Policy Number	**DME104.003**
Policy Effective Date	**12/01/2025**

Scleral Shell

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Related Policies (if applicable)
None

Disclaimer

Carefully check state regulations and/or the member contract.
Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Legislative Mandates

EXCEPTION: For HCSC members **residing in the state of Arkansas**, § 23-79-1502 relating to craniofacial anomaly corrective surgery, requires coverage and benefits for reconstructive surgery and related medical care for a person of any age who is diagnosed as having a craniofacial anomaly if the surgery and treatment are medically necessary to improve a functional impairment that results from the craniofacial anomaly. Coverage shall also be required, annually, for Sclera contact lenses, including coatings, office visits, an ocular impression of each eye, and any additional tests or procedures that are medically necessary for a craniofacial patient. Coverage shall also be required every two [2] years, two [2] hearing aids and two [2] hearing aid molds for each ear; this includes behind the ear, in the ear, wearable bone conductions, surgically implanted bone conduction services, and cochlear implants. Medical care coverage required includes coverage for reconstructive surgery, dental care, and vision care. This applies to the following: Fully Insured Group, Student, Small Group, Mid-Market, Large Group, HMO, EPO, PPO, POS. Unless indicated by the group, this mandate or coverage will not apply to ASO groups.

Coverage

Scleral shell **may be considered medically necessary** for individuals with **one** or more of the following:

1. Eye that has been rendered sightless and shrunken by inflammatory disease, and scleral shell will support surrounding orbital tissue;

2. Individuals with absence or shrinkage of eye due to birth defect, trauma, or surgical removal;
3. "Dry eye" of diverse etiology (e.g., lacrimal gland disease), when used in combination with artificial tears.

Policy Guidelines

A scleral shell may, among other things, obviate the need for surgical enucleation and prosthetic implant and act to support the surrounding orbital tissue.

Tears ordinarily dry at a rapid rate and are continually replaced by the lacrimal gland. 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. The lens acts in this instance to substitute, in part, for the functioning of the diseased lacrimal gland.

Description

Scleral shell
Scleral shell (or shield) is a catchall term for different types of hard scleral contact lenses. 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. (1)

Dry Eye
The National Eye Institute notes that scleral contact lenses are hard contact lenses that sit on the sclera (the white part of the eye) instead of the cornea. The space between the scleral lens and the cornea can hold fluid to help heal damaged corneas and treat severe dry eye. (3)

Anophthalmia and Microphthalmia
Anophthalmia is when an individual is born without one or both of their eyes. Microphthalmia is when one or both of an individual's eyes are small. Both conditions are rare and can cause vision loss or blindness. Children with microphthalmia can wear a type of prosthetic called a scleral shell that fits over their smaller eye. (4)

Rationale

This policy is based on a review of coverage guidance from the Centers for Medicare and Medicaid Services (CMS) specific to scleral shell and eye prostheses. (1, 2)

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	None
HCPCS Codes	V2530, V2531, V2627

*Current Procedural Terminology (CPT®) ©2024 American Medical Association: Chicago, IL.

References

National and Local Coverage Determination:

1. Centers for Medicare & Medicaid Services—National Coverage Determination for Scleral Shell (80.5) Version 1. (January 1, 1966). Available at <https://www.cms.gov> (accessed September 8, 2025).
2. Centers for Medicare & Medicaid Services—Local Coverage Determination for Eye Prostheses (L33737) Revision 6. (January 1, 2020). Available at <https://www.cms.gov> (accessed September 8, 2025).

Other:

3. National Institutes for Health. National Eye Institute. Other Types of Contact Lenses. (July 1, 2019). Available at <https://www.nei.nih.gov> (accessed September 10, 2025).
4. National Institutes for Health. National Eye Institute. Eye Devices for Anophthalmia and Microphthalmia. (September 4, 2025). Available at <https://www.nei.nih.gov> (accessed September 10, 2025).

Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been changed since this medical policy document was written. See Medicare's National Coverage at <https://www.cms.hhs.gov>.

Policy History/Revision

Date	Description of Change

12/01/2025	Document updated. The following changes were made to the Coverage: 1) Criteria revised to be consistent with the Centers for Medicare and Medicaid Services specific to scleral shells; and 2) Removed criteria specific to therapeutic lenses from policy. Added references 2-4; others removed. Title changed from: Therapeutic Lenses, Scleral Shell.
02/01/2025	Document updated with literature review. Coverage unchanged. References updated; no new ones added.
05/01/2023	Reviewed. No changes.
12/01/2022	Document updated with literature review. Coverage unchanged. References 4 and 12 added, others removed.
01/01/2022	Reviewed. No changes.
05/01/2021	Documents updated with literature review. The following changes were made to Coverage: 1) Added "A scleral shell when used for any other indication, including: to improve the appearance of a discolored eye is considered not medically necessary", and 2) Modified not medically necessary statement on deluxe lens feature to now include deluxe frames as well. References updated.
01/15/2019	Reviewed. No changes.
03/15/2018	Document updated with literature review. Coverage unchanged.
07/01/2016	Reviewed. No changes.
06/01/2015	Document updated with literature review. The following changes were made to Coverage: 1) Eyeglasses or contact lenses to correct ocular surface disease resulting in pain and/or decreased visual acuity (e.g., exposure keratopathy, graft vs host disease, keratopathy, mucus membrane pemphigoid, neurotrophic, persistent epithelial defects, post glaucoma filtering surgery, postocular surface tumor excision, sequelae of Stevens Johnson syndrome, severe dry eye; 2) Added the following indications as non-surgical correction of the cornea (e.g., keratoglobus, pellucid marginal degeneration, Terrien marginal degeneration, Fuch's superficial marginal keratitis, postsurgical ectasia; 3) Expanded terminology of deluxe lens features to state "Deluxe lens features, including but not limited to tinting, mirror coating, progressive lens and scratch resistant coating, are considered convenience items and are considered not medically necessary." Policy description, references and rationale completely revised.
11/01/2012	Literature reviewed. No change
10/15/2009	CPT/HCPCS code(s) updated
04/01/2009	CPT/HCPCS code(s) updated
04/15/2008	Policy reviewed without literature review; new review date only. This policy is no longer scheduled for routine literature review and update.
08/15/2007	Revised/updated entire document