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Refractive and Therapeutic Keratoplasty

**Refraction and Therapeutic Keratoplasty**

**MP9461**

**Covered Service:** Yes—when meets criteria below

**Prior Authorization Required:** Yes—as shown below

**Additional Information:** None

**Prevea360 Health Plan 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 Quality and Care Management 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 Quality and Care Management Division and may be considered medically necessary for patients with corneal scarring, distortion, dystrophy, degenerations, keratoconus and thinning.

2.2 Epikeratoplasty (lamellar keratoplasty or non-penetrating keratoplasty) requires prior authorization through the Quality and Care Management Division and may be considered medically necessary in the treatment of childhood aphakia.

2.3 Penetrating keratoplasty (PK) for significant visual impairment requires prior authorization through the Quality and Care Management Division and may be considered medically necessary for any of the following indications:

2.3.1 Bullous keratoplasty; or
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2.3.2 Chemical burns to the eye; or
2.3.3 Fuchs’s dystrophy; or
2.3.4 Keratoconus; or
2.3.5 Severe corneal ulcers caused by bacterial, fungal, parasitic or viral eye infections; or
2.3.6 Severe traumatic injuries that pierce or cut the cornea; or
2.3.7 Severe corneal edema or scarring; or
2.3.8 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 refractive error (farsightedness/nearsightedness) of the eye are considered NOT medically necessary, include but are 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)
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<tr>
<th>Committee/Source</th>
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