



# Geisinger Health Plan Policies and Procedure Manual

**Policy: MP083**

**Section: Medical Benefit Policy**

**Subject: Contact Lenses**

**Applicable line of business:**

<b>Commercial</b>	<b>x</b>	<b>Medicaid</b>	<b>x</b>
<b>Medicare</b>	<b>x</b>	<b>ACA</b>	<b>x</b>
<b>CHIP</b>	<b>x</b>		

**I. Policy:** Contact Lenses

**II. Purpose/Objective:**

To provide a policy of coverage regarding Contact Lenses

**III. Responsibility:**

- A. Medical Directors
- B. Medical Management

**IV. Required Definitions**

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

**Commercial**

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

**Medicare**

Geisinger Gold Medicare Advantage HMO, PPO, and HMO D-SNP plans are offered by Geisinger Health Plan/Geisinger Indemnity Insurance Company, health plans with a Medicare contract. Continued enrollment in Geisinger Gold depends on contract renewal. Geisinger Health Plan/Geisinger Indemnity Insurance Company are part of Geisinger, an integrated health care delivery and coverage organization.

**CHIP**

Geisinger Health Plan Kids (GHP Kids) is a Children’s Health Insurance Program (CHIP) offered by Geisinger Health Plan in conjunction with the Pennsylvania Department of Human Services (DHS). Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

**Medicaid**

Geisinger Health Plan Family (GHP Family) is a Medical Assistance (Medicaid) insurance program offered by Geisinger Health Plan in conjunction with the Pennsylvania Department of Human Services (DHS). Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

## V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community.
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

### Medicaid Business Segment

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

*Chronic condition* - An illness which frequently recurs or persists for a period in excess of 3 months

### DESCRIPTION:

Contact lenses are considered medical devices and can be worn to correct refractive error, for cosmetic or therapeutic reasons. A rigid, gas-permeable contact lens is able to replace the natural shape of the cornea with a new refracting surface or to correct for corneal irregularities. Soft hydrophilic contact lenses are used for correction of refractive error and as moist corneal bandages for the treatment of acute or chronic corneal pathology.

### For Commercial Business Segment:

#### INDICATIONS:

Therapeutic soft (hydrophilic) contact lenses may be considered medically necessary when used as moist corneal bandages for the treatment of acute corneal abrasion, corneal ulcers and erosion, poorly healing eye wounds, or for other therapeutic reasons as determined by a Plan medical director.

Contact lenses, including gas-permeable rigid contact lenses (known as RGP or GP lenses), are covered for the treatment of progressive eye diseases, including but not limited to keratoconus.

#### EXCLUSIONS:

Contact lenses required solely due to correct refractive changes are **NOT COVERED**.

Supplies used in conjunction with non-covered services are **NOT COVERED**

### For Medicare Business Segment:

Hydrophilic contact lenses are covered as a prosthetic device when prescribed for an aphakic beneficiary.

Hydrophilic contact lenses are considered medically necessary when used as moist corneal bandages for the treatment of acute or chronic corneal pathology (eg., bullous keratopathy, dry eyes, corneal ulcers and erosion, keratitis, corneal edema, descemetocoele, corneal ectasia, Mooren's ulcer, anterior corneal dystrophy, neurotrophic keratoconjunctivitis, or for other therapeutic reasons as determined by a Plan medical director.)

Scleral shell may be considered medically necessary for

- In eyes rendered sightless and shrunken by inflammatory disease, a scleral shell may eliminate the need for surgical enucleation and prosthetic implant, and act to support the surrounding orbital tissue. In such a case, the device serves as an artificial eye. In this situation, payment may be made for a scleral shell under §1861(s)(8) of the Act.

- When used in combination with artificial tears in the treatment of "dry eye" of diverse etiology. The lens acts in this instance to substitute for the functioning of the diseased lacrimal gland and would be covered as a prosthetic device in the rare case when it is used in the treatment of "dry eye."

#### **EXCLUSIONS:**

Hydrophilic contact lenses are eyeglasses within the meaning of the exclusion in §1862(a)(7) of the Act and are not covered when used in the treatment of non-diseased eyes with spherical ametropia, refractive astigmatism, and/or corneal astigmatism.

#### **For Medicaid Business Segment:**

Contact lenses are considered to be medically necessary for the following conditions:

- Correction of refractive error
- Aphakia (congenital or surgical)
- Congenital cataracts
- Keratoconus (if vision cannot be corrected to 20/40 or better with eyeglasses)
- Anisometropia or Antimetropia when the difference is two diopters or greater and results in aniseikonia
- As moist corneal bandages for the treatment of acute or chronic corneal pathology (eg., bullous keratopathy, dry eyes, corneal ulcers and erosion, keratitis, corneal edema, descemetocele, corneal ectasia, Mooren's ulcer, anterior corneal dystrophy, neurotrophic keratoconjunctivitis, or for other therapeutic reasons as determined by a Plan medical director.)
- Ocular conditions as determined by Plan Medical Director which have no alternative treatment

Scleral shell may be considered medically necessary for

- Eyes rendered sightless and shrunken by inflammatory disease, and a scleral shell may obviate the need for surgical enucleation and prosthetic implant and act to support the surrounding orbital tissue. In such a case, the device serves essentially as an artificial eye. In this situation, payment may be made for a scleral shell under §1861(s)(8) of the Act.
- When used in combination with artificial tears in the treatment of "dry eye" of diverse etiology. The lens acts in this instance to substitute for the functioning of the diseased lacrimal gland and would be covered as a prosthetic device in the rare case when it is used in the treatment of "dry eye."

#### **For CHIP Business Segment:**

Prescription contact lenses are covered.

**LIMITATIONS:** One pair of contact lenses every 6 months. Financial limits may apply as outlined in the benefit document.

### **CONTACT LENS FITTING**

#### **(Medicaid)**

For members under 21, contact lens fittings are covered when medically necessary.

#### **(All Other Business Segments):**

Contact lens fitting is only covered if the contact lenses are being provided for a covered indication. Routine fitting for a non-covered indication is **not covered**.

**Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.**

#### **Medicaid Business Segment:**

Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

#### **CODING ASSOCIATED WITH: Hydrophilic Contact Lenses**

*The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider*

**reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at [www.cms.gov](http://www.cms.gov) or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements**

- 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, one 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; corneal 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 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; corneal lens
  - 92326 replacement of contact lens
  - 92071 Fitting of contact lens for treatment of ocular surface disease
  - 92072 Fitting of contact lens for management of keratoconus, initial fitting
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- 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
  - V2524 Contact lens, hydrophilic, spherical, photochromic additive, per lens
  - V2530 Contact lens, scleral, gas impermeable, per lens
  - V2531 contact lens, scleral, gas permeable, per lens
  - V2627 Scleral cover shell
  - V2599 Contact lens, other type

Current Procedural Terminology (CPT®) © American Medical Association: Chicago, IL

#### **LINE OF BUSINESS:**

**Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.**

#### **REFERENCES:**

Ryan RA, "Is a Bandage Lens the Answer For Corneal Healing?", 23rd Annual Contact Lens Report, <http://www.revoptom.com/archive/issue/ro04f8.htm>

Gurwood AS, "Managing Corneal Abrasions" Optometry, Dec 2001. [www.optometry.co.uk/articles/20001201/gurwood.pdf](http://www.optometry.co.uk/articles/20001201/gurwood.pdf)

Centers for Medicare & Medicaid Services. National Coverage Determination (NCD) for Hydrophilic Contact lens for Corneal Bandage (80.1)

Centers for Medicare & Medicaid Services. National Coverage Determination (NCD) for Hydrophilic Contact Lenses (80.4)

Centers for Medicare & Medicaid Services. National Coverage Determination (NCD) for Scleral Shell (80.5)

Noridian Local Carrier Determination (LCD L33793 Refractive Lenses

This policy will be revised as necessary and reviewed no less than annually.

**Devised:** 12/92

**Revised:** 9/02; 11/13, 2/20 (add gas-permeable rigid contact lens coverage); 3/22 (add contact lens fitting); 10/23 (clarify contact lens fitting)

**Reviewed:** 8/03; 9/04; 9/05; 9/06; 9/07; 9/08; 9/09; 11/10, 11/11, 11/14, 11/15, 11/16, 11/17, 11/18, 11/19, 2/21, 3/23, 10/24

**CMS UM Oversight Committee Approval:** 12/23

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Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at <https://www.geisinger.org/health-plan/providers/ghp-clinical-policies>

Please be advised that the use of the logos, service marks or names of Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company on a marketing, press releases or any communication piece regarding the contents of this medical policy is strictly prohibited without the prior written consent of Geisinger Health Plan. Additionally, the above medical policy does not confer any endorsement by Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company regarding the medical service, medical device or medical lab test described under this medical policy.