

Local Coverage Determination (LCD): Eye Prostheses (L33737)

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Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
CGS Administrators, LLC	DME MAC	17013 - DME MAC	J-B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi North Carolina New Mexico Oklahoma Puerto Rico South Carolina Tennessee Texas Virginia Virgin Islands West Virginia
CGS Administrators, LLC	DME MAC	18003 - DME MAC	J-C	Connecticut District of Columbia Delaware Massachusetts Maryland Maine New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont Alaska American Samoa Arizona California - Entire State Guam Hawaii Iowa Idaho Kansas Missouri - Entire State Montana North Dakota Nebraska Nevada Oregon South Dakota
Noridian Healthcare Solutions, LLC	DME MAC	16013 - DME MAC	J-A	
Noridian Healthcare Solutions, LLC	DME MAC	19003 - DME MAC	J-D	

LCD Information

Document Information

LCD ID
L33737Original Effective Date
For services performed on or after 10/01/2015Original ICD-9 LCD ID
[L11519](#)
[L27034](#)
[L11529](#)
[L194](#)Revision Effective Date
For services performed on or after 01/01/2017Revision Ending Date
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Eye ProsthesesRetirement Date
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Notice Period Start Date
N/ANotice Period End Date
N/A

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CMS National Coverage Policy None

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements.

The purpose of a Local Coverage Determination (LCD) is to provide information regarding "reasonable and necessary" criteria based on Social Security Act § 1862(a)(1)(A) provisions.

In addition to the "reasonable and necessary" criteria contained in this LCD there are other payment rules, which are discussed in the following documents, that must also be met prior to Medicare reimbursement:

- The LCD-related Standard Documentation Requirements Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- The LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- Refer to the Supplier Manual for additional information on documentation requirements.
- Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

For the items addressed in this LCD, the "reasonable and necessary" criteria, based on Social Security Act § 1862(a)(1)(A) provisions, are defined by the following coverage indications, limitations and/or medical necessity.

Eye prostheses are covered for a beneficiary 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 reasonable and necessary unless there is documentation in the medical record clearly explaining the medical necessity in the individual situation.

GENERAL

A Detailed Written Order (DWO) (if applicable) must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving a completed DWO, the claim shall be denied as not reasonable and necessary.

An item/service is correctly coded when it meets all the coding guidelines listed in CMS HCPCS guidelines, LCDs, LCD-related Policy Articles, or DME MAC articles. Claims that do not meet coding guidelines shall be denied as not reasonable and necessary/incorrectly coded.

Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. Proof of delivery documentation must be made available to the Medicare contractor upon request. All services that do not have appropriate proof of delivery from the supplier shall be denied as not reasonable and necessary.

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Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

N/A

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

N/A

CPT/HCPCS Codes

Group 1 Paragraph: The appearance of a code in this section does not necessarily indicate coverage.

HCPCS MODIFIERS:

EY - No physician or other licensed health care provider order for this item or service

LT - Left side

RT - Right side

HCPCS CODES:

Group 1 Codes:

L9900 ORTHOTIC AND PROSTHETIC SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS "L" CODE
V2623 PROSTHETIC EYE, PLASTIC, CUSTOM
V2624 POLISHING/RESURFACING OF OCULAR PROSTHESIS
V2625 ENLARGEMENT OF OCULAR PROSTHESIS
V2626 REDUCTION OF OCULAR PROSTHESIS
V2627 SCLERAL COVER SHELL
V2628 FABRICATION AND FITTING OF OCULAR CONFORMER
V2629 PROSTHETIC EYE, OTHER TYPE

ICD-10 Codes that Support Medical Necessity N/A

ICD-10 Codes that DO NOT Support Medical Necessity N/A

ICD-10 Additional Information

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General Information

Associated Information

DOCUMENTATION REQUIREMENTS

Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is

expected that the beneficiary's medical records will reflect the need for the care provided. The beneficiary's medical records include the treating practitioner's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

GENERAL DOCUMENTATION REQUIREMENTS

In order to justify payment for DMEPOS items, suppliers must meet the following requirements:

- Prescription (orders)
- Medical Record Information (including continued need/use if applicable)
- Correct Coding
- Proof of Delivery

Refer to the LCD-related Standard Documentation Requirements article, located at the bottom of this policy under the Related Local Coverage Documents section for additional information regarding these requirements.

Refer to the Supplier Manual for additional information on documentation requirements.

Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

Items covered in this LCD have additional policy-specific requirements that must be met prior to Medicare reimbursement.

Refer to the LCD-related Policy article, located at the bottom of this policy under the Related Local Coverage Documents section for additional information.

Miscellaneous

Appendices

Utilization Guidelines

Refer to Coverage Indications, Limitations and/or Medical Necessity

Sources of Information and Basis for Decision

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Revision History Information

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
01/01/2017	R4	Revision Effective Date: 01/01/2017 COVERAGE INDICATIONS, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Removed: Standard Documentation Language Added: New reference language and directions to Standard Documentation Requirements Added: General Requirements DOCUMENTATION REQUIREMENTS: Removed: Standard Documentation Language Added: General Documentation Requirements	<ul style="list-style-type: none">• Provider Education/Guidance

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
07/01/2016	R3	<p>Added: New reference language and directions to Standard Documentation Requirements POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Removed: Standard Documentation Language Added: Direction to Standard Documentation Requirements Removed: Supplier Manual reference from Miscellaneous Removed: PIM reference from Appendices RELATED LOCAL COVERAGE DOCUMENTS: Added: LCD-related Standard Documentation Requirements article Revision Effective Date: 07/01/2016 DOCUMENTATION REQUIREMENTS: Revised: Standard Documentation language Added: Repair/Replacement Requirements</p>	<ul style="list-style-type: none"> Provider Education/Guidance
07/01/2016	R2	<p>Effective July 1, 2016 oversight for DME MAC LCDs is the responsibility of CGS Administrators, LLC 18003 and 17013 and Noridian Healthcare Solutions, LLC 19003 and 16013. No other changes have been made to the LCDs. Revision Effective Date: 10/31/2014 COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility DOCUMENTATION REQUIREMENTS: Deleted: Reference to refill of supplies from Continued Use Revised: Standard Documentation Language to add who can enter date of delivery date on the POD Added: Instructions for Equipment Retained from a Prior Payer Revised: Repair to beneficiary-owned DMEPOS</p>	<ul style="list-style-type: none"> Change in Assigned States or Affiliated Contract Numbers
10/01/2015	R1	<p>Deleted: Reference to refill of supplies from Continued Use Revised: Standard Documentation Language to add who can enter date of delivery date on the POD Added: Instructions for Equipment Retained from a Prior Payer Revised: Repair to beneficiary-owned DMEPOS</p>	<ul style="list-style-type: none"> Provider Education/Guidance

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Associated Documents

Attachments N/A

Related Local Coverage Documents Article(s) [A52462 - Eye Prostheses - Policy Article](#)
[A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs](#)

Related National Coverage Documents N/A

Public Version(s) Updated on 05/03/2017 with effective dates 01/01/2017 - N/A [Updated on 11/04/2016 with effective dates 07/01/2016 - 12/31/2016](#) Updated on 06/07/2016 with effective dates 07/01/2016 - N/A Updated on 04/09/2015 with effective dates 10/01/2015 - 06/30/2016 Updated on 04/04/2014 with effective dates 10/01/2015 - N/A [Back to Top](#)

Keywords

N/A Read the [LCD Disclaimer](#) [Back to Top](#)

END OF LOCAL COVERAGE DETERMINATION

Per the Code of Federal Regulations, 42 C.F.R § 426. 325, only those portions of the currently effective Local Coverage Determination (LCD) that are based on section 1862(a)(1)(A) of the Social Security Act, may be challenged through an acceptable complaint as described in 42 C.F.R § 426.400. Also, per 42 C.F.R § 426.325 items that are not reviewable, and therefore cannot be challenged, include the Policy Article. Please note the distinction of the documents when reviewing the materials.

Local Coverage Article: Eye Prostheses - Policy Article (A52462)

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CGS Administrators, LLC	DME MAC	17013 -	DME MAC J-B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi North Carolina New Mexico Oklahoma Puerto Rico South Carolina Tennessee Texas Virginia Virgin Islands West Virginia Connecticut District of Columbia Delaware Massachusetts Maryland Maine New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont Alaska American Samoa Arizona California - Entire State Guam Hawaii Iowa Idaho Kansas Missouri - Entire State Montana North Dakota Nebraska Nevada Oregon South Dakota
CGS Administrators, LLC	DME MAC	18003 -	DME MAC J-C	
Noridian Healthcare Solutions, LLC	DME MAC	16013 -	DME MAC J-A	
Noridian Healthcare Solutions, LLC	DME MAC	19003 -	DME MAC J-D	

Article Information

General Information

Article ID

A52462

Original Article Effective Date

10/01/2015

Original ICD-9 Article ID

[A33712](#)[A47092](#)[A33613](#)[A33672](#)**Revision Effective Date**

01/01/2017

Revision Ending Date

N/A

Article Title

Eye Prostheses - Policy Article

Retirement Date

N/A

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Article Guidance

Article Text:**NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES**

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. Information provided in this policy article relates to determinations other than those based on Social Security Act §1862(a)(1)(A) provisions (i.e. "reasonable and necessary").

Eye prostheses are covered under the Medicare Artificial Legs, Arms and Eyes benefit (Social Security Act §1861(s)(9)). In order for a beneficiary's equipment to be eligible for reimbursement the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met. In addition, there are specific statutory payment policy requirements, discussed below, that also must be met.

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

The following services and items are included in the allowance for a eye prosthesis and, therefore, are not separately billable to or payable by Medicare under the prosthetic device benefit:

- Evaluation of the beneficiary
- Pre-operative planning
- Cost of materials
- Labor involved in the fabrication and fitting of the prosthesis
- Modifications to the prosthesis made at the time delivery of the prosthesis or within 90 days thereafter
- Repair due to normal wear or tear within 90 days of delivery
- Follow-up visits within 90 days of delivery of the prosthesis

Modifications to a prosthesis are separately payable when they occur more than 90 days after delivery of the prosthesis and they are required because of a change in the beneficiary's condition.

Repairs are covered when there has been accidental damage or extensive wear to the prosthesis that can be repaired. If the expense for repairs exceeds the estimated expense for a replacement prosthesis, no payments can be made for the amount of the excess.

Follow-up visits which occur more than 90 days after delivery and which do not involve modification or repair of the prosthesis are noncovered services.

Claims for eye prostheses from nonphysicians provided in an office or nursing home setting are submitted to the DME MAC. Claims for eye prostheses from physicians in these settings are submitted to the local carrier. Claims for eye prostheses provided in an outpatient hospital setting are submitted to the local intermediary. Eye prostheses provided in an inpatient hospital setting are included in the payment made to the hospital; and, therefore should not be submitted to the DME MAC. Implanted prosthesis anchoring components should not be billed to the DME MAC.

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 beneficiary's medical needs.

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

In addition to policy specific documentation requirements, there are general documentation requirements that are applicable to all DMEPOS policies. These general requirements are located in the DOCUMENTATION REQUIREMENTS section of the LCD.

Refer to the LCD-related Standard Documentation Requirements article, located at the bottom of this Policy Article under the Related Local Coverage Documents section for additional information regarding GENERAL DOCUMENTATION REQUIREMENTS and the POLICY SPECIFIC DOCUMENTATION REQUIREMENTS.

When billing for an item or service at a greater frequency than that described in the policy, there must be documentation in the beneficiary's medical records that corroborates the order and supports the medical necessity of the items and quantities billed. This information must be available upon request.

The physician's records must contain information which supports the medical necessity of the item ordered. The ocularist's documentation of the necessity for a replacement prosthesis is appropriate documentation for that claim if the replacement is necessitated by other than medical reasons.

CODING GUIDELINES

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. When the same code for bilateral items (left and right) is billed on the same date of service, bill for both items on the same claim line using the RTL modifiers and 2 units of service. Claims billed without the RT and/or LT modifiers will be rejected as incorrect coding.

Suppliers should contact the Pricing, Data Analysis and Coding (PDAC) Contractor for guidance on the correct coding of these items. [Back to Top](#)

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

N/A

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the article, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

N/A

CPT/HCPCS Codes N/A

ICD-10 Codes that are Covered N/A

ICD-10 Codes that are Not Covered N/A

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Revision History Information

Revision History Date	Revision History Number	Revision History Explanation
01/01/2017	R3	Revision Effective Date: 01/01/2017 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Removed: Reasonable Useful Lifetime verbiage

Revision History Date	Revision History Number	Revision History Explanation
07/01/2016	R2	POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Added: New reference language and directions to Standard Documentation Requirements
07/01/2016	R1	Added: Replacement instructions (previously in the related LCD) RELATED LOCAL COVERAGE DOCUMENTS: Added: LCD-related Standard Documentation Requirements Language Article Revision Effective Date: 07/01/2016 NON-MEDICAL NECESSITY COVERAGE & PAYMENT RULES: Added: Instructions for services and items included in the allowance of the eye prostheses, and not separately billable Effective July 1, 2016 oversight for DME MAC Articles is the responsibility of CGS Administrators, LLC 18003 and 17013 and Noridian Healthcare Solutions, LLC 19003 and 16013. No other changes have been made to the Articles.

[Back to Top](#) **Related Local Coverage Document(s)** Article(s) [A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs](#) LCD(s) [L33737 - Eye Prostheses](#)

Related National Coverage Document(s) N/A

Statutory Requirements URL(s) N/A

Rules and Regulations URL(s) N/A

CMS Manual Explanations URL(s) N/A

Other URL(s) N/A

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[Keywords](#)

N/A Read the [Article Disclaimer](#) [Back to Top](#)