement Policy Committee Approval
11/2025	Annual review • Update to the XEN gel stenting wording.
04/2025	Revised preamble
01/2025	Reimbursement Policy Committee Approval
04/2024	Revised preamble
08/2023	Removal of policy implemented by AmeriHealth Caritas VIP Care from Policy History section
01/2023	Template Revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section