Intrastromal Corneal Ring Segments for Keratoconus

Policy Number: MM.06.006
Original Effective Date: 11/08/2005
Line(s) of Business: HMO; PPO
Current Effective Date: 03/23/2012
Section: Surgery
Place(s) of Service: Outpatient

I. Description

Intrastromal corneal ring segments (ICRS) are small, semi-circular devices that are implanted circumferentially into the corneal stroma to flatten the cornea. This reversible surgery has been investigated as a treatment to correct mild myopia and as a treatment of keratoconus. INTACS prescription inserts are a type of ICRS indicated for the reduction or elimination of myopia and astigmatism in patients with keratoconus who are no longer able to achieve adequate vision with their contact lenses or spectacles, so that their functional vision may be restored and the need for a corneal transplant procedure may potentially be deferred.

Keratoconus is a non-inflammatory eye condition in which the normally round and dome-shaped cornea progressively thins, causing a cone-like bulge to develop. This results in significant visual impairment.

II. Criteria/Guidelines

INTACS prescription inserts are covered (subject to Limitations/Exclusions and Administrative Guidelines) for the treatment of keratoconus when all of the following criteria are met:

A. The patient is unable to achieve vision of at least 20/40 or better with contact lenses or glasses.
B. The patient is unable to perform activities of daily living or occupational functions due to progressive vision deterioration.
C. The thickness of the cornea is greater than or equal to 450 microns at the proposed incision site.
D. The central corneas are clear.
E. The patient's only other alternative to improve functional vision would be a corneal transplant.
III. Limitations/Exclusions

A. INTACS is contraindicated in patients taking any of the following medications: isotretinoin, amiodarone or sumitriptan.
B. INTACS is contraindicated in patients with collagen vascular, autoimmune or immunodeficiency diseases.
C. INTACS is not covered for any other indication except keratoconus.

IV. Administrative Guidelines

A. Precertification is not required.
B. Applicable codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0099T</td>
<td>Implantation of intrastromal corneal ring segments (INTACS)</td>
</tr>
<tr>
<td>L8699</td>
<td>Prosthetic implant, not otherwise specified</td>
</tr>
</tbody>
</table>

V. Important Reminder

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients' Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA's determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

VI. References


