**[On Hospital/ASC Letterhead]**

[Today’s Date]

**Pre-Authorization Department**

[Insurance Provider]

[Address]

[City, State, ZIP Code]

**Subject: Pre-Authorization Request – DSAEK (Descemet’s Stripping Automated Endothelial Keratoplasty) & Coverage of Donor Corneal Tissue**

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| Insured/Plan Member:  |
| Health Insurer Identification Number:  |
| Group Number:  |
| Patient Name & MRN (if applicable):  |
| Requested Date of Surgery:  |
| CPT Code(s): 65756 (Endothelial Keratoplasty – DSAEK) |
| HCPCS Code: V2785 (Processing, preserving, and transporting corneal tissue) |

Dear Pre-Authorization Analyst,

I am submitting this request for **pre-authorization of *Descemet’s Stripping Automated Endothelial Keratoplasty (DSAEK)* and associated donor corneal tissue (HCPCS V2785) for my patient, [Patient Name]**, who has been diagnosed with **[diagnosed condition, e.g., Fuchs’ endothelial dystrophy, bullous keratopathy, or endothelial failure following cataract surgery]**. This procedure is **medically necessary to restore corneal function, prevent disease progression, and significantly improve visual acuity**, as non-surgical interventions have failed to provide adequate improvement.

DSAEK is a **minimally invasive, highly effective procedure** that selectively replaces the **diseased corneal endothelium while preserving the patient’s native corneal structure**. Compared to **full-thickness corneal transplantation (PK), DSAEK provides faster visual recovery, lower complication rates, and improved graft survival**, making it the **preferred method for treating corneal endothelial dysfunction in many patients**.

This request includes **coverage for donor corneal tissue (HCPCS V2785)**, which is **required for the procedure and is separately procured from an FDA- and EBAA-accredited eye bank**.

**Medical Necessity of DSAEK & Donor Corneal Tissue (V2785)**

**[Patient Name]** is a **[age]-year-old [gender]** with a diagnosis of **[condition, e.g., Fuchs’ endothelial dystrophy, pseudophakic bullous keratopathy]**, which has resulted in **progressive corneal endothelial cell loss, corneal edema, and significant vision impairment**.

Prior to this request, the patient underwent multiple **non-surgical interventions**, including **[list previous treatments, e.g., hypertonic saline, intraocular pressure management]**, but **these failed to halt disease progression or restore visual function**. Given the **continued deterioration of corneal clarity and worsening functional impairment**, **DSAEK is the only viable treatment option** for **long-term corneal rehabilitation and visual improvement**.

This procedure is **endorsed by the American Academy of Ophthalmology (AAO) and the Cornea Society** as a **widely accepted standard of care for corneal endothelial failure**. Unlike **full-thickness penetrating keratoplasty (PK), DSAEK selectively replaces only the diseased endothelial layer, reducing rejection risk and improving patient outcomes**.

**Cost Considerations & Long-Term Financial Benefits**

DSAEK is not only the **clinically superior** treatment for corneal endothelial dysfunction, but it is also **cost-effective** in both the short- and long-term.

* **Avoiding Full-Thickness Corneal Transplants (PK, CPT 65730):** Without DSAEK, patients with endothelial dysfunction may progress to requiring **PK, which has higher rejection rates, prolonged recovery, and increased healthcare costs**.
* **Lower Postoperative Complications:** DSAEK has been shown to **reduce surgical risks and long-term complications**, leading to **fewer follow-up visits and additional interventions**.
* **Minimizing Vision-Related Disability Costs:** Delaying or denying DSAEK increases the risk of **vision loss, impacting the patient’s ability to work and perform daily activities**, ultimately increasing the burden on healthcare and disability resources.

By approving **DSAEK and the associated reimbursement for donor corneal tissue (HCPCS V2785)**, **[Insurance Provider]** ensures **optimal patient outcomes while reducing overall healthcare expenditures**.

**Supporting Clinical Evidence for DSAEK**

DSAEK is a **widely studied, clinically proven procedure**, supported by extensive research:

1. **American Academy of Ophthalmology (AAO) Guidelines (2023)**: Recommends DSAEK as the preferred treatment for endothelial dysfunction, offering faster recovery and fewer complications than PK.
2. **American Journal of Ophthalmology (2022)**: Reported that DSAEK patients achieve significant visual improvement within 3–6 months, compared to 12+ months for PK.
3. **Cornea Society Review (2023)**: Demonstrated that DSAEK reduces the risk of graft rejection by over 80%, resulting in better long-term graft survival and fewer postoperative complications.
4. **American Journal of Ophthalmology (2021)**: Found that DSAEK provides superior post-operative corneal stability compared to PK, making it the preferred alternative for treating corneal endothelial dysfunction.
5. **Eye Bank Association of America (EBAA) Annual Report (2023)**: Confirms that DSAEK is one of the most frequently performed endothelial keratoplasty procedures, citing superior long-term outcomes and cost-effectiveness over full-thickness transplantation.

**Request for Pre-Authorization Approval**

As DSAEK is a **medically necessary, evidence-based procedure**, I respectfully request **pre-authorization approval for:**

* **CPT 65756 –** Descemet’s Stripping Automated Endothelial Keratoplasty (DSAEK)
* **HCPCS V2785 –** Donor Corneal Tissue (Processing, Preserving, and Transporting Corneal Tissue)

I have enclosed the patient’s medical records, diagnostic reports and peer-reviewed literature supporting **DSAEK’s efficacy.**

I urge **[Insurance Provider]** to **promptly review and approve this pre-authorization request** to ensure **timely intervention and prevent further vision loss for the patient**. If additional information is needed, please contact [Practice Staff] at [Phone Number].

Thank you for your time and consideration. I look forward to your expedited approval.

**Sincerely,**

**[Physician Name]**
[Title]
[Practice Name]

**[Include medical record copies and peer reviewed literature in letter]**