Sentara Health Plans

Commercial

Keratoconus Lenses and Interventions- Piggyback Contact Lenses, Medical 03

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Implementation	6/1/2025
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Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual's benefit plan for details *.

Description & Definitions:

Intrastromal corneal ring segments (ICRS) are semicircular plastic implants surgically inserted between layers on the outer edge of the cornea to flatten lens.

Keratoconus lenses are gas permeable lenses (rigid gas permeable' or 'gas permeable' (RGP or GP) worn on the eye of an individual with keratoconus, the thinning and bulging of the cornea.

Piggyback contact lens also known as a "bandage or combination" contact lenses are two sets of lenses worn at the same time. A soft lens is placed on the eye first with a gas permeable lens (hard) on top to help improve vision for an individual with keratoconus.

Other common names: INTACS

Criteria:

Keratoconus lenes, treatment for individuals diagnosed with moderate to advanced keratoconus is considered medically necessary with **1 or more** of the following:

- **Piggyback contact lens** treatment (**V - CODE**) with **1 or more** of the following:
  - Rigid lenses are a poor fit
  - Rigid lenses cause the individual discomfort

- **Intrastromal corneal ring segments** (**65785**), (e.g., INTACS™) with **ALL** of the following:
  - Individual is 21 years of age or older
  - Individual has progressive deterioration in vision, such that individual can no longer achieve adequate functional vision on a daily basis with their contact lenses or spectacles
  - Individual has presence of a clear central cornea
  - Individual has corneal thickness of .45 mm or more at the proposed incision site
  - Individual's remaining option to improve functional vision is corneal transplantation

- **Replacement lenses** for individuals who has a change in physical condition (does not included refractive changes)

Keratoconus lens treatment with Intrastromal corneal ring segments or Piggyback contact lenes are considered **not medically necessary** for any use other than those indicated in clinical criteria.

Document History:

Revised Dates:

- 2025: March – Implementation date of 6/1/2025. Criteria updated and references updated.
- 2020: January
- 2016: February
- 2015: March
- 2014: February
- 2012: March, April, May
- 2010: February
- 2009: February
- 2008: May
- 2005: October
- 1998: February, October
- 1994: February

Reviewed Dates:

- 2024: March
- 2023: March
- 2022: March, May
- 2021: March
- 2020: March
- 2018: September, November
- 2017: December
- 2015: February
- 2013: February
- 2012: February
- 2011: February
- 2007: December
- 2004: October
- 2003: October, November
- 2002: October
- 2001: November
- 2000: November
- 1999: November
- 1996: February

Effective Date:

- June 1992

Coding:

Medically necessary with criteria:

Medical 03

Coding	Description
65785	Implantation of intrastromal corneal ring segments
92072	Fitting of contact lens for management of keratoconus, initial fitting
92325	MODIFICAJ CONTACT LENX SPX SUPVJ ADAPTATION
V2510	Contact lens, gas permeable, spherical, per lens
V2511	Contact lens, gas permeable, toric, prism ballast, per lens
V2512	Contact lens, gas permeable, bifocal, per lens
V2513	Contact lens, gas permeable, extended wear, per lens
V2520	Contact lens, hydrophilic, spherical, per lens (for use with piggy back contact lenses only)
V2521	Contact lens, hydrophilic, toric, or prism ballast, per lens (for use with piggy back contact lenses only)
V2522	Contact lens, hydrophilic, bifocal, per lens ◦ HCPCS V2523 - Contact lens, hydrophilic, extended wear, per lens (for use with piggy back contact lenses only)
V2523	Contact lens, hydrophilic, extended wear, per lens (for use with piggy back contact lenses only)
V2530	Contact lens, scleral, gas impermeable, per lens (for contact lens modification, see CPT Level I code 92325)
V2531	Contact lens, scleral, gas permeable, per lens (for contact lens modification, see CPT Level I code 92325)

Considered Not Medically Necessary:

Coding	Description
	None

U.S. Food and Drug Administration (FDA) - approved only products only.

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) 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 of these services as it applies to an individual member.

Special Notes: *

- Coverage:
  - See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to products:
  - Policy is applicable to Sentara Health Plan Commercial products.
- Authorization requirements:
  - Pre-certification by the Plan is required.
- Special Notes:
  - Commercial
    - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving, and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.
    - Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are

covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.

References:

Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Keywords:

Keratoconus Lenses and Interventions, Piggyback Contact Lenses, SHP Medical 03, eyes, eyesight, intacs, vision, cornea, keratoconus, lenses, contact lenses, intrastromal corneal ring, intacs, SHP Keratoconus Lenses and Interventions/Piggyback Contact Lenses