

<b>Policy Name</b>	Clinical Policy – Medically Necessary Contact Lenses
<b>Policy Number</b>	1309.00
<b>Department</b>	Clinical Product & Strategy
<b>Subcategory</b>	Medical Management
<b>Initial Approval Date</b>	02/06/2018
<b>Current MPC/CMO Approval Date</b>	01/05/2022
<b>Current Effective Date</b>	04/01/2022

**Company Entities Supported (Select All that Apply):**

- Superior Vision Benefit Management
- Superior Vision Services
- Superior Vision of New Jersey, Inc.
- Block Vision of Texas, Inc. d/b/a Superior Vision of Texas
- Davis Vision

(Collectively referred to as ‘Versant Health’ or ‘the Company’)

**ACRONYMS or DEFINITIONS**

n/a

**PURPOSE**

To provide the medical necessity criteria for contact lenses. Applicable procedure and material codes for medically necessary contact lenses are also defined.

**POLICY**
**A. Background**

The criteria for medically necessary contact lenses are defined by lens type, procedure, and materials codes.

**B. Medically Necessary Procedures**

**1. 92072** Fitting of contact lens for management of keratoconus, initial fitting.

<b>HCPCS</b>	
V2510	Contact lens, gas permeable, spherical, per lens
V2511	Contact lens, gas permeable, toric, prism ballast, per lens
V2530	Contact lens, scleral, gas impermeable, per lens (hybrid)
V2531	Contact lens, scleral, gas permeable, per lens

**Medically necessary conditions and criteria**

- i. For keratoconus corneal topography documenting inferior steepening or keratometry readings with irregular distorted mires and steepening.
- ii. For irregular astigmatism, two (+ or - 2) diopters of irregular astigmatism must be present in either eye to fulfill the requirements of medically necessary contact lenses for this indication.

**2. 92071** Fitting of contact lens for treatment of ocular surface disease

<b>HCPCS</b>	
V2531	Contact lens, scleral, gas permeable, per lens

**Medically necessary conditions and criteria**

Scleral lenses are considered medically necessary for the treatment of symptomatic dry eye disease when patients have failed to respond to a comprehensive trial of topical and systemic therapies and/or punctal occlusion including therapies for associated anterior blepharitis and meibomian gland dysfunction (MGD). Such agents would typically include:

- i. Non-preserved artificial tears
- ii. Non-corticosteroid immunomodulatory agents (e.g., cyclosporine)
- iii. LFA-1 antagonists (e.g., lifitegrast)
- iv. Topical secretagogues
- v. Oral macrolide and/or tetracycline antibiotics
- vi. Inability to afford continuous medical non tear supplement therapy.

**3. 92311** Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one (1) eye.

**92312** Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes.

<b>HCPCS</b>	
V2510	Contact lens, gas permeable, spherical, per lens
V2511	Contact lens, gas permeable, toric, prism ballast, 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

**Medically necessary conditions and criteria**

Patient having the absence of the crystalline lens with an eyeglass RX of +4.00 diopters or more in one or both eyes.

4. **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.

<b>HCPCS</b>	
V2599	Contact lens, other type, specified as prosthetic iris contact lens

**Medically necessary conditions and criteria**

Absence of iris, coloboma of iris, or congenital malformation of iris

5. **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.

<b>HCPCS</b>	
V2510	Contact lens, gas permeable, spherical, per lens
V2511	Contact lens, gas permeable, toric, prism ballast, 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

**Medically necessary conditions and criteria**

- a. The difference in prescription between the right and left eyes is  $\geq 3.00$  diopters in one meridian of one or both eyes; or,

- b. Eyeglass prescription is  $\geq - 6.00$  or  $\geq + 6.00$  diopters in any meridian; and,
  - i. Eyeglass best corrected visual acuity of 20/40 or worse in either eye; and,
  - ii. Visual acuity improvement of 2 lines or more with contact lenses; or,
  - iii. Eyeglass prescription is  $> - 8.00$  or  $> + 8.00$  diopters in any meridian, regardless of best corrected visual acuity.
- c. For patients with Thygeson's punctate Keratopathy, patients have failed to respond to topical corticosteroids and cyclosporine or for whom these agents are contraindicated or not tolerated.

### C. Documentation

Reimbursement must be supported by adequate and complete documentation in the patient's medical record that describes the procedure and the medical rationale for it. Documentation requires at a minimum all the following items. All items must be available upon request to initiate or sustain previous payments. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, date(s) of service). Services provided/ordered must be authenticated by the physician; stamped signatures are not acceptable.

1. A signed statement of medical necessity is required. This statement must document the specific indication appropriate to the patient and be accompanied by the supporting medical record.
2. The medical necessity statement must include the relevant medical history, physical examination, and results of the specified and any additional diagnostic tests or procedures.
3. The prescription for lenses.

### D. Procedural Detail

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
92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, 1 eye
92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes
92313	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens
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
92315	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens for aphakia, 1 eye

92316	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens for aphakia, both eyes
92317	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneoscleral lens
92325	Modification of contact lens (separate procedure), with medical supervision of adaptation
92326	Replacement of contact lens

**HCPC CODES**
**Description**

S0512	Daily wear specialty contact lens, per lens
S0514	Color contact lens, per lens
S0515	Scleral lens, liquid bandage device, per lens
S0592	Comprehensive contact lens evaluation
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
V2522	Contact lens, hydrophilic, bifocal, per lens
V2523	Contact lens, hydrophilic, extended wear, per lens
V2530	Contact lens, scleral, gas impermeable, per lens (for contact lens modification, see 92325)
V2531	Contact lens, scleral, gas permeable, per lens (for contact lens modification, see 92325)

V2599	Contact lens, other type
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<b>Required Modifiers for V2500 – V2599</b>	
Anatomical Modifiers	RT – right side LT – left side 50 – bilateral
<b>Invalid Modifiers for 92310 – 92317</b>	
EM Modifiers	These codes do not allow for EM modifiers. Modifiers 24, 25, 57, and 95 are not allowed to be appended to any surgery code.
Diagnostic Modifiers	There is no technical component on these codes because this service is not a diagnostic test; TC and 26 are not valid modifiers to append to any of the codes above for these codes.
Surgical Modifiers	Surgical modifiers are not allowed for this service. Modifiers AS, XE, XP, XS, XU, 22, 52, 54, 55, 58, 59, 76, 77, 78, 79, 80, 81, and 82 should not be appended to any of the codes above for medical contact lens claims.
<b>No required modifiers for contact lens fitting 92310 – 92317</b>	

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<b>RELATED POLICIES</b>	
1316.00	Eye Exams
1328.00	Keratoconus and Related Corneal Ectasias

<b>DOCUMENT HISTORY</b>		
<b><i>Approval Date</i></b>	<b><i>Revision</i></b>	<b><i>Effective Date</i></b>
02/06/2018	Initial Policy	02/06/2018
10/18/2019	High Ametropia, added indicator for coverage regardless of best corrected visual acuity. Irregular Astigmatism, added indicator of 2.00 diopters of astigmatism in either eye	01/01/2020
10/18/2019	Administrative correction to documentation requirements 02/11/2020	01/01/2020
06/03/2020	Criteria changes to sections 1, 2, 3, and 4.	09/01/2020
04/07/2021	Criteria for high ametropia metrics restated as applying to any meridian rather than spherical equivalent.	09/01/2021
10/06/2021	Added new indication, (Thygeson's Superficial Punctate Keratitis) for extended wear contact lenses. Revised criteria for Keratoconus and related corneal ectasias to be standalone ("or") instead of combined ("and").	04/01/2022 (superseded)
01/05/2022	Removed requirements for greater than 2.5 diopters of keratometric astigmatism; reorganized policy by procedural codes; deleted diagnoses codes within body of policy.	04/01/2022

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