Clinical Policy: Ocular Prosthesis

Description:
This policy describes the medical necessity requirements for prescription, fitting, supply, polishing & resurfacing of an ocular prosthesis or scleral shell.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® (Centene) that the prescription, fitting and supply of an ocular prosthesis is medically necessary for the following indications:
   A. Restore anatomy to an eviscerated or enucleated socket.

II. It is the policy of health plans affiliated with Centene that the prescription, fitting and supply of a scleral shell is medically necessary for the following indications:
   A. Sightless, shrunken eye;
   B. Severe dry eye.

III. It is the policy of health plans affiliated with Centene that the enlargement, reduction, or refitting and supply of an ocular prosthesis is medically necessary for the following indications:
   A. To align with anatomical changes in soft tissue of the orbit over time or to correct a poor fitting prosthesis, once in five years
   B. To accommodate for orbital growth in a pediatric patient, once in two years

IV. It is the policy of health plans affiliated with Centene that resurfacing and polishing of a scleral shell or ocular prosthesis is medically necessary for the following indications:
   A. As a preventive measure to remove scratches and prevent build-up of protein and other possible ocular irritants.

Background
Prescription, fitting, and supply of an ocular prosthetic is performed by an ophthalmologist, optometrist, ocularist, or technician who measures dimensions, selects colors, formulates modifications, and provides an ocular prosthesis of glass or plastic shaped and colored to specifications that resemble the anterior portion of the patient’s normal eye. The prosthesis is inserted into the patient’s eviscerated or enucleated socket. Polishing and re-surfacing of an ocular prosthesis is necessary as a preventative measure to remove scratches and prevent build-up of protein and other possible ocular irritants. A scleral shell fits over the entire exposed surface of the eye as opposed to a corneal contact lens, which covers only the central non-white area encompassing the pupil and iris. Where an eye has been rendered sightless and shrunken by inflammatory disease, a scleral shell may, among other things, obviate the need for surgical enucleation and prosthetic implant and act to support the surrounding orbital tissue.

Scleral shells are occasionally used in combination with artificial tears in the treatment of "dry eye" of diverse etiology. Tears ordinarily dry at a rapid rate, and are continually replaced by the lacrimal gland.
When the lacrimal gland fails, the half-life of artificial tears may be greatly prolonged by the use of the scleral contact lens as a protective barrier against the drying action of the atmosphere. Thus, the difficult and sometimes hazardous process of frequent installation of artificial tears may be avoided. The lens acts in this instance to substitute, in part, for the functioning of the diseased lacrimal gland and would be covered as a prosthetic device in the rare case when it is used in the treatment of "dry eye."

**Coding Implications**
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>V2623*</td>
<td>Prosthetic eye, plastic, custom</td>
</tr>
<tr>
<td>V2624</td>
<td>Polishing/resurfacing of ocular prosthesis</td>
</tr>
<tr>
<td>V2625</td>
<td>Enlargement of ocular prosthesis</td>
</tr>
<tr>
<td>V2626</td>
<td>Reduction of ocular prosthesis</td>
</tr>
<tr>
<td>V2627*</td>
<td>Scleral cover shell</td>
</tr>
<tr>
<td>V2628</td>
<td>Fabrication and fitting of ocular conformer</td>
</tr>
<tr>
<td>V2629*</td>
<td>Prosthetic eye, other type</td>
</tr>
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</table>

*(RT, LT Modifier)*

**ICD-10-CM Diagnosis Codes that Support Coverage Criteria**

+ Indicates a code requiring an additional character

The following diagnoses are considered for medical indications for an ocular prosthesis:

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Q11.1</td>
<td>Other anophthalmos [congenital absence of eye]</td>
</tr>
<tr>
<td>Z90.01</td>
<td>Acquired absence of eye</td>
</tr>
</tbody>
</table>

The following diagnoses are considered for medical indications for a scleral shell:

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>H04.121</td>
<td>Dry eye syndrome of right lacrimal gland</td>
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<tr>
<td>H04.122</td>
<td>Dry eye syndrome left lacrimal gland</td>
</tr>
<tr>
<td>H04.123</td>
<td>Dry eye syndrome bilateral lacrimal glands</td>
</tr>
<tr>
<td>H05.311</td>
<td>Atrophy of right orbit</td>
</tr>
<tr>
<td>H05.312</td>
<td>Atrophy of left orbit</td>
</tr>
</tbody>
</table>
## ICD-10-CM Code | Description
--- | ---
H05.313 | Atrophy of bilateral orbits
H05.321 | Deformity of right orbit due to bone disease
H05.322 | Deformity of left orbit due to bone disease
H05.323 | Deformity of bilateral orbits due to bone disease
H05.331 | Deformity of right orbit due to trauma or surgery
H05.332 | Deformity of left orbit due to trauma or surgery
H05.333 | Deformity of bilateral orbits due to trauma or surgery
H05.341 | Enlargement of right orbit
H05.342 | Enlargement of left orbit
H05.343 | Enlargement of bilateral orbits
H05.351 | Exostosis of right orbit
H05.352 | Exostosis of left orbit
H05.353 | Exostosis of bilateral orbits
H16.221 | Keratoconjunctivitis sicca, not specified as Sjögren's, right eye
H16.222 | Keratoconjunctivitis sicca, not specified as Sjögren's, left eye
H16.223 | Keratoconjunctivitis sicca, not specified as Sjögren's, bilateral
Q11.1 | Other anophthalmos [congenital absence of eye]
Z90.01 | Acquired absence of eye

## Reviews, Revisions, and Approvals

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<thead>
<tr>
<th>Description</th>
<th>Date</th>
<th>Approval Date</th>
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<tbody>
<tr>
<td>Annual Review</td>
<td>12/2019</td>
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<tr>
<td>Converted to new template</td>
<td>07/2020</td>
<td>10/2020</td>
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<td>Annual Review</td>
<td>12/2020</td>
<td>01/2021</td>
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## References

## Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy...
was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

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This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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