Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

Therapeutic Lenses

Effective: September 15, 2023

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below	Yes ☒ No ☐
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

☐ Harvard Pilgrim Health Care Commercial products; 800-232-0816

☒ Tufts Health Plan Commercial products; 617-972-9409

CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055

☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055

☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404

☒ Tufts Health Unify* – OneCare Plan (a dual-eligible product); 857-304-6304

*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

Senior Products

☐ Harvard Pilgrim Health Care Stride Medicare Advantage; 866-874-0857

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-673-0965

☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-673-0965

☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-673-0965

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Overview

The Plan defines Therapeutic Lenses, for the purpose of these Medical Necessity Guidelines, as lenses that provide visual rehabilitation for diseased or altered eyes (Kollbaum, 2003). These lenses can be either eyeglass or contact lenses and require prior authorization as described by the Coverage Guidelines below.

Contact lenses that are used to protect or reduce pain in injured eyes, including but not limited to bandage contact lenses, are covered when medically necessary without prior authorization.

Clinical Guideline Coverage Criteria

The Plan may provide coverage, without prior authorization, for the cost of either one set of contact lenses or one set of eyeglasses, when ordered by a physician or optometrist, and when the Member meets one of the following criteria:

1. The Member has aphakia or has had a covered eye surgery, for removal of the natural lens of the eye, without intraocular lens placement.

   NOTE: Coverage is provided for one pair of eyeglasses (standard prescription lenses and standard (non-deluxe) frames) **or** one set of contact lenses **per covered surgery**.

2. The Member has one of the following conditions **and** there has been a prescription change:

a. Keratoconus
b. Anisometropia (more than 3.0 diopters)
c. High myopia (more than 14.0 diopters)
d. Persistent epithelial defects
e. Post corneal transplant perforations
f. Aniridia

Note: Coverage is provided for one pair of eyeglasses (standard prescription lenses and standard (non-deluxe) frames) **or** one set of contact lenses **per benefit year**.

Limitations

1. The Plan will not cover the cost of supplies used to clean or otherwise maintain lenses.
2. The Plan will not cover the cost of sunglasses.
3. The Plan does not cover low-vision aids (including lenses) for low vision except for diabetics who are legally blind.
4. “Add On” to lenses, including but not limited to tints and progressive lenses are not covered.

Codes

The following code(s) require prior authorization for conditions other than what is listed below

Table 1: CPT/HCPCS Codes

Code	Description
92071	Fitting of contact lens for the treatment of ocular disease
92072	Fitting of contact lens for the management of keratoconus, initial fitting

The following ICD-10 Diagnosis codes do not require prior authorization

Table 2: ICD-10 Codes

Code	Description
H18.43	Other calcerous corneal degeneration
H18.441	Keratomalacia, right eye
H18.442	Keratomalacia, left eye
H18.443	Keratomalacia, bilateral
H18.449	Keratomalacia, unspecified eye
H18.451	Nodular corneal degeneration, right eye
H18.452	Nodular corneal degeneration, left eye
H18.453	Nodular corneal degeneration, bilateral
H18.459	Nodular corneal degeneration, unspecified eye
H18.461	Peripheral corneal degeneration, right eye
H18.462	Peripheral corneal degeneration, left eye
H18.463	Peripheral corneal degeneration, bilateral
H18.469	Peripheral corneal degeneration, unspecified eye
H18.49	Other corneal degeneration
H18.601	Keratoconus, unspecified, right eye
H18.602	Keratoconus, unspecified, left eye
H18.603	Keratoconus, unspecified, bilateral
H18.609	Keratoconus, unspecified, unspecified eye

Code	Description
H18.611	Keratoconus, stable, right eye
H18.612	Keratoconus, stable, left eye
H18.613	Keratoconus, stable, bilateral
H18.619	Keratoconus, stable, unspecified eye
H18.621	Keratoconus, unstable, right eye
H18.622	Keratoconus, unstable, left eye
H18.623	Keratoconus, unstable, bilateral
H18.629	Keratoconus, unstable, unspecified eye
H18.831	Recurrent erosion of cornea, right eye
H18.832	Recurrent erosion of cornea, left eye
H18.833	Recurrent erosion of cornea, bilateral
H18.839	Recurrent erosion of cornea, unspecified eye
H27.00	Aphakia, unspecified eye
H27.01	Aphakia, right eye
H27.02	Aphakia, left eye
H27.03	Aphakia, bilateral
H44.21	Degenerative myopia, right eye
H44.22	Degenerative myopia, left eye
H44.23	Degenerative myopia, bilateral
H44.2A1	Degenerative myopia with choroidal neovascularization, right eye
H44.2A2	Degenerative myopia with choroidal neovascularization, left eye
H44.2A3	Degenerative myopia with choroidal neovascularization, bilateral eye
H44.2A9	Degenerative myopia with choroidal neovascularization, unspecified eye
H44.2B1	Degenerative myopia with macular hole, right eye
H44.2B2	Degenerative myopia with macular hole, left eye
H44.2B3	Degenerative myopia with macular hole, bilateral eye
H44.2B9	Degenerative myopia with macular hole, unspecified eye
H44.2C1	Degenerative myopia with retinal detachment, right eye
H44.2C2	Degenerative myopia with retinal detachment, left eye
H44.2C3	Degenerative myopia with retinal detachment, bilateral eye
H44.2C9	Degenerative myopia with retinal detachment, unspecified eye
H44.2D1	Degenerative myopia with foveoschisis, right eye
H44.2D2	Degenerative myopia with foveoschisis, left eye
H44.2D3	Degenerative myopia with foveoschisis, bilateral eye
H44.2D9	Degenerative myopia with foveoschisis, unspecified eye
H44.2E1	Degenerative myopia with other maculopathy, right eye
H44.2E2	Degenerative myopia with other maculopathy, left eye
H44.2E3	Degenerative myopia with other maculopathy, bilateral eye

Code	Description
H44.2E9	Degenerative myopia with other maculopathy, unspecified eye
H52.31	Anisometropia
Q12.3	Congenital aphakia
Q13.1	Absence of iris
Z96.1	Presence of intraocular lens

References:

1. Kollbaum, P. What are therapeutic lenses? Indiana Optometric Education. July 10, 2003.
2. Davis, R. Medically Necessary Contact Lenses: Medical Plan or Vision Plan Responsibility? June 6, 2015. reviewofcontactlenses.com/content/c/61555. Accessed April 5, 2018.

Approval And Revision History

March 18, 2020: Reviewed by IMPAC, renewed without changes

Subsequent endorsement date(s) and changes made:

- March 24, 2020: Unify fax number updated
- March 17, 2021: Reviewed by IMPAC, renewed without changes
- May 18, 2022: Reviewed by Medical Policy Approval Committee (MPAC), renewed without changes
- April 19, 2023: Reviewed by MPAC, renewed without changes, effective June 1, 2023
- June 21, 2023: Reviewed by MPAC, renewed without changes

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.