Intrastromal Corneal Ring Segments (INTACS) for Keratoconus

I. Policy

University Health Alliance (UHA) will reimburse for intrastromal corneal ring segments when it is determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. Criteria/Guidelines

INTACS prescription inserts are covered (subject to Limitations/Exclusions and Administrative Guidelines) for the treatment of keratoconus in patients 21 years or older when all of the following criteria are met:

A. The low to moderate keratoconus patient is unable to tolerate contact lenses, and vision no longer effectively corrected with glasses for daily life activities or work.

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. Steepest keratometry should be less than or equal to 58 diopters for INTACS

E. The central corneas are clear.

F. The patient's only other alternative to improve functional vision would be a corneal transplant.

NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members’ individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

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. Prior authorization is required.
B. The request must include documentation substantiating the progressive deterioration of the patient’s vision.

C. To request prior authorization, please go to UHA’s website: https://uhahealth.com/page/prior-authorization-forms and submit via UHA’s online portal.

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<th>CPT Code</th>
<th>Description</th>
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<tr>
<td>65785</td>
<td>Implantation of intrastromal corneal ring segments</td>
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V. Policy History

Policy Number: MPP-0048-120301

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Original Document Effective Date: 03/01/2012

Previous Revision Dates: 07/01/2013

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