



CONTACT LENSES/EYEGLASSES

Effective Date: September 1, 2007

Review Dates: 10/97, 12/99, 4/01, 12/01, 2/02, 2/03,  
1/04, 1/05, 12/05, 12/06, 6/07, 4/08, 4/09

Date Of Origin: October 22, 1997

Status: Current

I. POLICY/CRITERIA

A. Contact lenses / eyeglasses and associated services and supplies are a covered benefit only for the specific medical or surgical conditions listed below and must be provided by a participating ophthalmologist or optometrist\*.

1. Aphakia. Absence of the lens may be either surgical (cataract extraction) or congenital. **Coverage for aphakia is available only if an intraocular lens (IOL) is not present and lenses are paid at the prosthetic benefit level.**

a. Surgical aphakia. Refractive lenses are covered for up to six months post-cataract surgery as follows:

- One pair of glasses or contact lenses per eye per lifetime
- Traditional single, bifocal or trifocal lenses
- Basic frames are covered only in conjunction with covered lenses

b. Congenital aphakia. Refractive lenses are covered annually as follows:

- One pair of glasses or contact lenses per eye
- Traditional single, bifocal or trifocal lenses
- Basic frames are covered only in conjunction with covered lenses

2. Contact lenses for corneal pathology. Coverage is provided only for the initial pair of contact lenses when used as a corneal bandage for treatment of acute or chronic corneal pathology (e.g. keratitis, corneal ulcers, keratoconus).

3. Intraocular lens:

The cost of conventional IOLs only are a covered benefit. If the member selects anything other than a standard IOL, i.e. a presbyopia-correcting IOL or other non-standard IOL, the cost of the additional function is not a covered benefit. (See code description.)

B. Non-covered services.

1. Replacement for loss, damage, misuse or abuse is not a covered benefit.



2. Coverage is not provided for: sunglasses, scratch resistant coating, transition/progressive lenses, or contact lens cleaning solution and normal saline.
3. Contact lens supplies (e.g. wetting and cleaning solutions, carrying cases) are not a covered benefit.
4. Low vision aids
5. Refractive keratoplasty (see policy 91529)
6. Intrastromal Corneal Ring Segments (ICRS, INTACS)

C. Contact lenses coverage criteria for Medicaid members

1. Priority Health provides services for contact lenses for Medicaid members who have certain medical conditions. These services include comprehensive contact lens evaluation with fitting and contact lenses.
  - a. A comprehensive contact lens evaluation is a benefit for Medicaid members and does not require prior authorization when the member presents with one of the following conditions and visual performance is expected to be significantly improved with the application of a contact lens. Documentation must be available if requested.
    - Aphakia (congenital or surgical).
    - Keratoconus (if vision cannot be improved to 20/40 or better with eyeglasses).
    - Anisometropia or Antimetropia (of two diopters or greater that results in aniseikonia).
    - Congenital cataracts up to age six.
    - Other conditions which have no alternative treatment.
  - b. Limitations
    - One contact lens replacement in a year for each eye is allowed for Medicaid members age 21 and over.
    - Two replacements per year are allowed for each eye for members under age 21. (One year is defined as 365 days from the date the first pair of contact lenses (initial or subsequent) was ordered.

**II. MEDICAL NECESSITY REVIEW**

Required

Not Required

Not Applicable

**\*Special Note:** Vision care, services, and supplies may be covered with rider or group contract language.

### III. APPLICATION TO PRODUCTS

Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

- ❖ **HMO/EPO:** *This policy applies to insured HMO/EPO plans.*
- ❖ **POS:** *This policy applies to insured POS plans.*
- ❖ **PPO:** *This policy applies to insured PPO plans.*
- ❖ **ASO:** *For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.*
- ❖ **INDIVIDUAL:** *For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.*
- ❖ **MEDICARE:** *Coverage is determined by the Centers for Medicare and Medicaid Services (CMS).*
- ❖ **MEDICAID:** *Coverage is determined by the Michigan Medicaid Provider Manual and the Michigan Medicaid Fee Schedule at: [http://www.michigan.gov/mdch/0,1607,7-132-2945\\_42542\\_42543\\_42546\\_42551-159815--,.00.html](http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,.00.html).*
- ❖ **MICHILD:** *For MICHILD members, this policy will apply unless MICHILD certificate of coverage limits or extends coverage.*

### IV. CODING INFORMATION

#### A. Contact Lens as Medical Benefit

##### ICD-9 Codes that support medical necessity:

- 370.00 Corneal ulcer, unspecified
- 370.01 Marginal corneal ulcer
- 370.02 Ring corneal ulcer
- 370.03 Central corneal ulcer
- 370.04 Hypopyon ulcer
- 370.05 Mycotic corneal ulcer
- 370.06 Perforated corneal ulcer
- 370.07 Mooren's ulcer
  
- 370.20 Superficial keratitis, unspecified
- 370.21 Punctate keratitis
- 370.22 Macular keratitis
- 370.23 Filamentary keratitis
- 370.24 Photokeratitis
- 370.31 Phlyctenular keratoconjunctivitis
- 370.32 Limbar and corneal involvement in vernal conjunctivitis
- 370.33 Keratoconjunctivitis sicca, not specified as Sjogren's
- 370.34 Exposure keratoconjunctivitis
- 370.35 Neurotrophic keratoconjunctivitis
- 370.40 Keratoconjunctivitis, unspecified
- 370.44 Keratitis or keratoconjunctivitis in exanthema
- 370.49 Other
- 370.50 Interstitial keratitis, unspecified
- 370.52 Diffuse interstitial keratitis

- 370.54 Sclerosing keratitis
- 370.55 Corneal abscess
- 370.59 Other
  
- 371.60 Keratoconus, unspecified
- 371.61 Keratoconus, stable condition
- 371.62 Keratoconus, acute hydrops
  
- V43.1 Organ or tissue replaced by other means
- 379.31 Aphakia
- 743.35 Congenital aphakia
  
- 743.30 Congenital cataract, unspecified
- 743.31 Capsular and subcapsular cataract
- 743.32 Cortical and zonular cataract
- 743.33 Nuclear cataract
- 743.34 Total and subtotal cataract, congenital
- 743.37 Congenital ectopic lens
- 743.39 Other congenital cataract

**CPT/HCPCS Codes supported by the non-routine diagnoses above:**

*Note: Not all codes are covered for Optometrists*

- 92070 Fitting of contact lens for treatment of disease, including supply lens
- 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 (*not covered for PriorityMedicaid*)
- 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, one eye (*not covered for PriorityMedicaid*)
- 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 (*not covered for PriorityMedicaid*)
- 92317 Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens (*not covered for PriorityMedicaid*)
- 92325 Modification of contact lens (separate procedure), with medical supervision of adaptation (*not covered for PriorityMedicaid*)
- 92326 Replacement of contact lens
  
- 92352 Fitting of spectacle prosthesis for aphakia; monofocal

- 92353 Fitting of spectacle prosthesis for aphakia; multifocal
- V2500 Contact lens, PMMA, spherical, per lens  
V2501 Contact lens, PMMA, toric or prism ballast, per lens  
V2502 Contact lens, PMMA, bifocal, per lens (*Not covered for PriorityMedicaid*)  
V2503 Contact lens, PMMA, color vision deficiency, per lens (*Not covered for PriorityMedicaid*)
- 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 (*Not covered for PriorityMedicaid*)
- V2513 Contact lens, gas permeable, extended wear, per lens (*Not covered for PriorityMedicaid*)
- V2520 Contact lens, hydrophilic, spherical, per lens  
V2521 Contact lens, hydrophilic, toric, or prism ballast, per lens  
V2522 Contact lens, hydrophilic, bifocal, per lens (*Not covered for PriorityMedicaid*)  
V2523 Contact lens, hydrophilic, extended wear, per lens  
V2530 Contact lens, scleral, gas impermeable, per lens (for contact lens modification, see CPT Level I code 92325)
- V2531 Contact lens, scleral, gas permeable, per lens (for contact lens modification, see CPT Level I code 92325) (*Not covered for PriorityMedicaid*)
- V2599 Contact lens, other type  
V2627 Scleral cover shell

(Payable in Physician office only)

- V2630 Anterior chamber intraocular lens  
V2631 Iris supported intraocular lens  
V2632 Posterior chamber intraocular lens

## B. NOT COVERED

### Routine vision ICD9 diagnosis:

*Services covered as vision benefit only:*

- 367.0 Hypermetropia  
367.1 Myopia  
367.20 Astigmatism, Unspecified  
367.21 Regular Astigmatism  
367.22 Irregular Astigmatism  
367.31 Anisometropia (*Not routine under Priority Medicare & Medicaid*)  
367.32 Aniseikonia (*Not routine under Priority Medicare & Medicaid*)  
367.4 Presbyopia  
367.81 Transient Refractive Change  
367.9 Unspecified Disorder of Refraction and Accommodation  
V72.0 Examination of Eyes and Vision

### CPT/HCPCS Codes:

*Not covered:*

- 0099T Implantation of intrastromal corneal ring segments
- 92354 Fitting of spectacle mounted low vision aid; single element system

- 92355 Fitting of spectacle mounted low vision aid; telescopic or other compound lens system
- 92065 Orthoptic and/or pleoptic training, with continuing medical direction and evaluation (*covered for Priority Medicare and Medicaid only*)
- G9041 Low vision rehabilitation services, qualified occupational therapist, direct face-to-face one-on-one, each 15 minutes
- G9042 Low vision rehabilitation services, certified orientation and mobility specialist, direct face-to-face one-on-one, each 15 minutes
- G9043 Low vision rehabilitation services, certified low vision therapist, direct face-to-face one-on-one, each 15 minutes
- G9044 Low vision rehabilitation services, qualified rehabilitation teacher, direct face-to-face one-on-one, each 15 minutes
- V2600 Hand held low vision aids and other nonspectacle mounted aids (*covered for PriorityMedicaid only*)
- V2610 Single lens spectacle mounted low vision aids (*covered for PriorityMedicaid only*)
- V2615 Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens system (*covered for PriorityMedicaid only*)
- V2788 Presbyopia correcting function of intraocular lens
- V2787 Astigmatism correcting function of intraocular lens

## V. REFERENCES

### **AMA CPT Copyright Statement:**

All Current Procedure Terminology (CPT) codes, descriptions, and other data are copyrighted by the American Medical Association.

---

*This document is for informational purposes only. It is not an authorization, certification, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of coverage. Eligibility and benefit coverage are determined in accordance with the terms of the member's plan in effect as of the date services are rendered. Priority Health's medical policies are developed with the assistance of medical professionals and are based upon a review of published and unpublished information including, but not limited to, current medical literature, guidelines published by public health and health research agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Priority Health reserves the right to review and update its medical policies at its discretion.*

*Priority Health's medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan's ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.*

*The name "Priority Health" and the term "plan" mean Priority Health, Priority Health Managed Benefits, Inc., Priority Health Insurance Company and Priority Health Government Programs, Inc.*