Policy Name	Clinical Policy – Medically Necessary Contact Lenses
Policy Number	1309.00
Department	Clinical Product & Strategy
Subcategory	Medical Management
Initial Approval Date	02/06/2018
Current MPC/CCO Approval Date	07/25/2023
Current Effective Date	01/01/2024

Company Entities Supported (Select All that Apply):
_X_ Superior Vision Benefit Management
_X_ Superior Vision Services
_X_ Superior Vision of New Jersey, Inc.
_X_ Block Vision of Texas, Inc. d/b/a Superior Vision of Texas
_X_ 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

Medically necessary contact lenses are contact lenses that are needed to correct reduced vision due to specific eye conditions as described below.

B. Medically Necessary

1. Contact lenses and contact lens fittings may be medically necessary for the following conditions and related clinical findings when spectacle lenses are not able to correct or improve a visual defect.

    a. Keratoconus and related corneal ectasias with the following clinical findings:
        i. Corneal topography documenting inferior steepening; or,
        ii. Keratometry readings with irregular distorted mires and steepening.
        iii. For unstable keratoconus[1], documentation must reflect progression over the previous 12 months as follows:
            1) Progression of maximum keratometry (Kmax) >1.0 D, as measured via keratometry or demonstrated on corneal topography; or,
            2) A change in refraction of >1.0 D in spherical equivalent; or,
            3) A change in astigmatism of >1.0 D.

    b. Irregular astigmatism demonstrated on corneal topography.

    c. High ametropia, including high myopia, high hypermetropia, or regular astigmatism, with the clinical finding that eyeglass prescription is equal to or greater than 8 diopters of ametropia in any meridian.

    d. Anisometropia, with the clinical finding of 3 or more diopters difference in prescription between the right and left eyes in any meridian.

    e. Aphakia

    f. Aniridia, coloboma of the iris, tonic iris or congenital malformation of the iris

    g. Thygeson's superficial punctate keratitis with the following clinical findings:[2]

        i. Persistent punctate keratitis; and,
        ii. Failure to respond to topical corticosteroids and cyclosporine; or,
        iii. Documented contraindication or intolerance to a trial of corticosteroids or cyclosporine.

2. Scleral lenses and associated contact lens fitting may be considered medically necessary for the treatment of the conditions listed above in (1.) that meets each condition's explicit criteria, moderate to severe dry eye and related conditions (e.g., Sicca syndrome, Sjogren's Syndrome), and neurotrophic keratoconjunctivitis[3] with the following findings:

    Failure to respond or comply to a comprehensive trial of therapies that includes:
        i. Non-preserved artificial tears, and,
        ii. Non-corticosteroid immunomodulary agents (e.g., cyclosporine); or,
        iii. LFA-1 antagonists (e.g., lifitegrast); or,
        iv. Topical secretagogue's; or,
        v. Oral macrolide and/or tetracycline antibiotics.

[1] Tian, 2022
[2] Forstot, 1979
[3] Vilares 2023

3. Hydrophilic soft (bandage) contact lenses are therapeutic bandages and are not addressed by this policy.

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. All items must be available upon request to initiate or sustain previous payments. For retrospective reviews the full operative report and medical care plan are required.

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.

D. Procedural Detail

CPT Codes	
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
HCPCS CODES	
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
V2524	Contact lens, hydrophilic, spherical, photochromic additive, per lens
V2525	Contact lens, hydrophilic, dual focus, 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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RELATED POLICIES	
1316	Eye Exams
1328	Keratoconus and Related Corneal Ectasias

DOCUMENT HISTORY		
Approval Date	***Revision***	***Effective Date***
02/06/2018	Initial Policy	02/06/2018

10/18/2019	Clarified indication of high ametropia, regardless of best corrected visual acuity; clarified irregular astigmatism, with measurement 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 all sections.	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
07/06/2022	Criteria changes: add disease specific criteria; delete criteria and HCPCS tables for materials and fittings; add CPT codes for hydrophilic lenses.	01/01/2023
7/12/2023	Add myopia and other vision indications when spectacles are unable to correct vision; add to indication of irregular astigmatism the requirement for measurement via keratometry or corneal topography; define unstable keratoconus with progressive measures; simplified scleral lens requirements.	01/01/2024
07/25/2023	2nd review and approval by MPC required. Deleted requirement of 2 D or more for irregular astigmatism.	01/01/2024

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