MEDICAL COVERAGE POLICY	
SERVICE: Keratoconus and Medical Contact Lens	
Policy Number:	229
Effective Date:	06/01/2020
Last Review:	04/22/2020
Next Review Date:	04/22/2021

Important note
Unless otherwise indicated, this policy will apply to all lines of business.
Even though this policy may indicate that a particular service or supply may be considered medically necessary and thus covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage (EOC) or Summary Plan Description (SPD) to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Medicare-linked plan members, this policy will apply unless there are Medicare policies that provide differing coverage rules, in which case Medicare coverage rules supersede guidelines in this policy. Medicare-linked plan policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the CMS website. Similarly, for Medicaid-linked plans, the Texas Medicaid Provider Procedures Manual (TMPPM) supersedes coverage guidelines in this policy where applicable.

SERVICE: Keratoconus and Medical Contacts

PRIOR AUTHORIZATION: Not required.

POLICY: Most SWHP medical plans exclude coverage of eyeglasses and corrective lens unless covered under a “vision” rider. Under medical plans with this exclusion, contact lenses are ONLY covered as a medical benefit for a select set of indications. A few plans exclude coverage of contact lens under ALL conditions. **If coverage of contact lens are NOT excluded for ALL conditions** SWHP may consider “corneal bandage” contacts medically necessary for the following indications:

1. SWHP considers external lenses and intraocular lenses medically necessary after cataract surgery. In this situation contacts or eyewear are viewed as “prosthetics” – replacing the lens. Coverage is limited to “standard” eyewear (i.e., special lens coatings, tint, polarization, scratch resistance, deluxe frames) are not considered medically necessary.
2. Therapeutic Hydrophilic Contact Lenses or “corneal bandage” is considered medically necessary for treatment of ocular surface disease such as:
   - Stevens-Johnson Syndrome
   - Chemical, thermal or other corneal injuries
   - Neurotrophic corneas
   - Keratoconjunctivitis sicca as in Sjogren’s Syndrome
   - Corneal disorders associated with autoimmune diseases (rheumatoid arthritis, dermatological disorders such as atopic, epidermolysis bullosa, epidermal dysplasia)
   - Epidermal ocular disorders (atopy, ectodermal dysplasia, epidermolysis bullosa)
   - Corneal exposure (e.g., anatomic, paralytic)
   - Neurotrophic (anesthetic) corneas

   Corneal bandage is considered experimental and investigational for all other indications.
3. Evaluation of members with keratoconus and other corneal disorders with astigmatism is considered medically necessary. However, unless the member’s plan includes coverage for

contact lens, contact lens will **NOT** be covered as a medical benefit for correction of astigmatism associated with these corneal disorders.

SWHP considers epithelium-off photochemical collagen cross-linkage using riboflavin (Photrexa) and ultraviolet A medically necessary for keratoconus and keratectasia when the following criteria are met:

- Member has progressive keratoconus; AND
- Member is between the ages of 14-65 years and is not pregnant; AND
- The central cornea is clear, without scarring or disease

OVERVIEW:

Keratoconus is a non-inflammatory disorder of the cornea of unknown etiology. It is characterized by progressive thinning and cone-shaped protrusion of the cornea leading to visual impairment.

There is no effective treatment of keratoconus. The mainstay of treatment focuses on correction of vision with spectacles or contact lenses. Keratoplasty may be considered when vision cannot be further corrected with contact lenses.

MANDATES:

CODES:

Important note:

CODES: Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.

CPT Codes:	92071 - Fitting of Contact Lens for Treatment of Ocular Surface Disease 92311, 92312, 92315, 92316 - Fitting of contact lens, corneal lens for aphakia 0402T - Collagen cross-linking of cornea (including removal of the corneal epithelium and intraoperative pachymetry when performed)
CPT Not Covered:	92072 - Fitting of Contact Lens for Management of Keratoconus
ICD10 codes:	Q12.3 - Congenital aphakia T26.60XA - T26.62XS - Corrosion of cornea and conjunctival sac D89.811 - Chronic graft-versus-host disease G90.1 - Familial dysautonomia [Riley-Day] H04.121 - H04.129 - Dry eye syndrome of lacrimal gland H16.211 - H16.219 - Exposure keratoconjunctivitis H16.221 - H16.229 - Keratoconjunctivitis sicca, not specified as Sjogren's H16.231 - H16.239 - Neutrophic keratoconjunctivitis H18.811 - H18.819 - Anesthesia and hypoesthesia of cornea L12.1 - Cicatricial pemphigoid L51.1 - Stevens-Johnson syndrome L51.2 - Toxic epidermal necrolysis [Lyell] L51.3 - Stevens-Johnson syndrome-toxic epidermal necrolysis overlap syndrome M05.00 - M06.9 Rheumatoid arthritis M35.00 - M35.09 Sicca syndrome Q13.1 - Absence of iris Q81.0 - Q81.9 - Epidermolysis bullosa Q82.4 - Ectodermal dysplasia (anhidrotic) Q87.89 - Other specified congenital malformation syndromes, not elsewhere classified [Seckle's syndrome]

	T26.00x+ - T26.92x+ - Burn and corrosion confined to eye and adnexa T66.xxx+ - Radiation sickness, unspecified [dry eyes due to radiation]
ICD10 Not covered:	H18.6xx Keratoconus
HCPCS Codes	V2520 – V2523 - contact lens specific for aphakia.

CMS:

POLICY HISTORY:

Status	Date	Action
New	03/07/2017	New policy
Reviewed	01/30/2018	No changes
Reviewed	03/28/2019	No changes
Reviewed	04/22/2020	Added collagen cross-linkage use criteria

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. SWHP will continue to review clinical evidence related to this policy and may modify it at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to SWHP so the information can be reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.

1. Watson SL, Barker NH. Interventions for recurrent corneal erosions. Cochrane Database Syst Rev. 2007:(4):CD001861.
2. Up-To-Date: Keratoconus. https://www.uptodate.com/contents/keratoconus?source=search_result&search=keratoconus&selectedTitle=1~19. Viewed 03/07/2017.