

Medical Policy

Contact Lens and Scleral Lens

Policy Number: OCA 3.28

Version Number: 15

Version Effective Date: 07/01/16

Product Applicability

All Plan⁺ Products

Well Sense Health Plan

- New Hampshire Medicaid
- NH Health Protection Program

Boston Medical Center HealthNet Plan

- MassHealth
- Qualified Health Plans/ConnectorCare/Employer Choice Direct
- Senior Care Options ◊

Notes:

+ Disclaimer and audit information is located at the end of this document.

◊ The guidelines included in this Plan policy are applicable to members enrolled in Senior Care Options only if there are no criteria established for the specified service in a Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) on the date of the prior authorization request. Review the member's product-specific benefit documents at www.SeniorsGetMore.org to determine coverage guidelines for Senior Care Options.

Policy Summary

The Plan considers a contact lens or a scleral lens to be medically necessary for certain medical eye conditions if the Plan's applicable medical criteria are met. Plan prior authorization is required. Contact lenses worn by a member as an elective vision correction option are considered a cosmetic choice rather than a medical need, and therefore are not covered by the Plan.

It will be determined during the Plan's prior authorization process if a contact lens is considered cosmetic for the requested use. See the Plan's policy, *Cosmetic, Reconstructive, and Restorative Services* (policy number OCA 3.69), for the product-specific definitions of cosmetic services, cosmetic surgery, and/or reconstructive surgery and procedures.

Contact Lens and Scleral Lens

⁺ Plan refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

Description of Item or Service

Contact Lens: A small plastic disc that is placed directly on the eye to float on a film of tears in front of the cornea; a contact lens is used to correct or restore vision. A corneal contact lens covers only the central, non-white area of the eye, encompassing the pupil and iris. A contact lens may be a soft (hydrophilic) lens or a hard (hydrophobic) lens that is rigid and not water absorbent (either gas permeable or non-gas permeable). Soft (silicone hydrogel) lenses are made of very flexible plastics that are water absorbent (up to 90 percent of the lens weight). Conventional hard contact lenses are made of a fairly stiff plastic (polymethyl methacrylate, or PMMA), which does not mold to the shape of the eye. Rigid gas-permeable (RGP) hard contact lenses are gas-permeable lenses that are somewhat less durable than conventional hard lenses, but they are more comfortable than conventional hard lenses.

Scleral Lens (Scleral Shell): A scleral lens is a large-diameter rigid gas permeable lens, ranging in size from 14 mm to over 20 mm in diameter. The scleral lens rests entirely on the sclera, fitting over the entire exposed surface of the eye as opposed to a corneal contact lens which covers only the central non-white area encompassing the pupil and iris. The scleral lens avoids all contact with the sensitive cornea. A patient with an irregular cornea (with a condition such as keratoconus) and/or who is intolerant of a conventional contact lens may benefit from a scleral lens. Where an eye has been rendered sightless and shrunken by inflammatory disease, a scleral shell may, among other things, obviate the need for surgical enucleation and prosthetic implant and act to support the surrounding orbital tissue.

Medical Policy Statement

The Plan considers the use of a conventional contact lens or scleral lens to be medically necessary when the medical record documentation supports that ALL of the following criteria have been met for the applicable type of lens, as specified below in EITHER item 1 (for conventional contact lens) or item 2 (for scleral lens):

1. Conventional Contact Lens: †

Conventional contact lenses are considered medically necessary for ANY of the following conditions (as specified below in items a through e) under the medical benefit when documented in the member's medical record:

- a. Anisometropia of more than 3.00 diopters (D): OR
- b. Cataract extraction (postoperative); OR
- c. Keratoconus; OR

Contact Lens and Scleral Lens

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- d. Hyperopia of more than 7.00D; OR
- e. Myopia of more than 7.00D (i.e., myopia with a measurement of greater than [-]7.00D)

†Note: A supply of medically necessary disposable contact lenses requires Plan prior authorization on an **annual** basis. See Plan reimbursement policy, Vision Services (policy number 4.38), for reimbursement and coverage guidelines for contact lenses for members enrolled in a BMC HealthNet Plan product.

2. Scleral Lens (Scleral Shell):

Scleral lens is covered for a member when ALL of the following criteria are met and documented in the member's medical record, as specified below in items a, b, c and d. **A request for a scleral lens requires Plan Medical Director review and approval.**

- a. The member has keratoconus; AND
- b. The member cannot be fitted with a conventional contact lens, thus leaving scleral lens as the only option for recovering and retaining functional vision; AND
- c. ALL of the following documentation must be submitted to the Plan for prior authorization review, as specified below in items (1), (2), and (3):
 - (1) Ophthalmological examination results; AND
 - (2) Corneal topographic modeling; AND
 - (3) Medical necessity documentation to support the member's diagnosis and need for a scleral lens, as specified below in item (a) or item (b):
 - (a) Documented evidence of an attempt to use a conventional contact lens, when appropriate, with an unfavorable result; OR
 - (b) Documented clinical reason why a conventional lens cannot be used for the member's condition; AND
- d. Scleral lens is FDA-approved for the specified indication.

Limitations

1. Contact lenses are not covered when used in the treatment of non-diseased eyes for refractive changes; this is considered a cosmetic use of contact lenses rather than a medically necessary use of contact lenses.
2. Replacement lenses are considered medically necessary only if there is a change in the member's medical condition and Plan criteria are met. Refer to Plan policy, *Medically Necessary* (policy number OCA 3.14), for information regarding medical necessity criteria.
3. For a non-disposable, conventional contact lens, the cost of replacement of a contact lens (or pair of lenses, based on the member's prescription) that is lost or damaged is covered by the Plan no more frequently than one (1) lens per year (or pair of lenses, when based on the member's prescription). A request for a replacement lens for other indications will be reviewed on an individual basis according to the Plan's policy, *Clinical Criteria* (policy number OCA 3.201).
4. The initial scleral lens will be covered when medical criteria are met and Plan prior authorization is obtained. The cost of replacement of an FDA-approved scleral contact lens that is lost or damaged will be reviewed on an individual basis according to the Plan's policy, *Clinical Criteria* (policy number OCA 3.201).

Definitions

Anisometropia: A condition in which the lenses of the two eyes have different focal lengths and are in different states of myopia (nearsightedness) and hyperopia (farsightedness).

Aphakia: The loss or absence of the lens of the eye.

Diopter (D): A unit of measure of the refractive power (focusing power) of a lens, having the dimension of the reciprocal of length and a unit equal to the reciprocal of one (1) meter.

Hyperopia: A vision condition in which distant objects are usually seen clearly, but close ones do not come into proper focus. (Condition is also known as farsightedness.)

Keratoconus: A vision disorder that occurs when the normally round cornea becomes thin and irregular (cone) shaped. This abnormal shape prevents the light entering the eye from being focused correctly on the retina and causes distortion of vision.

Myopia: A vision condition in which near objects are seen clearly, but distant objects do not come into proper focus. (Condition is also known as nearsightedness.)

Applicable Coding

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United States by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Because the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Medical Policy Statement section and Limitation section of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in the Applicable Coding section of this Plan policy. Coverage for services is subject to benefit eligibility under the member's benefit plan. Please refer to the member's benefits document in effect at the time of the service to determine coverage or non-coverage as it applies to an individual member. See Plan reimbursement policies for Plan billing guidelines.

CPT Codes	Description: Codes Covered When Medically Necessary
92071	Fitting of contact lens for treatment of ocular surface disease
92072	Fitting of contact lens for management of keratoconus, initial fitting
92310	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia
92314	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes except for aphakia
92325	Modification of contact lens (separate procedure), with medical supervision of adaptation
92326	Replacement of contact lens
HCPCS Codes	Description: Codes Covered When Medically Necessary
V2500	Contact lens, PMMA, spherical, per lens
V2501	Contact lens, PMMA, toric or prism ballast, per lens
V2502	Contact lens, PMMA, bifocal, per lens
V2503	Contact lens, PMMA, color vision deficiency, per lens
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

Contact Lens and Scleral Lens

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V2513	Contact lens, gas permeable, extended wear, per lens
V2520	Contact lens, hydrophilic, spherical, per lens Plan note: See the applicable Centers for Medicare & Medicaid Services (CMS) national coverage determination on the date of the prior authorization request for hydrophilic contact lenses for Senior Care Options members
V2521	Contact lens, hydrophilic, toric, or prism ballast, per lens Plan note: See the applicable Centers for Medicare & Medicaid Services (CMS) national coverage determination on the date of the prior authorization request for hydrophilic contact lenses for Senior Care Options members
V2522	Contact lens, hydrophilic, bifocal, per lens Plan note: See the applicable Centers for Medicare & Medicaid Services (CMS) national coverage determination on the date of the prior authorization request for hydrophilic contact lenses for Senior Care Options members
V2523	Contact lens, hydrophilic, extended wear, per lens Plan note: See the applicable Centers for Medicare & Medicaid Services (CMS) national coverage determination on the date of the prior authorization request for hydrophilic contact lenses for Senior Care Options members
V2599	Contact lens, other type

CPT Codes	Description: Codes Covered When Medically Necessary After Review from Plan Medical Director
92313	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens
92317	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneoscleral lens
HCPCS Codes	Description: Codes Covered When Medically Necessary After Review from Plan Medical Director
V2530	Contact lens, scleral, gas impermeable, per lens Plan note: See the applicable Centers for Medicare & Medicaid Services (CMS) national coverage determination on the date of the prior authorization request for scleral lenses/scleral shells for Senior Care Options members
V2531	Contact lens, scleral, gas permeable, per lens Plan note: See the applicable Centers for Medicare & Medicaid Services (CMS) national coverage determination on the date of the prior authorization request for scleral lenses/scleral shells for Senior Care Options members

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Clinical Background Information

At the time of the Plan's most recent policy review, the Centers for Medicare & Medicaid Services (CMS) has national coverage determination (NCD) #80.1 for hydrophilic contact lens used as a corneal bandage when approved by the Food and Drug Administration (FDA) for this indication and is a supply incident to a physician's service. According to NCD #80.4, hydrophilic contact lenses are eyeglasses and are not covered when used in the treatment of non-diseased eyes with spherical ametropia, refractive astigmatism, and/or corneal astigmatism; Medicare payment may be made under the prosthetic device benefit, however, for FDA-approved hydrophilic contact lenses when prescribed for an aphakic patient. CMS includes guidelines for coverage of scleral lenses/scleral shells in NCD # 80.5. Verify CMS criteria in the applicable NCD or local coverage determination (LCD) in effect on the date of the prior authorization request for a Senior Care Options member.

References

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American Academy of Ophthalmology (AAO). Information Statement. Extended Wear Contact Lenses. 2013. Accessed at: <http://www.aao.org/clinical-statement/extended-wear-of-contact-lenses--january-2008>

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American Optometric Association. Optometric Clinical Practice Guideline. Care of the Patient with Accommodative and Vergence Dysfunction. Accessed at: <http://www.aoa.org/optometrists/tools-and-resources/clinical-care-publications/clinical-practice-guidelines?sso=y>

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American Optometric Association. Optometric Clinical Practice Guideline. Care of the Patient with Myopia. Accessed at: <http://www.aoa.org/optometrists/tools-and-resources/clinical-care-publications/clinical-practice-guidelines?sso=y>

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Centers for Medicare & Medicaid Services (CMS). National Coverage Determination (NCD) for Hydrophilic Contact Lens for Corneal Bandage (80.1). Manual Section Number 80.1. Version 1. Publication Number 100-3. Accessed at: <https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=136&ncdver=1&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=Massachusetts&Keyword=contact+lens&KeywordLookup=Title&KeywordSearchType=And&bc=gAAAABAAAAAAA%3d%3d&>

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Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Approved by
Regulatory Approval: N/A Internal Approval: 09/06/05	11/01/05 Version 1	Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) and member of Quality Improvement Committee (QIC)	Quality and Clinical Management Committee (Q&CMC)

*Effective Date for the BMC HealthNet Plan Commercial Product(s): 01/01/12.

*Effective Date for the Well Sense Health Plan New Hampshire Medicaid Product(s): 01/01/13 until 11/30/13 (and no Longer Applicable for the Well Sense Health Plan Products as of 12/01/13).

*Effective Date for Senior Care Options Product(s): 01/01/16.

Policy renamed *Contact Lens and Scleral Lens* as of 07/01/16; policy formerly titled *Contact Lens*.

Policy Revisions History			
Review Date	Summary of Revisions	Revision Effective Date and Version Number	Approved by
02/06/07	Updated coverage criteria.	Version 2	02/06/07: Q&CMC
06/10/08	No changes.	Version 3	06/10/08: MPCTAC 06/24/08: Utilization Management Committee (UMC) 08/13/08: QIC
06/23/09	No changes to criteria. Reformatted text and added benefit information for	Version 4	06/23/09: MPCTAC 06/23/09: UMC

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Policy Revisions History

	Plan products.		07/22/09: QIC
06/01/10	No changes to code list or criteria. Updated references.	Version 5	06/30/10: MPCTAC 07/28/10: QIC
08/01/11	Updated clinical criteria, definitions, references, and coding.	Version 6	09/21/11: MPCTAC 10/26/11: QIC
07/29/12	Off cycle review for Well Sense Health Plan. Updated code list.	Version 7	08/13/12: MPCTAC 09/13/12: QIC
09/01/12	Revised language in the Summary, Medical Policy Statement, and Applicable Coding sections. Specified policy limitations. Revised applicable code list. Updated and added references. Referenced the following Plan policies: <i>Medically Necessary</i> , <i>Clinical Criteria</i> , and <i>Cosmetic, Reconstructive, and Restorative Services</i> .	Version 8	09/19/12: MPCTAC 10/24/12: QIC
04/01/13	Review for effective date of 08/01/13. Updated applicable code list.	08/01/13 Version 9	04/17/13: MPCTAC 05/16/13: QIC
11/01/13	Ad hoc revision to policy with effective date of 12/01/13. Removed Well Sense Health Plan New Hampshire Medicaid as an applicable product. Updated References section.	12/01/13 Version 10	11/20/13: MPCTAC 11/21/13: QIC
03/01/14	Review for effective date 05/01/14. Added scleral lens and revised text in the Description of Item or Service section. Clarified language in the Medical Policy Statement section without changing criteria. Updated Definitions and References sections.	05/01/14 Version 11	03/19/14: MPCTAC 04/16/14: QIC
09/01/14	Review for effective date 11/01/14. Clarified criterion for severity of myopia without changing guidelines in the Medical Policy Statement section. Updated references.	11/01/14 Version 12	09/17/14: MPCTAC 10/15/14: QIC
03/01/15	Review for effective date 05/01/15. Updated references. Removed Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products because the products are no longer available.	05/01/15 Version 13	03/18/15: MPCTAC 04/08/15: QIC
11/25/15	Review for effective date 01/01/16.	01/01/16	11/18/15: MPCTAC

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Policy Revisions History

	Updated template with list of applicable products and notes. Revised language in the Applicable Coding section. Updated references.	Version 14	11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
03/01/16	Review for effective date 07/01/16. Revised the Summary, Description of Item or Service, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. Added Plan notes to the Applicable Coding section without changing the applicable code list. Revised criteria in the Medical Policy Statement section. Revised policy title.	07/01/16 Version 15	03/16/16: MPCTAC 04/13/16: QIC

Last Review Date

03/01/16

Next Review Date

03/01/17

Authorizing Entity

QIC

Other Applicable Policies

Administrative Policy - *Clinical Criteria*, policy number OCA 3.201
 Medical Policy - *Cosmetic, Reconstructive, and Restorative Services*, policy number OCA 3.69
 Medical Policy - *Medically Necessary*, policy number OCA 3.14
 Reimbursement Policy - *Vision Services*, policy number 4.38

Reference to Applicable Laws and Regulations

78 FR 48164-69. Centers for Medicare & Medicaid Services (CMS). Medicare Program. Revised Process for Making National Coverage Determinations. August 7, 2013. Accessed at: <https://www.cms.gov/Medicare/Coverage/DeterminationProcess/Downloads/FR08072013.pdf>

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The Commonwealth of Massachusetts. MassHealth Vision Regulations. 130 CMR 402.000: Vision Care Services. Accessed at: <http://www.mass.gov/courts/docs/lawlib/116-130cmr/130cmr402.pdf>

Disclaimer Information:+

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

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