Coverage of any medical intervention discussed in a WellFirst Health medical policy is subject to the limitations and exclusions outlined in the member's benefit certificate or policy and to applicable state and/or federal laws.

<table>
<thead>
<tr>
<th>Service Information</th>
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<tbody>
<tr>
<td><strong>Refractive and Therapeutic Keratoplasty</strong></td>
<td>MP9461</td>
</tr>
<tr>
<td><strong>Covered Service:</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Prior Authorization Required:</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Additional Information:</strong></td>
<td>None</td>
</tr>
</tbody>
</table>

**WellFirst Health Medical Policy:**

1.0 **Post-Cataract Post-Transplant Corneal Surgery**

   1.1 The correction of surgically induced astigmatism with a corneal relaxing incision (including limbal relaxing incisions) or corneal wedge resection requires prior authorization through the Health Services Division and is considered medically necessary if the member had previous corneal transplant (penetrating keratoplasty) within the past 60 months or cataract surgery within the last 36 months (3 years) and both of the following criteria are met:

   1.1.1 The degree of astigmatism must be 3.00 diopters or greater; **AND**

   1.1.2 The member must be intolerant of glasses or contact lenses.

2.0 **Therapeutic Procedures**

   2.1 Non-penetrating keratoplasty requires prior authorization through the Health Services Division and may be considered medically necessary for treatment of corneal disease, including scarring, edema, distortion, dystrophies, degenerations, keratoconus and thinning.

   2.2 Epikeratoplasty (lamellar keratoplasty or non-penetrating keratoplasty) requires prior authorization through the Health Services Division and may be considered medically necessary for the treatment of ANY of the following:

   2.2.1 Childhood aphakia;

   2.2.2 Scarred corneas and corneas affected with endothelial dystrophy;
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2.2.3 Adult aphakia in circumstances where secondary implantation of an intra-ocular lens is not feasible because reentering the eye could affect outcome.

2.2.4 Epikeratoplasty is considered experimental and investigational, and therefore not medically necessary for correction of refractive errors and for all other cases of adult aphakia.

2.3 Penetrating keratoplasty (PK) for treatment of corneal diseases requires prior authorization through the Health Services Division and may be considered medically necessary for ANY of the following indications:

2.3.1 Improve visual acuity caused by an opaque cornea;

2.3.2 To restore altered corneal structure or to prevent loss of the globe that has been punctured;

2.3.3 Bullous keratoplasty;

2.3.4 Corneal scar with opacity;

2.3.5 Keratitis;

2.3.6 Corneal transplant rejection;

2.3.7 Fuch’s dystrophy;

2.3.8 Corneal degeneration;

2.3.9 Herpes simplex keratitis;

2.3.10 Keratoconus;

2.3.11 Severe corneal ulcers caused by bacterial, fungal, parasitic or viral eye infections;

2.3.12 Severe traumatic injuries that pierce or cut the cornea;

2.3.13 Severe corneal edema or scarring;

2.3.14 Descemetocele (corneal thinning)

3.0 Refractive Procedures

3.1 Procedures on the eye that are primarily refractive (changing the direction of light rays to correct vision) in nature or that are primarily to compensate for the native
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refractive error (farsightedness/nearsightedness) of the eye are considered not medically necessary, include but not limited to:

3.1.1 Astigmatic keratotomy (AK), whether performed independently or as a part of another service;

3.1.2 Automated lamellar keratoplasty (ALK);

3.1.3 Conductive keratoplasty (CK) (thermal keratoplasty);

3.1.4 Epikeratoplasty (Epikeratophakia), when used primarily to compensate for native refractive errors;

3.1.5 Hexagonal keratotomy (HK);

3.1.6 Keratophakia;

3.1.7 Laser-In-Situ keratomileusis (LASIK);

3.1.8 Minimally invasive radial keratotomy (MINI-RK);

3.1.9 Standard keratomileusis (ALK)