MEDICAL COVERAGE POLICY

SERVICE: **Keratoconus and Medical Contact Lenses**

Policy Number:	**229**
Effective Date:	**05/01/2025**
Last Review:	**04/14/2025**
Next Review:	**04/14/2026**

Important note: *Unless otherwise indicated, medical policies will apply to all lines of business. Medical necessity as defined by this policy does not ensure the benefit is covered. This medical policy does not replace existing federal or state rules and regulations for the applicable service or supply. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan documents. See the member plan specific benefit plan document for a complete description of plan benefits, exclusions, limitations, and conditions of coverage. In the event of a discrepancy, the plan document always supersedes the information in this policy.*

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PRIOR AUTHORIZATION: Not required

POLICY: Please review the plan's EOC (Evidence of Coverage) or Summary Plan Description (SPD) for details. Most BSWHP 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.

Note: Unless otherwise indicated (see below), this policy will apply to all lines of business.

For Medicare plans, please refer to appropriate Medicare NCD (National Coverage Determination) or LCD (Local Coverage Determination). Medicare NCD or LCD specific InterQual criteria may be used when available. If there are no applicable NCD or LCD criteria, use the criteria set forth below.

For Medicaid plans, please confirm coverage as outlined in the Texas Medicaid Provider Procedures Manual | TMHP (TMPPM). If there are no applicable criteria to guide medical necessity decision making in the TMPPM, use the criteria set forth below.

If coverage of contact lenses is NOT excluded for ALL conditions, then **BSWHP may consider contact lenses medically necessary** for the following indications:

1. BSWHP 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 the 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
- Bullous keratopathy
- Corneal abrasion

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

4. BSWHP may consider **epithelium-off photochemical collagen cross-linkage using riboflavin (Photrexa) and ultraviolet A medically necessary** for keratoconus and keratectasia when the following criteria are met:
   a. Member has progressive keratoconus; AND
   b. Member is between the ages of 14 - 65 years and is not pregnant; AND
   c. The central cornea is clear, without scarring or disease

BACKGROUND:

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: None

CODES:
Important note: *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)

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CPT Codes Not Covered	92072 - Fitting of Contact Lens for Management of Keratoconus
ICD-10 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]
ICD-10 Codes Not Covered	H18.6xx - Keratoconus
HCPCS Codes	V2520 – V2523 - contact lens specific for aphakia

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
Reviewed	04/22/2021	No changes
Reviewed	04/21/2022	No changes
Reviewed	04/27/2023	No changes
Updated	05/25/2023	Incorporated covered conditions from external reviewer
Reviewed	05/13/2024	Formatting changes, added hyperlinks to TMPPM, beginning and ending note sections updated to align with CMS requirements and business entity changes
Reviewed	04/14/2025	No changes

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. BSWHP 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 BSWHP 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?search=keratoconus&source=search_result&selectedTitle=1~20&usage_type=default&display_rank=1. Viewed 04/20/2021.

***Note**:*

Health Maintenance Organization (HMO) products are offered through Scott and White Health Plan dba Baylor Scott & White Health Plan, and Scott & White Care Plans dba Baylor Scott & White Care Plan. Insured PPO and EPO products are offered through Baylor Scott & White Insurance Company. Scott and White Health Plan dba Baylor Scott & White Health Plan serves as a third-party administrator for self-funded employer-sponsored plans. Baylor Scott & White Care Plan and Baylor Scott & White Insurance Company are wholly owned subsidiaries of Scott and White Health Plan. These companies are referred to collectively in this document as Baylor Scott & White Health Plan.

RightCare STAR Medicaid is offered through Scott and White Health Plan in the Central Texas Medicaid Rural Service Area (MRSA); FirstCare STAR is offered through SHA LLC dba FirstCare Health Plans (FirstCare) in the Lubbock and West MRSAs; and FirstCare CHIP is offered through FirstCare in the Lubbock Service Area.