



PROVIDER POLICIES & PROCEDURES

CORNEAL SURGICAL PROCEDURES

The primary purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP Providers) with the information needed to support a medical necessity determination for corneal surgical procedures, *other than corneal collagen cross-linking*. By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

Corneal surgical procedures encompass a variety of treatments that are performed to correct vision problems, repair structural damage, reshape the eye, and treat severe eye conditions.

Note:

For coverage of similar items, HUSKY Health will use the following criteria/policies:

- InterQual® criteria (transplantation of donor corneal tissue)
- [HUSKY Health Medical Policy Corneal Collagen Cross-linking](#)

CLINICAL GUIDELINE

Prior authorization requests for corneal surgical procedures, other than corneal collagen cross-linking, will be reviewed on a case-by-case basis using the DSS definition of Medical Necessity. These procedures include:

- Corneal Relaxing/Corneal Wedge Resection (CPT Codes 65772/65775)
- Keratoprosthesis (CPT Code 65770/HCPSC Code L8609)
- Keratomileusis (CPT code 65760)
- Keratophakia (CPT code 65765)
- Radial keratotomy (CPT code 65771)

DSS Definition of Medical Necessity

Medically Necessary or Medical Necessity: (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.

Please note that authorization is based on medical necessity at the time the authorization is issued and is not a guarantee of payment. Payment is based on the individual having active coverage, benefits and policies in effect at the time of service.

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To determine if a service or procedure requires prior authorization, CMAP Providers may refer to the *Benefit and Authorization Grids* summaries on www.ct.gov/husky by clicking on "For Providers" followed by "Benefit Grids". For a definitive list of benefits and service limitations, CMAP Providers may access the CMAP provider fee schedules and regulations at www.ctdssmap.com.

NOTE: EPSDT Special Provision

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE

Requests for coverage of corneal surgical procedures, other than corneal collagen cross-linking, will be reviewed in accordance with procedures in place for reviewing requests for surgical procedures. Coverage determinations will be based upon a review of requested and/or submitted case-specific information.

The following information is needed to review requests for corneal surgical procedures:

1. Fully completed authorization request via on-line web portal; or
2. Fully completed Outpatient Prior Authorization Request Form; and
3. Documentation from the requesting physician supporting medical necessity; and
4. Other information as requested by CHNCT.

EFFECTIVE DATE

This Clinical Guideline is effective for prior authorization requests for individuals covered under the HUSKY A, B, C, and D programs on or after August 01, 2026.

LIMITATIONS

N/A

CODES:**Codes Reviewed Using Policy**

Code	Definition
65760	Keratomileusis
65765	Keratophakia
65770	Keratoprosthesis
65771	Radial keratotomy
65772	Corneal relaxing incision for correction of surgically induced astigmatism
65775	Corneal wedge resection for correction of surgically induced astigmatism
66999	Unlisted procedure, anterior segment of eye
L8609	Artificial Cornea

Codes Reviewed Using InterQual® Criteria

Code	Definition
65767	Transplantation of donor corneal tissue

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DEFINITIONS

1. **HUSKY A:** Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
2. **HUSKY B:** Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
3. **HUSKY C:** Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
4. **HUSKY D:** Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).
5. **HUSKY Health Program:** The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.
6. **HUSKY Limited Benefit Program or HUSKY, LBP:** Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.
7. **Medically Necessary or Medical Necessity:** (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.
8. **Prior authorization:** A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary.

ADDITIONAL RESOURCES AND REFERENCES:

N/A

PUBLICATION HISTORY

Status	Date	Action Taken
Original publication	June 2026	Approved at the CHNCT Medical Reviewer meeting on June 10, 2026. Approved by the CHNCT Clinical Quality Subcommittee on June 17, 2026. Approved by DSS on July 02, 2026.

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