UTILIZATION REVIEW CRITERIA

Strabismus iCare Criteria #673.00

STRABISMUS SURGERY: Adult and Pediatric Guidelines – CPT CODES: 67311, 67312, 67314, 67316, 67318

Coverage Indications, Limitations, and/or Medical Necessity:

Adult Strabismus Surgery:

The following criteria will be considered for medically necessary authorization of strabismus surgery in the adult patient (≥18 years of age). In the absence of the following criteria, strabismus surgery will be considered cosmetic, and as such, not covered as medically necessary.

Clinical limitations required to support clinical findings for adult:

- Restoration of binocular fusion and elimination of diplopia
- Acute cranial nerve palsy (duration of less than two years)
- Thyroid ophthalmopathy
- Acquired vertical strabismus, i.e., following cataract surgery
- Breakdown of an intermittent deviation

Pediatric Strabismus Surgery:

Strabismus surgery is considered medically necessary for children (<18 years of age) diagnosed with strabismus. Strabismus is an inability of one eye to attain binocular vision with the other because of imbalances of muscles of the eyeball. The treatment plan should include planned type of strabismus surgery including each EOM involved.

LIMITATIONS for both Adult and Pediatric Surgery:

Strabismus surgery will be considered cosmetic if any of the following exist:

- No light perception (or extremely poor vision)
- A strabismic deviation that has been present and not addressed for over five years
- Clinical findings that do not support restoration of binocular vision with prisms without inducing diplopia
- Patients with no complaint of diplopia (or a disturbance from the motility disorder)
- Angle of strabismus less than 12 prism diopters horizontal or less than 5 prism diopters vertical

Documentation Requirements:

- All documentation must be maintained in the patient's medical record and made available upon request. *The provider has a responsibility to maintain a record for possible post payment review.*
- Every page of the record must be legible and include appropriate patient identification information (ex. complete name, date of birth, dates of service[s]).
- The documentation must include the legible signature of the physician responsible for and providing the care to the patient.
- The submitted medical record must support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS code must describe the service performed.

- Office notes supplying documentation of complaints or symptomatology for visual disturbances and the effect on activities of daily living.
- Diagnostic test results.
- Documentation of risk, benefits, and alternatives having been explained to the patient and/or the patient's legal guardian.
- Documentation of informed consent to complete the procedure must be obtained from the patient and/or the patient's legal guardian.
- Pre-operative notes must be signed by the provider that will be performing the procedure.

Sources:

Portions of the criteria herein may have been adopted in whole or in part from Local Coverage Determinations as provided by the applicable fiscal intermediary and/or criteria from certain health plan partners.

- American Academy of Ophthalmology. Adult Strabismus Preferred Practice Pattern®. San Francisco, CA: AAO; 2023.
- American Academy of Ophthalmology. Pediatric Eye Evaluations Preferred Practice Pattern®. San Francisco, CA: AAO; 2022.
- MacEwen C, Gregson R, Manual of Strabismus Surgery, 2003.

REVIEW AND REVISION HISTORY		
Date	**Description**	**Approver & Title**
January 15, 2024	Approval by PAC Committee	Approved by PAC Committee
November 2023	Administrative revisions (non-clinical)	Dr. Smith Blanc, Director of UM
July 17, 2023	Approval by PAC Committee (clinical documentation changes made)	Approved by PAC Committee
January 23, 2023	Approval by PAC Committee	Approved by PAC Committee
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