PAYMENT POLICY STATEMENT: MEDICARE ADVANTAGE

Original Effective Date	Next Annual Review Date	Last Review / Revision Date
05/17/2016	05/17/2017	05/17/2016

Policy Name	Policy Number
Hydrophilic Contact Lenses	PY-0058

Policy Type		
☐ Medical	☐ Administrative	☒ Payment

Payment Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Payment Policies.

In addition to this Policy, payment of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

A. SUBJECT

Hydrophilic Contact Lenses

B. BACKGROUND

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be determined based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment.

C. DEFINITIONS

- **Hydrophilic contact lenses** are eyeglasses within the meaning of the exclusion in §1862(a)(7) of the Social Security Act and are not covered when used in the treatment of non-diseased eyes with spherical ametrophia, refractive astigmatism, and/or corneal astigmatism.

Payment may be made under the prosthetic device benefit, however, for hydrophilic contact lenses when prescribed for an aphakic patient.

D. POLICY

I. CareSource will reimburse providers for Hydrophilic Contact Lenses utilized through Medicare Advantage when approved by CareSource.

II. If required, providers must submit their prior authorization number their claim form, as well as appropriate HCPCS and/or CPT codes along with appropriate modifiers in accordance with CMS.

For Medicare Plan members, reference the Applicable National Coverage Determinations (NCD) and Local Coverage Determinations (LCD). Compliance with NCDs and LCDs is required where applicable.

CONDITIONS OF COVERAGE

Reimbursement is dependent on, but not limited to, submitting CMS approved HCPCS and CPT codes along with appropriate modifiers. Please refer to:
https://www.cms.gov/Medicare/Medicare.html

CPT/HCPCS Codes	
Code	Description
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

Modifiers	
Code	Description
LT	Left side
RT	Right side

AUTHORIZATION PERIOD

If applicable, reimbursement is dependent upon products and services frequency, duration and timeframe set forth by CMS.

E. RELATED POLICIES/RULES

Further information can be found at: National Coverage Determinations (NCD): NCD 80.4 Hydrophilic Contact Lenses https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=233&ncdver=1&DocID=80.4&kq=true&bc=gAAAAAgAAAAAAA%3d%3d&

F. REVIEW/REVISION HISTORY

Date Issued: 05/17/2016
Date Reviewed: 05/17/2016
Date Revised:

G. REFERENCES

1. Centers for Medicare & Medicaid. (2016, April). Retrieved May 12, 2016, from https://www.cms.gov/medicare-coverage-database/(S(v0cxhe45alguxjupvjx24zai))/details/ncd-details.aspx?NCDId=281&ncdver=5&CALId=97&ver=5&CalName=Prothrombin Time and Fecal Occult Blood (Revision of ICD-9-CM Codes for Injury to Gastrointestinal Tract)&bc=gAgAAAAAgAIAAA==&

The Payment Policy Statement detailed above has received due consideration as defined in the Payment Policy Statement Policy and is approved.