Sentara Health Plans

Medicaid

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

All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Purpose:

This policy addresses 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 is 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
V2512	Contact lens, gas permeable, bifocal, per lens
V2513	Contact lens, gas permeable, 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)
	Below codes are used only for piggy back contact lenses and should be used in conjunction with one of above codes
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

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:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

Federal Regulations. Federal Register. National Archives and Records Administration. Federal Trade Commission. Final Rule. 8.17.2022. Retrieved 3.11.24. https://www.federalregister.gov/documents/2020/08/17/2020-14206/contact-lens-rule

U.S . Food and Drug Administration. U.S. Department of Health & Human Services. Listing of CDRH Humanitarian Device Exemptions. 2.18.2021. Retrieved 3.11.24. https://www.fda.gov/medical-devices/hde-approvals/listing-cdrh-humanitarian-device-exemptions

Hayes. A symplr company. Health Technology Assessment February 17, 2022. Intacs For The Treatment Of Keratoconus. Retrieved 3.11.24. https://evidence.hayesinc.com/report/dir.intacs851

Centers for Medicare & Medicaid Services. CMS.gov. Local Coverage Determination (LCD). Refractive Lenses. L33793. 10.1.2020. Retrieved 3.11.24. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33793

Commonwealth of Virginia. Department of Medical Assistance Services. Provider Manual Title: Practitioner . Revision Date: 12/2/2022 Appendix D: Service Authorization Information. Retrieved 3.11.24. https://vamedicaid.dmas.virginia.gov/sites/default/files/2023-08/Physician-Practitioner%20Manual%20App%20D%20%28Updated%2012.2.22%29_Final.pdf

National Comprehensive Cancer Network. Retrieved 3.11.24. https://www.nccn.org/search-result?indexCatalogue=nccn-search-index&searchQuery=Keratoconus%20Lenses

Carelon. Carelon Medical Benefits Management clinical appropriateness guidelines and cancer treatment pathways. Retrieved 3.11.24. https://guidelines.carelonmedicalbenefitsmanagement.com/no-search-results-found/

Asbell, P, Petratos, T. American Academy of Ophthalmology. Keratoconus. 3.13.2023. Retrieved 3.11.24. https://eyewiki.org/Keratoconus

National Keratoconus Foundation (NKCF). How is Keratoconus Treated. 2024. Retrieved 3.11.24. https://nkcf.org/how-is-keratoconus-treated/.

MCG Informed Care Strategies. 27th Edition. Retrieved 3.11.24. https://careweb.careguidelines.com/ed27/index.html

Special Notes: *

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

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.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

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