

## Clinical Policy: Ocular Prosthesis

Reference Number: OC.UM.CP.0044

Last Review Date: 11/2022

[Coding Implications](#)

[Revision Log](#)

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### Description

This policy describes the medical necessity requirements for prescribing, fitting, supplying, resizing, polishing & resurfacing an ocular prosthesis or scleral shell.

### Policy/Criteria

- I. It is the policy of health plans affiliated with Envolve Vision, Inc.<sup>®</sup> (Envolve) that the prescription, fitting and supply of an ocular prosthesis is **medically necessary** for the following indications:
  - A. Restore anatomy to an eviscerated or enucleated socket.
  
- II. It is the policy of health plans affiliated with Envolve that the prescription, fitting and supply of a scleral shell is **medically necessary** for the following indications:
  - A. Sightless, shrunken eye;
  - B. Severe dry eye.
  
- III. It is the policy of health plans affiliated with Envolve that the enlargement, reduction, or refitting and supply of an ocular prosthesis is **medically necessary** for the following indications:
  - A. To align with anatomical changes in soft tissue of the orbit over time or to correct a poor fitting prosthesis, once in five years
  - B. To accommodate for orbital growth in a pediatric patient, once in two years
  
- IV. It is the policy of health plans affiliated with Envolve that resurfacing and polishing of a scleral shell or ocular prosthesis is **medically necessary** for the following indications:
  - A. As a preventive measure to remove scratches and prevent build-up of protein and other possible ocular irritants.

### Background

Prescription, fitting, and supply of an ocular prosthetic is performed by an ophthalmologist, optometrist, ocularist, or technician who measures dimensions, selects colors, formulates modifications, and provides an ocular prosthesis of glass or plastic shaped and colored to specifications that resemble the anterior portion of the patient's normal eye. The prosthesis is inserted into the patient's eviscerated or enucleated socket. Polishing and re-surfacing of an ocular prosthesis is necessary as a preventative measure to remove scratches and prevent build-up of protein and other possible ocular irritants. A scleral shell fits over the entire exposed surface of the eye as opposed to a corneal contact lens, which covers only the central non-white area encompassing the pupil and iris. Where an eye has been rendered sightless and shrunken by inflammatory disease, a scleral shell may, among other things, obviate the need for surgical enucleation and prosthetic implant and act to support the surrounding orbital tissue.

Scleral shells are occasionally used in combination with artificial tears in the treatment of "dry eye" of diverse etiology. Tears ordinarily dry at a rapid rate, and are continually replaced by the lacrimal gland.

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When the lacrimal gland fails, the half-life of artificial tears may be greatly prolonged by the use of the scleral contact lens as a protective barrier against the drying action of the atmosphere. Thus, the difficult and sometimes hazardous process of frequent installation of artificial tears may be avoided. The lens acts in this instance to substitute, in part, for the functioning of the diseased lacrimal gland and would be covered as a prosthetic device in the rare case when it is used in the treatment of "dry eye."

**Coding Implications**

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HCPCS Codes	Description
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

\*(RT, LT Modifier)

**ICD-10-CM Diagnosis Codes that Support Coverage Criteria**

+ Indicates a code requiring an additional character

The following diagnoses are considered for medical indications for an ocular prosthesis:

ICD-10-CM Code	Description
Q11.1	Other anophthalmos [congenital absence of eye]
Z90.01	Acquired absence of eye

The following diagnoses are considered for medical indications for a scleral shell:

ICD-10-CM Code	Description
H04.121	Dry eye syndrome of right lacrimal gland
H04.122	Dry eye syndrome left lacrimal gland
H04.123	Dry eye syndrome bilateral lacrimal glands
H05.311	Atrophy of right orbit
H05.312	Atrophy of left orbit

ICD-10-CM Code	Description
H05.313	Atrophy of bilateral orbits
H05.321	Deformity of right orbit due to bone disease
H05.322	Deformity of left orbit due to bone disease
H05.323	Deformity of bilateral orbits due to bone disease
H05.331	Deformity of right orbit due to trauma or surgery
H05.332	Deformity of left orbit due to trauma or surgery
H05.333	Deformity of bilateral orbits due to trauma or surgery
H05.341	Enlargement of right orbit
H05.342	Enlargement of left orbit
H05.343	Enlargement of bilateral orbits
H05.351	Exostosis of right orbit
H05.352	Exostosis of left orbit
H05.353	Exostosis of bilateral orbits
H16.221	Keratoconjunctivitis sicca, not specified as Sjogren's, right eye
H16.222	Keratoconjunctivitis sicca, not specified as Sjogren's, left eye
H16.223	Keratoconjunctivitis sicca, not specified as Sjogren's, bilateral
Q11.1	Other anophthalmos [congenital absence of eye]
Z90.01	Acquired absence of eye

Reviews, Revisions, and Approvals	Date	Approval Date
Annual Review	12/2019	12/2019
Converted to new template	07/2020	10/2020
Annual Review	12/2020	12/2020
Annual Review	12/2021	12/2021
Annual Review	11/2022	11/2022

**References**

1. Tania Sethi, Mohit Kheur, Colin Haylock, and Husain Harianawala, Fabrication of a Custom Ocular Prosthesis. Middle East Afr J Ophthalmol. 2014 Jul-Sep; 21(3): 271–274.
2. Sajjad A (December 06, 2012) Ocular Prosthesis - A Simulation of Human Anatomy: A Literature Review. Cureus 4(12): e74. doi:10.7759/cureus.74

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to

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the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Envolve Vision, Inc., or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members**, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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