Note: If the member's subscriber contract excludes coverage for a specific service it is not covered under that contract. In such cases medical policy criteria are not applied.

Note: Criteria for Family Health Plus members pertain to services rendered prior to 1/1/15.

POLICY STATEMENT:

I. Contact lenses are considered **medically necessary** for any of the following indications:
   A. Congenital aphakia;
   B. Acquired aphakia after cataract surgery (adult and pediatric);
   C. Irregular corneas/corneal scarring when vision cannot be corrected with spectacles (e.g., keratoconus, post corneal graft surgery, post corneal infection);
   D. As a corneal bandage to promote wound healing (e.g., corneal ulcer/erosion, keratitis); or
   E. Refractive errors that cannot be achieved to an acuity level of 20/40 with eyeglasses.

II. Contact lenses are considered **not medically necessary** for the following conditions:
   A. Albinism- as an alternative to tinted glasses to reduce severe light sensitivity or photophobia;
   B. Amblyopia- as an alternative to traditional eye patching/occlusion therapy; or
   C. Correction of refractive errors in lieu of eyeglasses except as stated above.

POLICY GUIDELINES:

I. Prior approval is required for all contact lens service.

II. Contact lenses utilized in the treatment of a medical condition of the eye are covered under the **Eye Care and Low Vision Services** benefit for Medicaid, Family Health Plus and Child Health Plus members.
   A. Contact lenses for Medicaid members are eligible for coverage once every 24 months, unless there has been a change in vision warranting a change in prescription or the lenses are lost or damaged.
   B. Contact lenses for Family Health Plus members are eligible for coverage once every 24 months.
   C. Contact lenses for Child Health Plus members are eligible for coverage once every 12 months.

III. Multiple contact lens changes may be required in pediatric patients with either acquired or congenital aphakia.

IV. Request for contact lens must include all of the following:
   A. Medical necessity documentation;
   B. Best corrected vision both with and without eyeglasses;
   C. Best corrected vision both with and without contact lens;
   D. Date of last complete eye exam; and
   E. Refractive error.

DESCRIPTION:

Contact lenses are small plastic discs that are placed directly on the eye, where they float on a film of tears in front of the cornea. There are several types of contact lenses. Hard (rigid) lenses, rigid gas-permeable and soft (hydrogel) lenses are the most commonly prescribed. Contact lenses are usually worn as an alternative to spectacles (eyeglasses) to correct a refractive error such as nearsightedness, farsightedness or astigmatism, but may also be worn to correct a variety of medical conditions involving the eye.

RATIONALE:

Unlike the eye of an adult patient with aphakia, a child’s eye continues to grow. As the eye length increases, the power needed to correct the child’s vision will decrease. This causes frequent changes in a child’s contact lens. Infants typically require a change in contact lens fit at 6-8 weeks old, 6-9 months and around 1 year old. After 1 year of age, a child is seen less frequently, every 2-3 months, and requires fewer changes. The average child goes through 8 lenses per eye during the first year and 4 lenses per eye, thereafter, including fit changes, loss and breakage.
Keratoconus, an irregular protrusion of the cornea is a slowly progressive condition often presenting in the teens or early twenties. During the early stages of this disease, vision may still be correctable with glasses. As the cornea steepens and becomes more irregular, glasses are no longer capable of providing adequate visual improvement. Nearly 90% of patients with progressive keratoconus can be managed indefinitely with gas permeable contact lenses.

**CODES:**

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92071</td>
<td>Fitting of contact lens for treatment of ocular surface disease</td>
</tr>
<tr>
<td>92072</td>
<td>Fitting of contact lens for management of keratoconus, initial fitting</td>
</tr>
<tr>
<td>92310-92326</td>
<td>Contact lens services (code range)</td>
</tr>
</tbody>
</table>

*Eligibility for reimbursement is based upon the benefits set forth in the member’s subscriber contract.*

**CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.**

Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.

**CPT:**
- 92071: Fitting of contact lens for treatment of ocular surface disease
- 92072: Fitting of contact lens for management of keratoconus, initial fitting
- 92310-92326: Contact lens services (code range)

**HCPCS:**
- V2500-V2599: Contact lens (code range)

**ICD9:**
- 366.00-.09: Infantile, juvenile and presenile cataract
- 366.10-.19: Senile cataract
- 366.9: Unspecified cataract
- 370.20-.24: Keratitis code range
- 370.00-370.07: Corneal ulcer code range
- 371.00-.04: Corneal scar code range
- 371.60-371.62: Keratoconus code range
- 371.70-.73: Corneal deformity
- 379.31: Aphakia
- 743.30-.34: Congenital cataract and lens anomalies code range
- 743.35: Congenital aphakia

**ICD10:**
- H16.00-H16.079: Corneal ulcer (code range)
- H16.101- H161.49: Keratitis (code range)
- H17.00-H17.03: Adherent leukoma (code range)
- H17.10-H17.829: Corneal opacity (code range)
- H17.89: Other corneal scars and opacities
- H17.9: Unspecified corneal scar and opacity
- H18.601-H18.629: Keratoconus (code range)
- H18.71-H18.719: Corneal ectasia (code range)
- H18.721-H18.729: Corneal staphyloma (code range)
- H18.731-H18.739: Descemetocele (code range)
H187.91-H187.99 Other corneal deformities (code range)
H25.011-H25.9 Age-related cataract (code range)
H26.001-H26.09 Infantile and juvenile cataract (code range)
H26.9 Unspecified cataract
H27.00-H27.03 Aphakia (code range)
Q12.3 Congenital aphakia

REFERENCES:


