**Medical Policy:**
**Intrastromal Corneal Ring Segments (Commercial)**

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<tr>
<th>POLICY NUMBER</th>
<th>LAST REVIEW DATE</th>
<th>APPROVED BY</th>
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<td>MG.MM.ME.65b</td>
<td>09/11/2020</td>
<td>MPC (Medical Policy Committee)</td>
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**IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:**

Property of ConnectiCare, Inc. All rights reserved. The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Each benefit plan defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies(LMRP). All coding and web site links are accurate at time of publication.

**Definitions**

| Keratoconus (KC) | Keratoconus (KC) is a noninflammatory condition in which the cornea undergoes progressive thinning, resulting in a conical shape that can result in significant visual impairment. The condition may appear in the late teens and early twenties and may progress for decades before slowing or stabilizing and can be asymmetric. The condition can be associated with a family history of keratoconus, as well as with frequent eye rubbing, or conditions including retinitis pigments, Down syndrome, Ehlers-Danlos syndrome. If a layer of the cornea, the Descemets membrane, is disrupted, corneal edema can occur known as hydrops, which can lead to corneal scarring that further disrupts the visual acuity. |
Guideline
Insertion of intrastromal corneal ring segments (ICRS) for Keratoconus (e.g., Intacs®) is considered medically necessary for members who:

- Have experienced a progressive deterioration in their vision, such that they can no longer achieve adequate functional vision on a daily basis with their contact lenses or spectacles.
- Are ≥ 21 years of age
- Have clear a central cornea
- Have a corneal thickness of ≥ 450 micron at the proposed incision site
- Have corneal transplantation as the only remaining option to improve functional vision

Limitations/Exclusions
- Intracorneal ring segment implantation is contraindicated in true pellucid marginal degeneration.
- Intrastromal corneal ring segments are not considered medically necessary when adequate vision correction is achieved through use of glasses or contact lenses.
- Requests for post LASIK keratectasia, a complication of laser in situ keratocmileusis (LASIK), will be reviewed on a case-by-case basis.

Applicable Coding
To access the codes, please download the policy to your computer, and click on the paperclip icon within the policy

References


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(Commercial)

Specialty matched clinical peer review.


Revision history

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<th>DATE</th>
<th>REVISION</th>
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<tr>
<td>09/2020</td>
<td>• Added that Intracorneal ring segment implantation is contraindicated in true pellucid marginal degeneration</td>
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| 10/2019 | • Connecticare has adopted the clinical criteria of its parent corporation, EmblemHealth  
• Reformatted and reorganized policy, transferred content to new template |