Eye Prosthesis

Adopted from the National Government Services website.

For any item to be covered by The Health Plan, it must:

1. Be eligible for a defined Medicare or The Health Plan benefit category
2. Be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member
3. Meet all other applicable Medicare and/or The Health Plan statutory and regulatory requirements

For the items addressed in this medical policy, the criteria for "reasonable and necessary" are defined by the following indications and limitations of coverage and/or medical necessity. Please refer to individual product lines certificates of coverage for possible exclusions of benefit.

For an item to be covered by The Health Plan, the supplier must receive a written, signed, and dated order before a claim is submitted to The Health Plan. If the supplier bills for an item addressed in this policy without first receiving the completed order, the item will be denied as not reasonable and necessary.

Suppliers are to follow The Health Plan requirements for precertification, as applicable.

Eye prostheses require precertification.

<table>
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<tr>
<th>CMS National Coverage Policy</th>
<th>None</th>
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| Review/Revisions Effective Date | For service performed on or after 05/01/14  
Reviewed: 04/01/17, 01/01/16 |
| The Health Plan | Plans will follow Coverage Determination posted on the CGS website unless otherwise indicated in sections of this policy, contractual agreements, or benefit plan documents. |

DESCRIPTION

An ocular prosthesis or artificial eye is a type of craniofacial prosthesis that replaces an absent natural eye following an enucleation, evisceration, or orbital exenteration. The prosthesis fits over an orbital implant and under the eyelids.

COVERAGE GUIDELINES

Eye prosthesis is covered for a patient with absence or shrinkage of an eye due to birth defect, trauma, or surgical removal.

Polishing and resurfacing (V2624) is covered on a twice per year basis.

One enlargement (V2625) or reduction (V2626) of the prosthesis is covered without documentation. Additional enlargements or reductions are rarely medically necessary and are therefore covered only
when there is information in the medical record which supports medical necessity. This information must be available upon request.

If an item or service does not meet the criteria specified in this section, it will be denied as not medically necessary unless there is documentation in the medical record clearly explaining the medical necessity in the individual situation.

CODING INFORMATION

CPT/HCPCS codes: The appearance of a code in this section does not necessarily indicate coverage.

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<th>HCPCS MODIFIERS</th>
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<tr>
<th>HCPCS CODES</th>
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<td><strong>L9900</strong></td>
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<td><strong>V2623</strong></td>
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There are no specified diagnoses or ICD-10 codes that indicate medical necessity.

DOCUMENTATION REQUIREMENTS

For the purposes of this policy, it is expected that the medical record will support the need for the care provided. It is generally understood that the medical record includes the physician’s office records, hospital records, nursing home records, home health agency records, records from other health care professionals and test reports.

This documentation must be available with precertification.
Medicare has made changes to its requirements for dispensing orders, detailed written orders, and proof of delivery. The Health Plan will require the following:

1. Physician detailed written order. Order must include the following:
   a. Member’s name
   b. Date
   c. Description of item. The medical record must contain the information that supports the request for each item and must be submitted with the precertification, if the item requires precertification, or with the claim, if no precertification was required
   d. Order must include diagnosis code
   e. Physician signature with date. Date stamps are not appropriate
   f. Quantity of items required and duration. A new order is required if there is an increase in the quantity of the supply used per month and/or the type of supply used

   The supplier is to contact The Health Plan in this instance to update referral

2. There must be documentation in the supplier’s records to support the medical necessity of that item. This information must be available upon request, usually with precertification per The Health Plan policy.

3. Proof of delivery to be kept on file by the provider of the item.

   Note: If templates or forms are submitted, (i.e., a Medicare Certificate of Medical Necessity, and/or a provider created form), and all of the required information is not included, The Health Plan reserves the right to request the medical record, that may include, but not limited to, the physician office notes, hospital and nursing facility records, and home health records.

   Note: Template provider forms, prescriptions, and attestation letters are not considered part of the medical record, even if signed by the ordering physician.

Precertification is required when supplies used are greater than the usual maximum quantity listed in above. There must be adequate, clear documentation in the medical record corroborating the medical necessity of this amount. This documentation is to be submitted with precertification.

BILLING GUIDELINES

Trial scleral cover shells are not separately payable. They are included in the allowance for scleral cover shells, V2627.

Replacement of an ocular prosthesis is governed by the five year reasonable useful lifetime rule.
Replacement of a prosthesis or prosthetic component prior to five years is covered if the prosthesis is irreparably damaged, lost, or stolen.

Replacement of an ocular prosthesis because of loss or irreparable damage may be reimbursed without a physician’s order when it is determined that the prosthesis as originally ordered still fills the patient’s medical needs.
Trial scleral shells must be billed with code L9900.

The right (RT) and/or left (LT) modifiers must be used with all HCPCS codes in this policy. Claims billed without modifiers RT and/or LT will be rejected as incorrect coding.

**KX, GA, and GZ MODIFIERS**

Suppliers may submit a claim with a KX modifier only if all the criteria for that item is met.

If coverage criteria are not met, the GA or GZ modifier must be used. When there is an expectation of a medical denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or the GZ modifier, if they have not obtained a valid ABN.

**ADVANCED BENEFICIARY NOTICE**

The Health Plan expects providers to follow the Medicare policy on ABN across all Medicare, Medicaid, and Commercial plans.

**NOTE:** Providers may be held financially responsible if they furnish the above items without notifying the member, verbally and in writing, that the specific service being provided is not covered. This must be done prior to the dispensing of the device. The provider must submit the waiver or ABN to The Health Plan with the claim showing the member agreed to pay for the device. Generalized statements on waivers or ABN are not acceptable.

**PRICING, DATA ANALYSIS, AND CODING (PDAC)**

The Health Plan has implemented use of Medicare’s PDAC contractor for review of authorizations. Please refer to PDAC website for the appropriate product classification list. Suppliers should contact the PDAC contractor for guidance on the correct coding of these items. [dmepdac.com](http://dmepdac.com/)

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**INTERNET LINKS AND SOURCES**


The Health Plan Provider Procedural Manual. Payment Voucher, Section 14, Page 11