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 lean that vaults over the cornea and helps manage ocular surface disease.

PROSE: Prosthetic Replacement Ocular Ecosystem.

Policy
Contact lenses are covered for the below conditions. Prior authorization is required for Scleral and PROSE systems as defined below.

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 ectasia, 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 covered member’s only)

Contact lenses are covered for Masshealth member’s for treatment of Postoperative cataract extraction, Keratoconus, Anisometropia of more than 300D, and Myopia/Hyperopia of more than 7.00D. These conditions are covered regardless of age.

Exclusions

• The use of any 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.

Codes

<table>
<thead>
<tr>
<th>Code type</th>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>HCPCS</td>
<td>V2500</td>
<td>Contact lens, PMMA, spherical, per lens</td>
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<td>V2501</td>
<td>Contact lens, PMMA, toric or prism ballast, per lens</td>
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<td>V2502</td>
<td>Contact lens, PMMA, bifocal, per lens</td>
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<td></td>
<td>V2503</td>
<td>Contact lens, pmma, color vision deficiency, per lens</td>
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<td>V2510</td>
<td>Contact lens, gas permeable, spherical, per lens</td>
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<td>V2511</td>
<td>Contact lens, gas permeable, toric, prism ballast, per lens</td>
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<td>V2512</td>
<td>Contact lens, gas permeable, bifocal, per lens</td>
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<td>V2513</td>
<td>Contact lens, gas permeable, extended wear, per lens</td>
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<td>V2520</td>
<td>Contact lens, hydrophilic, spherical, per lens</td>
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<td></td>
<td>V2521</td>
<td>Contact lens, hydrophilic, toric, or prism ballast, per lens</td>
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<td>V2523</td>
<td>Contact lens, hydrophilic, extended wear, per lens</td>
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<td>V2530</td>
<td>Contact lens, scleral, gas impermeable, per lens (for contact lens modification, see CPT Level I code 92325)</td>
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<td>V2531</td>
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<td>V2599</td>
<td>Contact lens, other type</td>
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<tr>
<td></td>
<td>V2627</td>
<td>Scleral Cover Shell</td>
</tr>
</tbody>
</table>
References

5. CMS National Coverage Determination (NCD) for Scleral Shell (80.5).
6. Noridian Health Care Solutions LLC. CMS Local Coverage Determination (LCD), Refractive Lenses (L33793), originally effective October 1, 2015. Last Updated January 1, 2017

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)

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.