Sentara® Health Plans

Commercial

Keratoconus Lenses and Interventions/Piggyback Contact Lenses

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Effective Date	6/1992
Next Review Date	3/26/2024
Coverage Policy	Medical 03
Version	6

Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual's benefit plan for details *.

Purpose:

This policy addresses the medical necessity of Keratoconus Lenses and Interventions/Piggyback Contact Lenses.

Description & Definitions:

Keratoconus lenses are gas permeable lenses worn on the eye of an individual with keratoconus to help improve vision.

Piggyback contact lenses are two sets of lenses worn at the same time. A soft lens is placed on the eye first with a gas permeable lens on top to help improve vision for an individual with keratoconus.

Intrastromal corneal ring segments are implants surgically inserted between layers on the outer edge of the cornea to flatten lens.

Criteria:

Keratoconus lenses are considered medically necessary as indicated by **1 or more** of the following:

- Initial lenses with **All** of the following:
  - Individual is diagnosed with keratoconus
- Replacement lenses with **All** of the following**:**
  - Individual has a change in physical condition (does not included refractive changes)
- Piggyback contact lenses (two different lenses for the individual affected eye) with ALL the following:
  - Individual has moderate to advanced keratoconus
  - Individual has **1 or more** of the following:
    - Rigid lenses are a poor fit
    - Rigid lenses cause the individual discomfort
- Intrastromal corneal ring segments (e.g., INTACS™) with **All** of the following:
  - Individual is 21 years of age or older
  - Individual has progressive deterioration in vision, such that individual can no longer achieve adequate functional vision on a daily basis with their contact lenses or spectacles

- Individual has presence of a clear central cornea
- Individual has corneal thickness of .45 mm or more at the proposed incision site
- Individual's remaining option to improve functional vision is corneal transplantation

Keratoconus Lenses and Interventions/Piggyback Contact Lenses are considered **not medically necessary** for uses other than those listed in the clinical criteria.

Coding:

Medically necessary with criteria:

Coding	Description
65785	Implantation of intrastromal corneal ring segments
92072	Fitting of contact lens for management of keratoconus, initial fitting
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
V2513	Contact lens, gas permeable, extended wear, per lens
V2520	Contact lens, hydrophilic, spherical, per lens (for use with piggy back contact lenses only)
V2521	Contact lens, hydrophilic, toric, or prism ballast, per lens (for use with piggy back contact lenses only)
V2522	Contact lens, hydrophilic, bifocal, per lens ◦ HCPCS V2523 - Contact lens, hydrophilic, extended wear, per lens (for use with piggy back contact lenses only)
V2523	Contact lens, hydrophilic, extended wear, per lens (for use with piggy back contact lenses only)
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)

Considered Not Medically Necessary:

Coding	Description
	None

U.S. Food and Drug Administration (FDA) - approved only products only.

Document History:

Revised Dates:

- 2020: January
- 2016: February
- 2015: March
- 2014: February
- 2012: March, April, May
- 2010: February
- 2009: February
- 2008: May
- 2005: October
- 1998: February, October
- 1994: February

Reviewed Dates:

- 2024: March

- 2023: March
- 2022: March, May
- 2021: March
- 2020: March
- 2018: September, November
- 2017: December
- 2015: February
- 2013: February
- 2012: February
- 2011: February
- 2007: December
- 2004: October
- 2003: October, November
- 2002: October
- 2001: November
- 2000: November
- 1999: November
- 1996: February

Effective Date:

- June 1992

References:

Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Special Notes: *

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving, and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.

Keywords:

Keratoconus Lenses and Interventions, Piggyback Contact Lenses, SHP Medical 03, eyes, eyesight, intacs, vision, cornea, keratoconus, lenses, contact lenses, intrastromal corneal ring, intacs, SHP Keratoconus Lenses and Interventions/Piggyback Contact Lenses