Medical Policy

Implantation of Intrastromal Corneal Ring Segments

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Policy Number: 235
BCBSA Reference Number: 9.03.14
NCD/LCD: NA

Related Policies
• Corneal Collagen Cross-linking, #905
• Keratoprosthesis, #221
• Endothelial Keratoplasty, #180

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity Medicare HMO BlueSM and Medicare PPO BlueSM Members

Implantation of intrastromal corneal ring segments may be MEDICALLY NECESSARY for the treatment of keratoconus in patients 21 years of age or older who meet the following criteria:
• The patient has experienced a progressive deterioration in their vision, such that they can no longer achieve adequate functional vision with contact lenses or spectacles, AND
• Corneal transplantation is the only alternative to improve their functional vision, AND
• The patient has a clear central cornea with a corneal thickness of 450 microns or greater at the proposed incision site.

Implantation of intrastromal corneal ring segments as a treatment for myopia is NOT MEDICALLY NECESSARY.

Implantation of intrastromal corneal ring segments for all other conditions is INVESTIGATIONAL.

Prior Authorization Information

Inpatient
• For services described in this policy, precertification/preauthorization IS REQUIRED for all products if the procedure is performed inpatient.

Outpatient
• For services described in this policy, see below for products where prior authorization might be required if the procedure is performed outpatient.
Outpatient

<table>
<thead>
<tr>
<th></th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial Managed Care (HMO and POS)</td>
<td>Prior authorization is not required.</td>
</tr>
<tr>
<td>Commercial PPO and Indemnity</td>
<td>Prior authorization is not required.</td>
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<tr>
<td>Medicare HMO Blue℠</td>
<td>Prior authorization is not required.</td>
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<tr>
<td>Medicare PPO Blue℠</td>
<td>Prior authorization is not required.</td>
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CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

CPT Codes

<table>
<thead>
<tr>
<th>CPT codes:</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>65785</td>
<td>Implantation of intrastromal corneal ring segments</td>
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</tbody>
</table>

The following ICD Diagnosis Codes are considered medically necessary when submitted with the CPT codes above if medical necessity criteria are met:

ICD-10 Diagnosis Codes

<table>
<thead>
<tr>
<th>ICD-10 diagnosis codes:</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H18.601</td>
<td>Keratoconus, unspecified, right eye</td>
</tr>
<tr>
<td>H18.602</td>
<td>Keratoconus, unspecified, left eye</td>
</tr>
<tr>
<td>H18.603</td>
<td>Keratoconus, unspecified, bilateral</td>
</tr>
<tr>
<td>H18.609</td>
<td>Keratoconus, unspecified, unspecified eye</td>
</tr>
<tr>
<td>H18.611</td>
<td>Keratoconus, stable, right eye</td>
</tr>
<tr>
<td>H18.612</td>
<td>Keratoconus, stable, left eye</td>
</tr>
<tr>
<td>H18.613</td>
<td>Keratoconus, stable, bilateral</td>
</tr>
<tr>
<td>H18.619</td>
<td>Keratoconus, stable, unspecified eye</td>
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<tr>
<td>H18.621</td>
<td>Keratoconus, unstable, right eye</td>
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<tr>
<td>H18.622</td>
<td>Keratoconus, unstable, left eye</td>
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<tr>
<td>H18.623</td>
<td>Keratoconus, unstable, bilateral</td>
</tr>
<tr>
<td>H18.629</td>
<td>Keratoconus, unstable, unspecified eye</td>
</tr>
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</table>

Description

Vision Disorders

Keratoconus is a progressive bilateral dystrophy characterized by paracentral steepening and stromal thinning that impairs visual acuity.

Pellucid marginal degeneration is a noninflammatory progressive degenerative disease, typically characterized by bilateral peripheral thinning (ectasia) of the inferior cornea. Deterioration of functional vision results from the irregular astigmatism induced by asymmetric distortion of the cornea, and visual acuity typically cannot be restored by using spherocylindrical lenses.


**Treatment**

Initial treatment for keratoconus often consists of hard contact lenses. A penetrating keratoplasty (ie, corneal grafting) was traditionally considered the next line of treatment in patients who developed intolerance to contact lenses. While visual acuity is typically improved with penetrating keratoplasty, perioperative complications are an associated risk; long-term topical steroid use is required; and endothelial cell loss occurs over time, which is a particular concern in younger patients. As an alternative, a variety of keratorefractive procedures have been attempted, broadly divided into subtractive and additive techniques. Subtractive techniques include photorefractive keratectomy or laser in situ keratomileusis (LASIK), although, generally, results of these techniques have been poor. In deep anterior lamellar keratoplasty, pathologic corneal stromal tissue is selectively removed to the level of the Descemet membrane, followed by transplantation of a donor graft. Implantation of intrastromal corneal ring segments (ICRS) represents an additive technique, in which the implants are intended to reinforce the cornea, prevent further deterioration, and potentially obviate the need for penetrating keratoplasty.

Rigid gas permeable contact lenses may be used to treat pellucid marginal degeneration. ICRS, crescentic lamellar keratoplasty, penetrating keratoplasty, and corneal wedge excision have also been proposed as treatments.

ICRS correct myopia by flattening the center of the cornea and represent an alternative to LASIK and other refractive surgeries. A proposed advantage of ICRS is that their insertion does not affect the central cornea and, thus, their effect is not related to the healing process in the cornea. No corneal tissue is removed, and the implants may be removed or replaced. However, mild myopia is effectively treated with spectacles or contact lenses.

**Intrastromal Corneal Ring Segments**

ICRS are composed of microthin soft plastic inserts of variable thickness that are placed in the periphery of the cornea. They are inserted through an incision made in the cornea, into which channels have been created by rotating a lamellar dissector or by using a femtosecond laser. One or 2 segments are implanted in each channel, and various implants with a range of thicknesses are available for different degrees of correction. They affect refraction in the eye by physically changing the shape of the cornea (flattening the front of the eye), thereby correcting the irregular corneal shape and restoring a degree of functional vision. If required, the implants can be removed or replaced at a later date.

**Summary**

Intrastromal corneal ring segments (ICRS) are composed of microthin soft plastic inserts of variable thickness that are placed in the periphery of the cornea. They have been investigated as a means of improving vision in diseases such as keratoconus and pellucid marginal degeneration, and for astigmatism following penetrating keratoplasty.

For individuals who have keratoconus who receive ICRS, the evidence includes primarily single-institution case series. Relevant outcomes are change in disease status, functional outcomes, and treatment-related morbidity. A number of single-center case series with sample sizes ranging from 19 to 105 eyes have been published. These series have generally reported that a substantial proportion of patients with keratoconus treated with this device have improved vision at 1 to 2 years of follow-up. More limited data are available on long-term efficacy. ICRS is associated with a number of adverse events and explanation. The net health outcome is uncertain. The evidence is insufficient to determine the effects of the technology on health outcomes.

Clinical input obtained in 2009 strongly supported the use of ICRS in a select group of patients with advanced keratoconus whose only other option for restoration of functional vision was the more invasive penetrating keratoplasty. Some clinicians may opt to delay a more invasive procedure, although the success rate of this strategy is as yet unproven. Therefore, use of ICRS may be considered medically necessary in patients with keratoconus who meet the U.S. Food and Drug Administration humanitarian device exemption criteria for use of this device.
For individuals who have pellucid marginal degeneration who receive ICRS, the evidence includes a few case series. Relevant outcomes are change in disease status, functional outcomes, and treatment-related morbidity. A small number of case series with fewer than 25 eyes per study have evaluated ICRS in patients with pellucid marginal degeneration. Most reports have assessed devices not available in the United States. In 1 study, which included some patients implanted with Intacs, there was no improvement in uncorrected visual acuity 6 months after surgery. Moreover, complication occurred in about 20% of eyes due to visual deterioration. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have astigmatism after penetrating keratoplasty who receive ICRS, the evidence includes a few case series. Relevant outcomes are change in disease status, functional outcomes, and treatment-related morbidity. Two case series, with 9 and 54 patients, were identified; both used devices not available in the United States. ICRS was associated with adverse events such as extrusion and Descemet membrane detachment. The evidence is insufficient to determine the effects of the technology on health outcomes.

Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>4/2017</td>
<td>New references added from BCBSA National medical policy.</td>
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<tr>
<td>4/2016</td>
<td>New references added from BCBSA National medical policy.</td>
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<tr>
<td>1/2016</td>
<td>Clarified coding information.</td>
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<tr>
<td>11/2015</td>
<td>New references added from BCBSA National medical policy.</td>
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<td>6/2014</td>
<td>Updated Coding section with ICD10 procedure and diagnosis codes. Effective 10/2015.</td>
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<tr>
<td>12/2013</td>
<td>New references from BCBSA National medical policy.</td>
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<tr>
<td>5/2007</td>
<td>BCBSA National medical policy review. No changes to policy statements.</td>
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Information Pertaining to All Blue Cross Blue Shield Medical Policies
Click on any of the following terms to access the relevant information:
- Medical Policy Terms of Use
- Managed Care Guidelines
- Indemnity/PPO Guidelines
- Clinical Exception Process
- Medical Technology Assessment Guidelines

References