

Local Coverage Determination (LCD): Refractive Lenses (L33793)

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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
CGS Administrators, LLC	DME MAC	18003 - DME MAC	J-C	Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi North Carolina New Mexico Oklahoma Puerto Rico South Carolina Tennessee Texas Virginia Virgin Islands West Virginia
Noridian Healthcare Solutions, LLC	DME MAC	16013 - DME MAC	J-A	Connecticut District of Columbia Delaware Massachusetts Maryland Maine New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Noridian Healthcare Solutions, LLC	DME MAC	19003 - DME MAC	J-D	Alaska American Samoa Arizona California - Entire State Guam Hawaii Iowa Idaho Kansas Missouri - Entire State Montana North Dakota Nebraska Nevada Oregon South Dakota Utah Washington Wyoming Northern Mariana Islands

LCD Information

Document Information

LCD ID

L33793

Original ICD-9 LCD ID

[L27037](#)

[L11522](#)

[L11532](#)

[L51](#)

LCD Title

Refractive Lenses

Proposed LCD in Comment Period

N/A

Source Proposed LCD

N/A

Original Effective Date

For services performed on or after 10/01/2015

Revision Effective Date

For services performed on or after 01/01/2017

Revision Ending Date

N/A

Retirement Date

N/A

Notice Period Start Date

N/A

Notice 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.

Statutory coverage criteria for refractive lenses are specified in the related Policy Article.

For beneficiaries who are aphakic (i.e., who have had a cataract removed but do not have an implanted intraocular lens (IOL) or who have congenital absence of the lens), the following lenses or combinations of lenses are covered when determined to be medically necessary:

1. Bifocal lenses in frames; or
2. Lenses in frames for far vision and lenses in frames for near vision; or
3. When a contact lens(es) for far vision is prescribed (including cases of binocular and monocular aphakia), payment will be made for the contact lens(es), and lens(es) in frames for near vision to be worn at the same time as the contact lens(es) and lenses in frames to be worn when the contacts have been removed.

For beneficiaries who are pseudophakic (i.e., those who have an IOL), refer to the Policy Article for information about coverage of the initial pair of lenses.

For aphakic beneficiaries (i.e., those who do not have an IOL), replacement lenses are covered when they are medically necessary. Refer to the Policy Article for information about noncoverage of replacement lenses for pseudophakic beneficiaries.

Anti-reflective coating (V2750), tints (V2744, V2745) or oversize lenses (V2780) are covered only when they are medically necessary for the individual beneficiary and the medical necessity is documented by the treating physician. When these features are provided as a beneficiary preference item and are billed with an EY modifier (see LCD-related Standard Documentation Requirements Article), they will be denied as not reasonable and necessary.

UV protection is considered reasonable and necessary following cataract extraction; therefore, additional medical necessity justification by the treating physician beyond inclusion on the order is not necessary.

The addition of UV coating (V2755) is not reasonable and necessary for polycarbonate lenses (V2784). Claims for code V2755 billed in addition to code V2784 will be denied as not reasonable and necessary. Additional information regarding the coding and billing of UV coating (V2755) on lenses with UV protective properties inherent in the material may be found in the related Policy Article.

Tinted lenses (V2745), including photochromatic lenses (V2744), used as sunglasses, which are prescribed in addition to regular prosthetic lenses to an aphakic beneficiary, will be denied as not reasonable and necessary.

Lenses made of polycarbonate or other impact-resistant materials (V2784) are covered only for beneficiaries with functional vision in only one eye. In this situation, an impact-resistant material is covered for both lenses, if eyeglasses are covered. Claims for code V2784 that do not meet this coverage criterion will be denied as not reasonable and necessary.

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.

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

GA – Waiver of liability statement issued as required by payer policy, individual case

GY - Item or service statutorily excluded or doesn't meet the definition of any Medicare benefit category

GZ – Item or service expected to be denied as not reasonable and necessary

KX – Requirements specified in the medical policy have been met

LT - Left side

RT - Right side

HCPCS CODES:

FRAMES:

Group 1 Codes:

CODE	DESCRIPTION
V2020	FRAMES, PURCHASES
V2025	DELUXE FRAME

Group 2 Paragraph:

EYEGLOSS LENSES

Group 2 Codes:

CODE	DESCRIPTION
V2100	SPHERE, SINGLE VISION, PLANO TO PLUS OR MINUS 4.00, PER LENS
V2101	SPHERE, SINGLE VISION, PLUS OR MINUS 4.12 TO PLUS OR MINUS 7.00D, PER LENS
V2102	SPHERE, SINGLE VISION, PLUS OR MINUS 7.12 TO PLUS OR MINUS 20.00D, PER LENS
V2103	SPHEROCYLINDER, SINGLE VISION, PLANO TO PLUS OR MINUS 4.00D SPHERE, .12 TO 2.00D CYLINDER, PER LENS
V2104	SPHEROCYLINDER, SINGLE VISION, PLANO TO PLUS OR MINUS 4.00D SPHERE, 2.12 TO 4.00D CYLINDER, PER LENS
V2105	SPHEROCYLINDER, SINGLE VISION, PLANO TO PLUS OR MINUS 4.00D SPHERE, 4.25 TO 6.00D CYLINDER, PER LENS
V2106	SPHEROCYLINDER, SINGLE VISION, PLANO TO PLUS OR MINUS 4.00D SPHERE, OVER 6.00D CYLINDER, PER LENS

CODE	DESCRIPTION
V2107	SPHEROCYLINDER, SINGLE VISION, PLUS OR MINUS 4.25 TO PLUS OR MINUS 7.00 SPHERE, .12 TO 2.00D CYLINDER, PER LENS
V2108	SPHEROCYLINDER, SINGLE VISION, PLUS OR MINUS 4.25D TO PLUS OR MINUS 7.00D SPHERE, 2.12 TO 4.00D CYLINDER, PER LENS
V2109	SPHEROCYLINDER, SINGLE VISION, PLUS OR MINUS 4.25 TO PLUS OR MINUS 7.00D SPHERE, 4.25 TO 6.00D CYLINDER, PER LENS
V2110	SPHEROCYLINDER, SINGLE VISION, PLUS OR MINUS 4.25 TO 7.00D SPHERE, OVER 6.00D CYLINDER, PER LENS
V2111	SPHEROCYLINDER, SINGLE VISION, PLUS OR MINUS 7.25 TO PLUS OR MINUS 12.00D SPHERE, .25 TO 2.25D CYLINDER, PER LENS
V2112	SPHEROCYLINDER, SINGLE VISION, PLUS OR MINUS 7.25 TO PLUS OR MINUS 12.00D SPHERE, 2.25D TO 4.00D CYLINDER, PER LENS
V2113	SPHEROCYLINDER, SINGLE VISION, PLUS OR MINUS 7.25 TO PLUS OR MINUS 12.00D SPHERE, 4.25 TO 6.00D CYLINDER, PER LENS
V2114	SPHEROCYLINDER, SINGLE VISION, SPHERE OVER PLUS OR MINUS 12.00D, PER LENS
V2115	LENTICULAR, (MYODISC), PER LENS, SINGLE VISION
V2118	ANISEIKONIC LENS, SINGLE VISION
V2121	LENTICULAR LENS, PER LENS, SINGLE
V2199	NOT OTHERWISE CLASSIFIED, SINGLE VISION LENS
V2200	SPHERE, BIFOCAL, PLANO TO PLUS OR MINUS 4.00D, PER LENS
V2201	SPHERE, BIFOCAL, PLUS OR MINUS 4.12 TO PLUS OR MINUS 7.00D, PER LENS
V2202	SPHERE, BIFOCAL, PLUS OR MINUS 7.12 TO PLUS OR MINUS 20.00D, PER LENS
V2203	SPHEROCYLINDER, BIFOCAL, PLANO TO PLUS OR MINUS 4.00D SPHERE, .12 TO 2.00D CYLINDER, PER LENS
V2204	SPHEROCYLINDER, BIFOCAL, PLANO TO PLUS OR MINUS 4.00D SPHERE, 2.12 TO 4.00D CYLINDER, PER LENS
V2205	SPHEROCYLINDER, BIFOCAL, PLANO TO PLUS OR MINUS 4.00D SPHERE, 4.25 TO 6.00D CYLINDER, PER LENS
V2206	SPHEROCYLINDER, BIFOCAL, PLANO TO PLUS OR MINUS 4.00D SPHERE, OVER 6.00D CYLINDER, PER LENS
V2207	SPHEROCYLINDER, BIFOCAL, PLUS OR MINUS 4.25 TO PLUS OR MINUS 7.00D SPHERE,.12 TO 2.00D CYLINDER, PER LENS
V2208	SPHEROCYLINDER, BIFOCAL, PLUS OR MINUS 4.25 TO PLUS OR MINUS 7.00D SPHERE, 2.12 TO 4.00D CYLINDER, PER LENS
V2209	SPHEROCYLINDER, BIFOCAL, PLUS OR MINUS 4.25 TO PLUS OR MINUS 7.00D

CODE	DESCRIPTION
	SPHERE, 4.25 TO 6.00D CYLINDER, PER LENS
V2210	SPHEROCYLINDER, BIFOCAL, PLUS OR MINUS 4.25 TO PLUS OR MINUS 7.00D SPHERE, OVER 6.00D CYLINDER, PER LENS
V2211	SPHEROCYLINDER, BIFOCAL, PLUS OR MINUS 7.25 TO PLUS OR MINUS 12.00D SPHERE, .25 TO 2.25D CYLINDER, PER LENS
V2212	SPHEROCYLINDER, BIFOCAL, PLUS OR MINUS 7.25 TO PLUS OR MINUS 12.00D SPHERE, 2.25 TO 4.00D CYLINDER, PER LENS
V2213	SPHEROCYLINDER, BIFOCAL, PLUS OR MINUS 7.25 TO PLUS OR MINUS 12.00D SPHERE, 4.25 TO 6.00D CYLINDER, PER LENS
V2214	SPHEROCYLINDER, BIFOCAL, SPHERE OVER PLUS OR MINUS 12.00D, PER LENS
V2215	LENTICULAR (MYODISC), PER LENS, BIFOCAL
V2218	ANISEIKONIC, PER LENS, BIFOCAL
V2219	BIFOCAL SEG WIDTH OVER 28 MM
V2220	BIFOCAL ADD OVER 3.25D
V2221	LENTICULAR LENS, PER LENS, BIFOCAL
V2299	SPECIALTY BIFOCAL (BY REPORT)
V2300	SPHERE, TRIFOCAL, PLANO TO PLUS OR MINUS 4.00D, PER LENS
V2301	SPHERE, TRIFOCAL, PLUS OR MINUS 4.12 TO PLUS OR MINUS 7.00D, PER LENS
V2302	SPHERE, TRIFOCAL, PLUS OR MINUS 7.12 TO PLUS OR MINUS 20.00, PER LENS
V2303	SPHEROCYLINDER, TRIFOCAL, PLANO TO PLUS OR MINUS 4.00D SPHERE, .12-2.00D CYLINDER, PER LENS
V2304	SPHEROCYLINDER, TRIFOCAL, PLANO TO PLUS OR MINUS 4.00D SPHERE, 2.25-4.00D CYLINDER, PER LENS
V2305	SPHEROCYLINDER, TRIFOCAL, PLANO TO PLUS OR MINUS 4.00D SPHERE, 4.25 TO 6.00 CYLINDER, PER LENS
V2306	SPHEROCYLINDER, TRIFOCAL, PLANO TO PLUS OR MINUS 4.00D SPHERE, OVER 6.00D CYLINDER, PER LENS
V2307	SPHEROCYLINDER, TRIFOCAL, PLUS OR MINUS 4.25 TO PLUS OR MINUS 7.00D SPHERE, .12 TO 2.00D CYLINDER, PER LENS
V2308	SPHEROCYLINDER, TRIFOCAL, PLUS OR MINUS 4.25 TO PLUS OR MINUS 7.00D SPHERE, 2.12 TO 4.00D CYLINDER, PER LENS
V2309	SPHEROCYLINDER, TRIFOCAL, PLUS OR MINUS 4.25 TO PLUS OR MINUS 7.00D SPHERE, 4.25 TO 6.00D CYLINDER, PER LENS
V2310	SPHEROCYLINDER, TRIFOCAL, PLUS OR MINUS 4.25 TO PLUS OR MINUS 7.00D SPHERE, OVER 6.00D CYLINDER, PER LENS

CODE	DESCRIPTION
V2311	SPHEROCYLINDER, TRIFOCAL, PLUS OR MINUS 7.25 TO PLUS OR MINUS 12.00D SPHERE, .25 TO 2.25D CYLINDER, PER LENS
V2312	SPHEROCYLINDER, TRIFOCAL, PLUS OR MINUS 7.25 TO PLUS OR MINUS 12.00D SPHERE, 2.25 TO 4.00D CYLINDER, PER LENS
V2313	SPHEROCYLINDER, TRIFOCAL, PLUS OR MINUS 7.25 TO PLUS OR MINUS 12.00D SPHERE, 4.25 TO 6.00D CYLINDER, PER LENS
V2314	SPHEROCYLINDER, TRIFOCAL, SPHERE OVER PLUS OR MINUS 12.00D, PER LENS
V2315	LENTICULAR, (MYODISC), PER LENS, TRIFOCAL
V2318	ANISEIKONIC LENS, TRIFOCAL
V2319	TRIFOCAL SEG WIDTH OVER 28 MM
V2320	TRIFOCAL ADD OVER 3.25D
V2321	LENTICULAR LENS, PER LENS, TRIFOCAL
V2399	SPECIALTY TRIFOCAL (BY REPORT)
V2410	VARIABLE ASPHERICITY LENS, SINGLE VISION, FULL FIELD, GLASS OR PLASTIC, PER LENS
V2430	VARIABLE ASPHERICITY LENS, BIFOCAL, FULL FIELD, GLASS OR PLASTIC, PER LENS
V2499	VARIABLE SPHERICITY LENS, OTHER TYPE

Group 3 Paragraph:

CONTACT LENSES

Group 3 Codes:

CODE	DESCRIPTION
V2500	CONTACT LENS, PMMA, SPHERICAL, PER LENS
V2501	CONTACT LENS, PMMA, TORIC OR PRISM BALLAST, PER LENS
V2502	CONTACT LENS, PMMA, BIFOCAL, PER LENS
V2503	CONTACT LENS, PMMA, COLOR VISION DEFICIENCY, PER LENS
V2510	CONTACT LENS, GAS PERMEABLE, SPHERICAL, PER LENS
V2511	CONTACT LENS, GAS PERMEABLE, TORIC, PRISM BALLAST, PER LENS
V2512	CONTACT LENS, GAS PERMEABLE, BIFOCAL, PER LENS
V2513	CONTACT LENS, GAS PERMEABLE, EXTENDED WEAR, PER LENS
V2520	CONTACT LENS, HYDROPHILIC, SPHERICAL, PER LENS
V2521	CONTACT LENS, HYDROPHILIC, TORIC, OR PRISM BALLAST, PER LENS
V2522	CONTACT LENS, HYDROPHILIC, BIFOCAL, PER LENS

CODE	DESCRIPTION
V2523	CONTACT LENS, HYDROPHILIC, EXTENDED WEAR, PER LENS
V2530	CONTACT LENS, SCLERAL, GAS IMPERMEABLE, PER LENS (FOR CONTACT LENS MODIFICATION, SEE 92325)
V2531	CONTACT LENS, SCLERAL, GAS PERMEABLE, PER LENS (FOR CONTACT LENS MODIFICATION, SEE 92325)
V2599	CONTACT LENS, OTHER TYPE

Group 4 Paragraph:

LOW VISION AIDS

Group 4 Codes:

CODE	DESCRIPTION
V2600	HAND HELD LOW VISION AIDS AND OTHER NONSPECTACLE MOUNTED AIDS
V2610	SINGLE LENS SPECTACLE MOUNTED LOW VISION AIDS
V2615	TELESCOPIC AND OTHER COMPOUND LENS SYSTEM, INCLUDING DISTANCE VISION TELESCOPIC, NEAR VISION TELESCOPES AND COMPOUND MICROSCOPIC LENS SYSTEM

Group 5 Paragraph:

MISCELLANEOUS

Group 5 Codes:

CODE	DESCRIPTION
V2700	BALANCE LENS, PER LENS
V2702	DELUXE LENS FEATURE
V2710	SLAB OFF PRISM, GLASS OR PLASTIC, PER LENS
V2715	PRISM, PER LENS
V2718	PRESS-ON LENS, FRESNELL PRISM, PER LENS
V2730	SPECIAL BASE CURVE, GLASS OR PLASTIC, PER LENS
V2744	TINT, PHOTOCHROMATIC, PER LENS
V2745	ADDITION TO LENS; TINT, ANY COLOR, SOLID, GRADIENT OR EQUAL, EXCLUDES PHOTOCHROMATIC, ANY LENS MATERIAL, PER LENS
V2750	ANTI-REFLECTIVE COATING, PER LENS
V2755	U-V LENS, PER LENS
V2756	EYE GLASS CASE
V2760	SCRATCH RESISTANT COATING, PER LENS
V2761	MIRROR COATING, ANY TYPE, SOLID, GRADIENT OR EQUAL, ANY LENS MATERIAL, PER LENS

CODE	DESCRIPTION
V2762	POLARIZATION, ANY LENS MATERIAL, PER LENS
V2770	OCCLUDER LENS, PER LENS
V2780	OVERSIZE LENS, PER LENS
V2781	PROGRESSIVE LENS, PER LENS
V2782	LENS, INDEX 1.54 TO 1.65 PLASTIC OR 1.60 TO 1.79 GLASS, EXCLUDES POLYCARBONATE, PER LENS
V2783	LENS, INDEX GREATER THAN OR EQUAL TO 1.66 PLASTIC OR GREATER THAN OR EQUAL TO 1.80 GLASS, EXCLUDES POLYCARBONATE, PER LENS
V2784	LENS, POLYCARBONATE OR EQUAL, ANY INDEX, PER LENS
V2786	SPECIALTY OCCUPATIONAL MULTIFOCAL LENS, PER LENS
V2797	VISION SUPPLY, ACCESSORY AND/OR SERVICE COMPONENT OF ANOTHER HCPCS VISION CODE
V2799	VISION ITEM OR SERVICE, MISCELLANEOUS

ICD-10 Codes that Support Medical Necessity

N/A

ICD-10 Codes that DO NOT Support Medical Necessity

Group 1 Paragraph:

Not specified

Group 1 Codes: N/A

Additional ICD-10 Information

N/A

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 physician'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.

Appendices

Utilization Guidelines

Refer to Coverage Indications, Limitations, and/or Medical Necessity

Sources of Information and Basis for Decision

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
01/01/2017	R3	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	<ul style="list-style-type: none">• Provider Education/Guidance

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		<p>Added: General Requirements</p> <p>DOCUMENTATION REQUIREMENTS:</p> <p>Removed: Standard Documentation Language</p> <p>Added: General Documentation Requirements</p> <p>Added: New reference language and directions to Standard Documentation Requirements</p> <p>POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:</p> <p>Removed: Standard Documentation Language</p> <p>Added: Direction to Standard Documentation Requirements</p> <p>Removed: PIM reference from Appendices</p> <p>RELATED LOCAL COVERAGE DOCUMENTS:</p> <p>Added: LCD-related Standard Documentation Requirements article</p>	
07/01/2016	R2	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.	<ul style="list-style-type: none"> • Change in Assigned States or Affiliated Contract Numbers
10/01/2015	R1	<p>Revision Effective Date: 10/01/2015</p> <p>COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:</p> <p>Revised: Standard Documentation Language regarding Medicare coverage</p> <p>HCPCS CODING:</p> <p>Revised: HCPCS V2799 Narrative</p> <p>DOCUMENTATION REQUIREMENTS:</p> <p>Revised: Standard Documentation Language to add who can enter date of delivery date on the POD</p> <p>Added: Continued need, continued use, request for refill documentation requirements and repair/replacement</p> <p>Revised: Changed ICD-9 reference to diagnosis</p>	<ul style="list-style-type: none"> • Provider Education/Guidance • Revisions Due To CPT/HCPCS Code Changes

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Article(s)

A52499 - Refractive Lenses - Policy Article

A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs

Related National Coverage Documents

N/A

Public Version(s)

Updated on 04/28/2017 with effective dates 01/01/2017 - N/A

Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.

Keywords

N/A

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: Refractive Lenses - Policy Article (A52499)

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Article Information

General Information

Article ID

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Original Article Effective Date

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Original ICD-9 Article ID

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[A23658](#)

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Revision Effective Date

03/01/2019

Revision Ending Date

N/A

Article Title

Refractive Lenses - 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").

Refractive lenses are covered under the Prosthetics and Artificial Limbs benefit category (Social Security Act §1861(s)(8)). 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.

Refractive lenses are covered when they are used to restore the vision normally provided by the natural lens of the eye of an individual lacking the organic lens because of surgical removal or congenital absence. Covered diagnoses are limited to pseudophakia (condition in which the natural lens has been replaced with an artificial intraocular lens

[IOL]), aphakia (condition in which the natural lens has been removed but there is no IOL), and congenital aphakia. Lenses provided for other diagnoses will be denied as noncovered.

Refractive lenses are covered even though the surgical removal of the natural lens occurred before Medicare entitlement.

For beneficiaries with pseudophakia, coverage is limited to one pair of eyeglasses or contact lenses after each cataract surgery with insertion of an IOL. Replacement frames, eyeglass lenses and contact lenses are noncovered. If a beneficiary has a cataract extraction with IOL insertion in one eye, subsequently has a cataract extraction with IOL insertion in the other eye, and does not receive eyeglasses or contact lenses between the two surgical procedures, Medicare covers only one pair of eyeglasses or contact lenses after the second surgery. If a beneficiary has a pair of eyeglasses, has a cataract extraction with IOL insertion, and receives only new lenses but not new frames after the surgery, the benefit would not cover new frames at a later date (unless it follows subsequent cataract extraction in the other eye).

Refer to the Local Coverage Determination (LCD) for information about coverage of lenses for aphakic beneficiaries (i.e., those who do not have an IOL).

Because coverage of refractive lenses is based upon the Prosthetic Device benefit category, there is no coverage for frames or lens add-on codes unless there is a covered lens(es). Frames provided without a covered lens(es) will be denied as noncovered.

Tinted lenses (V2745), including photochromatic lenses (V2744), used as sunglasses, which are prescribed in addition to regular prosthetic lenses to a pseudophakic beneficiary, will be denied as noncovered.

Scratch resistant coating (V2760), mirror coating (V2761), polarization (V2762), deluxe lens feature (V2702) and progressive lenses (V2781) will be denied as noncovered.

Use of polycarbonate or similar material (V2784) or high index glass or plastic (V2782, V2783) for indications such as light weight or thinness will be denied as a noncovered deluxe feature.

Specialty occupational multifocal lenses (V2786) will be denied as noncovered.

Only standard frames (V2020) are covered. Additional charges for deluxe frames (V2025) will be denied as noncovered.

When hydrophilic soft contact lenses (V2520-V2523) are used as a corneal dressing, they are denied as noncovered because in this situation they do not meet the definition of a prosthetic device.

Eyeglass cases (V2756) will be denied as noncovered.

Contact lens cleaning solution and normal saline for contact lenses will be denied as noncovered.

Low vision aids (V2600-V2615) will be denied as noncovered because coverage under the Medicare prosthetic benefit is limited to persons with congenital absence or surgical removal of the lens of the eye.

Vision supplies, accessories, and/or service components of another HCPCS vision code (V2797) will be denied as not separately payable.

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 discussed below.

The diagnosis code that justifies the need for these items must be included on the claim.

MODIFIERS

KX, GA, GY and GZ MODIFIERS:

For anti-reflective coating (V2750), tints (V2744, V2745) or oversized lenses (V2780), if medical necessity is documented by the treating physician, the KX modifier must be added to the code. For polycarbonate or Trivex TM lenses (V2784), if they are for a beneficiary with monocular vision, the KX modifier must be added to the code. The KX modifier may only be used when these requirements are met. When the KX modifier is billed, documentation to support the medical necessity of the lens feature must be available upon request.

For anti-reflective coating (V2750), polycarbonate or Trivex TM lenses (V2784), tints (V2744, V2745) or oversized lenses (V2780), if the coverage criteria have not been met, the GA or GZ modifier must be added to the code. When there is an expectation of a denial as not reasonable and necessary, 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.

Claims lines for anti-reflective coating (V2750), tints (V2744, V2745), oversized lenses (V2780) or polycarbonate or Trivex TM lenses (V2784) billed without a KX, GA, GY or GZ modifier will be rejected as missing information.

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

CODING GUIDELINES

Deluxe lens features (V2702) include services and features such as lens edge treatments and lens drilling.

Photochromatic lenses (V2744) are those in which the degree of tint changes in response to changes in ambient light. Code V2744 is used for any type of photochromatic lens, either glass or plastic.

Code V2745 is used for any type or color of lens tint, excluding photochromatic lenses.

Code V2755 must be used only if a UV coating is applied to a lens and not as an add-on code for the UV protection inherent in the lens material.

Anti-reflective coating (V2750) is a clear lens treatment used to decrease glare and internal/external reflections.

Mirror coatings (V2761) are colored, highly reflective lens treatments.

Progressive lens (V2781) is a multifocal lens that gradually changes in lens power from the top to the bottom of the lens, eliminating the line(s) that would otherwise be seen in a bifocal or trifocal lens.

Code V2784 is an add-on used for lenses made of impact-resistant material such as polycarbonate or Trivex™. Codes V2782 and V2783 (high index) must not be billed in addition to code V2784.

Codes V2100 – V2114, V2199 – V2214, V2299 – V2314, V2399 - V2499, V2700, and V2770 describe specific eyeglass lenses. Only one of these codes may be billed for each lens provided. These codes include both aspheric and nonaspheric lenses.

Codes V2115, V2118, V2121, V2215, V2218 – V2221, V2315, V2318 – V2321, V2710 - V2760, and V2780 – V2797 describe add-on features of lenses. They are billed in addition to codes for the basic lens.

When billing claims for deluxe frames, use code V2020 for the cost of standard frames and a second line item using code V2025 for the difference between the charges for the deluxe frames and the standard frames.

When billing claims for progressive lens, use the appropriate code for the standard bifocal (V2200 - V2299) or trifocal (V2300 - V2399) lens and a second line item using code V2781 for the difference between the charge for the progressive lens and the standard lens.

The RT and/or LT modifiers must be used with all HCPCS codes in this policy except codes V2020, V2025 and V2600. Effective for claims with dates of service (DOS) on or after 3/1/2019, when lenses are provided bilaterally and the same code is used for both lenses, bill each item on two separate claim lines using the RT and LT modifiers and 1 unit of service (UOS) on each claim line. Do not use the RTLTLT modifier on the same claim line and billed with 2 UOS. Claims billed without modifiers RT and/or LT, or with RTLTLT on the same claim line and 2 UOS, will be rejected as incorrect coding.

PROSE® Device

PROSE® (BostonSight, Needham, MA) devices are designed to rest on the sclera or white part of the eye and are used to treat ocular surface diseases, including some types of "dry eye." For Medicare billing purposes correct HCPCS coding for this item is determined based upon the condition(s) being treated. When the PROSE® device is used as a treatment for either of the following indications listed below, the correct HCPCS code to use is V2627 (SCLERAL COVER SHELL):

- Treatment of an eye rendered sightless and shrunken by inflammatory disease; or,
- Treatment of "dry eye" where the PROSE® device serves as a substitute for the function of the diseased lacrimal gland.

When the PROSE® device is used for any conditions other than those listed above, the device must be coded with HCPCS code V2531 (CONTACT LENS, SCLERAL, GAS PERMEABLE, PER LENS (FOR CONTACT LENS MODIFICATION, SEE 92325)) and is subject to the Medicare refractive lens statutory coverage exclusion.

Suppliers should contact the Pricing, Data Analysis and Coding (PDAC) Contractor for guidance on the correct coding of these items.

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

N/A

ICD-10 Codes that are Covered

Group 1 Paragraph:

N/A

Group 1 Codes:

ICD-10 CODE	DESCRIPTION
H27.00	Aphakia, unspecified eye
H27.01	Aphakia, right eye
H27.02	Aphakia, left eye
H27.03	Aphakia, bilateral
Q12.3	Congenital aphakia
Z96.1	Presence of intraocular lens

ICD-10 Codes that are Not Covered

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
03/01/2019	R4	Revision Effective Date: 03/01/2019 CODING GUIDELINES: Revised: RT and LT modifier billing instructions Added: Coding guidelines for PROSE® devices <i>02/07/2019: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.</i>
01/01/2017	R3	Revision Effective Date: 01/01/2017 POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Added: Diagnosis requirement on a claim and Modifier instructions RELATED LOCAL COVERAGE DOCUMENTS: Added: LCD-related Standard Documentation Requirements Language Article
07/01/2016	R2	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.
10/01/2015	R1	Revision Effective Date: 10/01/2015 (February 2015 Publication) Removed: Reference to ICD-9 located in the narrative

Associated Documents

Related Local Coverage Document(s)

Article(s)

[A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs](#)

LCD(s)

[L33793 - Refractive Lenses](#)

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

Public Version(s)

Updated on 01/31/2019 with effective dates 03/01/2019 - N/A

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