Contact and Scleral Lenses
Clinical Coverage Criteria

Overview

Fallon Health provides coverage of Contact and Scleral Lenses for certain medically necessary diagnoses. Though there are other uses of these types of lenses the coverage is limited based on the diagnoses outlined in this policy.

The paramount goals in the use of therapeutic contact lenses are the relief of pain and enhanced corneal epithelial healing. Fluid-ventilated, gas-permeable scleral contact lenses are a valuable front-line tool in the management of severe ocular surface disease. The postoperative use of bandage contact lenses can be extremely valuable when treating surgical conditions of the cornea and ocular surface. It is appropriate to treat persistent epithelial defects and chronic epitheliopathies with bandage contact lens therapy. They also have the potential to greatly reduce disabling ocular pain and photophobia. It is not unusual for the extended wear of an appropriately designed gas permeable scleral contact lens to effectively promote the healing of persistent corneal epithelial defects in some eyes that have failed to heal after other therapeutic measures.

Definitions

Contact Lens: A thin lens designed to fit over the cornea and usually worn to correct defects in vision.
Scleral Lens: A contact lens worn directly over the sclera fitting underneath the eyelids.
Scleral Lens Liquid Bandage: A fluid-ventilated, oxygen-permeable lens that vaults over the cornea and helps manage ocular surface disease.
PROSE: Prosthetic Replacement Ocular Surface Ecosystem.

Policy

This Policy applies to the following Fallon Health products:

☒ Commercial
☒ Medicare Advantage
☒ MassHealth ACO
☒ NaviCare
☒ PACE

Fallon Health uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations for Medicare Advantage, NaviCare and PACE plan members. National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and guidance in the Medicare manuals are the basis for coverage determinations. When there is no NCD, LCD, LCA or manual guidance, Fallon Health Clinical Coverage Criteria are used for coverage determinations.

See Part II. below for covered indications for contact and scleral lenses for Medicare Advantage, NaviCare and PACE plan members.

Prior authorization is required. Any condition that warrants the use of hard, soft, gas-permeable or therapeutic contact lenses must be fully documented in the member's medical record.

Part I. Commercial and MassHealth members
Contact lenses are covered for the below conditions. Prior authorization is required for Scleral and PROSE systems as defined below. These requests must be supported by the treating provider(s) medical records.

Corneal Contact Lenses
- For post-cataract surgery with the insertion of intraocular lenses.
- For the treatment of aphakia (absence of the natural lens).
- For the treatment of keratoconus (irregular protrusion/thing of the cornea).
- As moist corneal bandages for the treatment of acute or chronic corneal pathology, such as bullous keratopathy, dry eyes, corneal ulcers and erosion, keratitis, corneal edema, descemetocele, corneal ectasis, Mooren's ulcer, anterior corneal dystrophy, or neurotrophic keratoconjunctivitis.

Scleral Contact Lenses
- To treat eyes 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.
- When used in combination with artificial tears in the treatment of “dry eye” of diverse etiology.

PROSE Lens CPT V2627
Due to conflicting studies involving this lens any request for PROSE will be reviewed on a case by case basis. Ineligibility or contraindications to standard treatment will be given consideration as part of the review.

Contact Lenses (Masshealth member’s only)
Hard, soft or gas-permeable contact lenses are covered for Masshealth member’s (regardless of age) for the treatment of the following conditions:
- Postoperative cataract extraction,
- Keratoconus,
- Anisometropia of more than 300D, and
- Myopia/Hyperopia of more than 7.00D.

Source: MassHealth Program Regulations 130 CMR 402.433 (04-06-2018).

Part II. Medicare Advantage, NaviCare and PACE plan members
Refer to the following Medicare NCDs for covered indications for contact and scleral lenses:
- **National Coverage Determination (NCD) for Hydrophilic Contact Lens For Corneal Bandage (80.1)**
- **National Coverage Determination (NCD) for Hydrophilic Contact Lenses (80.4)**
- **National Coverage Determination (NCD) for Scleral Shell (80.5)**

Refer to **Noridian Healthcare Solutions, LLC. Local Coverage Determination (LCD) for Refractive Lenses (L33793)** an**d Local Coverage Article (LCA) for Refractive Lenses (A52499)** for covered indications for contact lenses, including the PROSE lens.

Exclusions
- Any use of contact or scleral lens for the treatment of conditions not listed as covered.
- Miscellaneous fitting costs associated with PROSE lenses.
- Codes V2521 and V2523 are enhanced lenses that correct a vision problem unrelated to the surgery and are not covered.

Coding

The following codes are included below for informational purposes only; inclusion of a code does not constitute or imply coverage or reimbursement.

Code	Description
92071	Fitting of contact lens for treatment of ocular surface disease
92072	Fitting of contact lens for management of keratoconus, initial fitting
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
V2513	Contact lens, gas permeable, extended wear, per lens
V2520	Contact lens, hydrophilic, spherical, per lens
V2521	Contact lens, hydrophilic, toric, or prism ballast, per lens
V2523	Contact lens, hydrophilic, extended wear, per lens
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)
V2599	Contact lens, other type
V2627	Scleral Cover Shell

References

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3. Statson WB, et al. Clinical Benefits of the Boston Ocular Surface Prosthesis. Am J Ophthalmol. 2010 Jan; 149(1):54-61.
4. Medicare National Coverage Determination (NCD) for Scleral Shell (80.5).
5. Medicare National Coverage Determination (NCD) for Hydrophilic Contact Lens For Corneal Bandage (80.1).
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Policy history

Origination date:	01/1994
Approval(s):	Utilization and Care Management Committee: 03/2001, 06/2003 Benefit Oversight Committee: 01/1994, 08/2005 Technology Assessment Committee: 03/2001, 06/2003, 07/23/2014 updated new template, combined with Scleral Lens Liquid Bandage policy, updated references) 07/22/2015 (updated coding and references) 06/22/2016 (clarified language regarding prior authorization, updated references), 07/26/2017 (clarified codes V2521 and V2523 are not covered, updated references), 06/27/2018 (updated references), 06/26/2019 (updated references) *06/15/2021 (Added clarifying language related to Medicare Advantage, NaviCare and PACE under policy section).*

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully-insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans. For Medicare and Medicaid members, this policy will apply unless Medicare and Medicaid policies extend coverage beyond this policy.