Medical Policy

Policy:	**95034**	**Initial Effective Date:**	**02/02/1996**
SUBJECT:	**Adult Strabismus Surgery**	**Annual Review Date:**	**11/03/2023**
		Last Revised Date:	**11/03/2023**

Prior approval is required for some or all procedure codes listed in this Corporate Medical Policy.

Definition: Strabismus is an ocular misalignment characterized by positional deviation of the eye(s). Strabismus surgery consists of altering certain extraocular muscles to improve ocular alignment, aiming to eliminate or reduce associated sensory adaptations and diplopia while improving visual fields and depth perception.

Medical Necessity: The Company considers adult (age ≥18 years) strabismus surgery (**CPT Codes 67311, 67312, 67314, 67316, 67318, 67320, 67331, 67332, 67334, 67335, 67340, and applicable ICD-10-CM Procedure Codes) medically necessary** and eligible for reimbursement providing that ***at least one*** of the following medical criteria are met:

- Diplopia; or
- Visual confusion; or
- Restoration of binocular vision; or
- Intolerance of prism glasses or patch; or
- Restoration of visual field in adults with esotropia; or
- Elimination or improvement of abnormal head posture; or
- Improvement in psychosocial function or vocational status.

NOTE: The Company considers strabismus surgery **cosmetic** and **not** eligible for reimbursement if no improvement in binocular vision or fusion is expected.

Medical record documentation: Requests for strabismus surgery must be submitted with medical record documentation including ***all*** of the following:

- Corrected vision of both eyes; and
- Symptoms; and
- Amount of deviation.

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member, and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical

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necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results, and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply, and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

Prior approval is required for all procedure codes listed in the Corporate Medical Policy if age is ≥18 years.

NOTE: After reviewing the relevant documentation, the Company reserves the right to apply this policy to the service, or procedure, supply, product, or accommodation performed or furnished regardless of how the service, or procedure, supply, product, or accommodation was coded by the Provider.

Approval or clearance by the U.S. Food and Drug Administration alone is not a basis for coverage.

Coverage may differ for Medicare Advantage plan members; please see any applicable national and/or local coverage determinations for details. This information may be available at the Centers for Medicare & Medicaid Services (CMS) website.

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Applicable Code(s):	
CPT:	**67311, 67312, 67314, 67316, 67318, 67320, 67331, 67332, 67334, 67335, and 67340**
HCPCS:	**N/A**
ICD10 Procedure Codes:	**08BL0ZZ, 08BL3ZZ, 08BM0ZZ, 08BM3ZZ, 08QL0ZZ, 08QL3ZZ, 08QM0ZZ, 08QM3ZZ, 08SL0ZZ, 08SL3ZZ, 08SM0ZZ, 08SM3ZZ**
ICD10 Diagnosis Codes:	**H49.00-H49.9, H50.00-H50.9, H51.0-H51.9, H53.0-H53.039, R29.891**

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