CLINICAL CRITERIA POLICY

CLINICAL CRITERIA POLICY TO ESTABLISH MEDICAL NECESSITY					
BENEFIT	**EYE CARE**	**POLICY SECTION**	**200 MATERIALS & LENSES**	**POLICY NO**	**200.02**
POLICY TITLE	**MEDICALLY NECESSARY CONTACT LENSES & FITTING**				
POLICY DATE	**01/01/2020**	**REVISION DATE**	**02/10/2022**	**APPROVAL DATE**	**08/10/2022**
DISCLAIMER LANGUAGE	- **Policy content and application may have state specific variance and considerations** - **Health Plan specific 'Indications and Limitations of Coverage' may apply as specified** - **Line of Business considerations (i.e., Medicaid, Medicare, Commercial) may apply as specified**				
EXCLUSIONS	- **There are no exclusions to this policy**				

I. POLICY STATEMENT

Coverage for medically necessary contact lenses and fitting will be provided when medically indicated and in accordance with applicable state requirements and, as specific to Medicare, national and local coverage determinations. To effectively establish medical necessity for this service, Avēsis aligns its criteria with evidence and consensus based clinical practice guidelines set forth by the American Optometric Association (AOA)[1] and the College of Optometrists in Vision Development (COVD)[2]. The AOA incorporates evidence based best practice and FDA approval and/or recommendations; COVD has a Vision Development and Rehabilitation Review Board comprised of national professional membership. Avēsis Medical Directors and clinical staff are licensed medical professionals and review criteria and documentation submitted by requesting providers using sound medical judgment.

II. INDICATIONS AND LIMITATION OF COVERAGE

1.0 Contact lenses may be fitted and dispensed for medical reasons to treat or manage diseases involving the cornea or when medically necessary in the appropriate treatment of the following conditions:
- 1.1 Keratoconus
- 1.2 Irregular Astigmatism
- 1.3 Corneal Disorders
- 1.4 Aphakia
- 1.5 Anisometropia and Aniseikonia
- 1.6 High Myopia

2.0 Medically necessary, contact lens services shall include, at a minimum:
- 2.1 Examination
- 2.2 Contact lens fitting
- 2.3 Insertion, removal, & care/cleaning training
  - 2.3.1 Written & verbal instructions
  - 2.3.2 Replacement guidelines discussed
- 2.4 Wearing schedule
  - 2.4.1 Written & verbal instructions
  - 2.4.2 Daily schedule & maintenance
- 2.5 Risk & responsibility counseling
- 2.6 Starter kit
- 2.7 Follow-up visits for a minimum of 60 days after completion of fitting
  - 2.7.1 Thorough evaluation at EACH follow up not simply a lens check

[1] American Optometric Association https://www.aoa.org/practice/clinical-guidelines/clinical-practice-guidelines?sso=y
[2] College of Optometrists in Vision Development https://www.covd.org/page/Review_Board

2.7.2 Health, fit, tolerance should be discussed & documented

**Note, 2.7 in totality subject to retrospective quality medical record review*

3.0 *State specific requirements apply as outlined in sections below.*

III. MEDICAL NECESSITY REQUIREMENTS FOR APPLICABLE CODES BY STATE

Note: unless specifically referenced by Age, criterion point applicable to both Adult and Children

1.0 To establish medical necessity, relevant diagnoses referenced below in Table 1 and all criterion points referenced below in Table 2 must be clearly & legibly documented in the medical record and made available to Avēsis upon request.

1.1 Areas where 'white out' is used are not accepted.

1.2 Areas with 'black out' or 'scribble' will not be accepted.

1.2.1 A single line through text where the text will remain readable is acceptable with provider initials and date.

2.0 Services will be denied for prior authorization requests when:

2.1 Documentation submitted by the requesting provider does not establish the medical necessity per requirements in Tables 1 and 2, respectively.

2.1.1 Specific to select CPT and HCPCS codes as outlined below in Table 2 ***which may vary by state,*** detailed documentation, procedure note, orders and/or formal testing interpretation must be submitted.

2.2 Documentation submitted is incomplete and provider fails to respond to requests for additional clarifying information.

2.2.1 Providers repeatedly failing to submit documentation timely will be referred to Quality.

3.0 Contact lens fitting, and dispensing, will be considered medically appropriate when submitted documentation substantiates need is specific to the treatment and/or management of disease related to the cornea:

3.1 Any condition (other than keratoconus) of congenital, pathological, or surgical etiology causing compromised integrity of the corneal curvature or media resulting in best correctable acuity of 20/40 or less with spectacles in one or both eyes.

4.0 Contact lens fitting, and dispensing will be considered medically appropriate when submitted documentation substantiates need is specific to the treatment and/or management for the following conditions:

4.1 Keratoconus

4.1.2 Diagnosis confirmed by keratometry readings or corneal topography

4.1.3 Best correctable visual acuity with spectacles of 20/40 or less in either eye

4.1.4 Contacts improve best corrected spectacle visual acuity (standard Snellen measurement) by at least 2 lines with rigid contact lenses

4.2 Irregular Astigmatism

4.2.1 ≥2.00 diopters of astigmatism in either eye where the principal meridians are separated by less than 90°

4.2.2 Best correctable visual acuity of 20/40 or less in the affected eye with spectacles

4.3 Aphakia

4.3.1 In one or both eyes of congenital, surgical, or traumatic etiology without implantation of an intraocular lens

4.4 Anisometropia and Aniseikonia

4.4.1 ≥3.00 diopters difference in prescription (spherical equivalent) between right and left eye

4.4.2 Unequal image size between right and left eye resulting in intermittent or constant diplopia, suppression, binocular rivalry, or less than 100° stereopsis

4.5 High Myopia

4.5.1 Refractive error greater than (+) or (-)10.00 diopters

4.5.2 Best correctable visual acuity with spectacles of 20/40 or less in either eye

4.5.3 At least 2 lines improvement in best correctable visual acuity (standard Snellen measurement) with contact lenses

5.0 If applicable, Provider and enrollee will receive written notification of adverse determination which outlines right to appeal with instructions on request procedure and applicable timeframes.

IV: ICD-10/CPT Codes Supportive of Medical Necessity – Applicable to ALL states

Table 1: ICD-10 Codes Supportive of Medical Necessity – Applicable to ALL states

ICD-10 CODE	DESCRIPTION
H18.601 – H18.609	Keratoconus, unspecified
H18.611 – H18.619	Keratoconus, stable
H18.621 – H18.629	Keratoconus, unstable
H27.00 – H27.03	Aphakia
H44.20 – H44.23	Degenerative myopia
H52.211 – H52.219	Irregular astigmatism
H52.31	Anisometropia
H52.32	Aniseikonia

Table 2: CPT/HCPCS CODES AND APPLICABLE CRITERION – NOTE: STATE SPECIFIC VARIABLES APPLY

This table outlines all codes applicable to this policy; however, codes may or may not be applicable to each participating state due to variance in state requirements. Codes which are not appliable to all states and/or which have state specific variance in requirements are denoted with an asterisk*.
Providers must confirm codes covered for state as outlined below.

Codes are representative of Managed Medicaid unless otherwise noted.

CODE	MEDICAL NECESSITY CRITERION POINT
92071*	Fitting of contact lens for treatment of ocular surface disease
92072*	Fitting of contact lens for management of keratoconus, initial fitting
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
V2510	Contact lens, gas permeable, spherical, per lens
V2511	Contact lens, gas permeable, toric or 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
V2530	Contact lens, scleral, gas impermeable, per lens
V2531*	Contact lens, scleral, gas permeable, per lens
V2599*	Contact lens, other type (i.e., SynergEyes)

Table 3: CPT/HCPCS CODES AND APPLICABLE CRITERION – NOTE: STATE SPECIFIC VARIABLES APPLY

Delaware	District of Columbia	Georgia	Illinois		Kentucky		Louisiana
Medicaid	Medicaid	Medicaid	Medicaid & MMP	Medicare Advantage	Medicaid	Medicare Advantage	Medicaid
V2500	92071	92071	92071	92071	92071	92071	V2500
V2501	92072	92072	92072	92072	92072	92072	V2501
V2502	V2500	V2500	V2500	V2500	V2500	V2500	V2502
V2503	V2501	V2510	V2510	V2501	V2501	V2501	V2503
V2510	V2502	V2513	V2520	V2502	V2503	V2502	V2510
V2511	V2503	V2520	V2531	V2503	V2510	V2503	V2511
V2512	V2510	V2523	V2599	V2510	V2511	V2510	V2512
V2513	V2511	V2599		V2511	V2513	V2511	V2513
V2520	V2512			V2512	V2520	V2512	V2520
V2521	V2513			V2513	V2523	V2513	V2521
V2522	V2520			V2520	V2530	V2520	V2522
V2523	V2521			V2521	V2531	V2521	V2523
V2530	V2522			V2522	V2599	V2522	V2530
V2531	V2523			V2523		V2523	V2531
V2599	V2530			V2524		V2524	V2599
	V2531			V2530		V2530	
	V2599			V2531		V2531	
				V2599		V2599	

Maryland	Michigan	Nebraska	New Hampshire	North Carolina	Texas
Medicaid	MMP	Medicaid	Medicaid	Medicaid	Medicaid
92071	92071	92071	92071	92071	92071
92072	92072	92072	92072	92072	92072
92310	V2500	V2500	V2524	V2510	V2500
92311	V2501	V2501	V2530	V2520	V2501
92312	V2510	V2502	V2531	V2599	V2502
92313	V2511	V2503	V2599		V2510
S0500	V2513	V2510			V2511
V2500	V2520	V2511			V2512
V2501	V2521	V2512			V2513
V2502	V2523	V2513			V2520
V2503	V2531	V2520			V2521
V2510	V2599	V2521			V2522
V2511		V2522			V2523
V2512		V2523			V2530
V2513		V2530			V2531
V2520		V2599			V2599
V2521					
V2522					
V2523					
V2530					
V2599					