I. POLICY/Criteria

An eye exam is not a covered benefit for common vision conditions, such as myopia, presbyopia, hyperopia, astigmatism. An eye exam performed by an ophthalmologist or optometrist is a covered benefit when a specific ophthalmic disease, medical condition or infective process is being monitored or treated such as glaucoma, diabetic retinopathy, cataracts, macular degeneration, keratoconus, strabismus and amblyopia.

Vision care, services, and supplies that are not related to a specific medical or surgical condition covered by this policy may be covered with a rider, group contract language or a stand-alone Vision policy. Pediatric Vision coverage is an essential health benefit under Individual ACA and Small Business ACA plans. Refer to plan documents.

A. Eye Exams

- Eye exams are a covered benefit for members when seen by an ophthalmologist for the purpose of treatment or diagnosis of a specific illness, symptom, or complaint.
- Refraction examinations for assessment of visual acuity are not covered. (Vision coverage for refraction may be a benefit if a vision rider has been purchased – see specific rider language for coverage details.)
- Comprehensive eye exams in the absence of known diseases affecting the eye are not covered.
- If, after a refractive eye exam initiated by the member (which would not be covered), an ophthalmic medical condition is found (e.g., glaucoma, retinal disease, etc.), subsequent diagnosis and treatment is covered. See medical policy #91529 Refractive Keratoplasty for specific covered conditions and criteria for refractive keratoplasty.

B. Diabetic Screening Eye Exams

- A self-referred, yearly diabetic eye exam (dilated eye exam) to screen for retinal disease for a diabetic member is a covered benefit for members when performed by an ophthalmologist or optometrist, or by the PCP when DigiScope/EyeTel services are available.
If after a yearly diabetic eye exam, a new ophthalmic medical condition is found, subsequent diagnosis and treatment is covered.

C. Contact lenses / eyeglasses and associated services and supplies are a covered benefit only for the specific medical or surgical conditions listed below and must be provided by an ophthalmologist or optometrist.

**Special Note:** Vision care, services, and supplies may be covered with a rider, group contract language or a stand-alone Vision policy.

1. Aphakia. Absence of the lens may be either surgical (cataract extraction) or congenital. **Coverage for aphakia is available only if an intraocular lens (IOL) is not present and lenses are paid at the prosthetic benefit level.**
   a. Surgical aphakia. Refractive lenses are covered for up to six months post-cataract surgery as follows:
      - One pair of glasses or contact lenses per eye per lifetime
      - Traditional single, bifocal or trifocal lenses
      - Basic frames are covered only in conjunction with covered lenses
   b. Congenital aphakia. Refractive lenses are covered annually as follows:
      - One pair of glasses or contact lenses per eye
      - Traditional single, bifocal or trifocal lenses
      - Basic frames are covered only in conjunction with covered lenses

2. Contact lenses for corneal pathology. Coverage is provided only for the initial pair of contact lenses when used as a corneal bandage for treatment of acute or chronic corneal pathology (e.g. keratitis, corneal ulcers, keratoconus).

3. Intrastromal corneal ring segments (e.g., INTACS® prescription inserts) are considered to be medically necessary in patients with keratoconus who meet ALL of the following criteria:
   - progressive deterioration in vision, such that adequate functional vision on a daily basis with contact lenses or spectacles can no longer be achieved
   - age 21 years of age or older
   - clear central corneas
   - corneal thickness of 450 microns or greater at the proposed incision site
• corneal transplantation is the only other remaining option for improving functional vision

4. Intraocular lens:

The cost of conventional IOLs only are a covered benefit. If the member selects anything other than a standard IOL, i.e. a presbyopia-correcting IOL or other non-standard IOL, the cost of the additional function is not a covered benefit. (See code description.)

D. Contact lenses coverage criteria for Medicaid/Healthy Michigan Plan members

1. Priority Health provides services for contact lenses for Medicaid/Healthy Michigan Plan members who have certain medical conditions. These services include comprehensive contact lens evaluation with fitting and contact lenses.

   a. A comprehensive contact lens evaluation is a benefit for Medicaid/Healthy Michigan Plan members and does not require prior authorization when the member presents with one of the following conditions and visual performance is expected to be significantly improved with the application of a contact lens. Documentation must be available if requested.

   • Aphakia (congenital or surgical).
   • Keratoconus (if vision cannot be improved to 20/40 or better with eyeglasses).
   • Anisometropia or Antimetropia (of two diopters or greater that results in aniseikonia).
   • Other conditions which have no alternative treatment.

   b. Limitations

   • One contact lens replacement in a year for each eye is allowed for Medicaid/Healthy Michigan Plan members age 21 and over.
   • Two replacements per year are allowed for each eye for Medicaid/Healthy Michigan Plan members under age 21. (One year is defined as 365 days from the date the first pair of contact lenses (initial or subsequent) was ordered.

E. Prosthesis (See also policy #91306 External Prosthetics)

A scleral shell to support a loss of orbital tissue is a covered benefit when an eye has been rendered sightless and shrunken by inflammatory disease.
An ocular prosthesis (artificial eye) is a covered benefit for members with an absence of an eye due to trauma, surgical removal or congenital defect.

Polishing and resurfacing of an ocular prosthesis is covered on an annual basis.

Replacement of an ocular prosthesis is covered every five years unless documentation supports the medical necessity of more frequent replacement.

F. Vision therapy / orthoptics: Office-based vision therapy / orthoptics is covered as a treatment only for convergence insufficiency (CI) in children. Use of this treatment / therapy for any other indication / diagnosis is considered to be experimental and investigational and is not a covered benefit.

Note: Coverage is subject to physical and occupational therapy benefit limits and applicable copays.

G. Bypass stents for the treatment of open-angle glaucoma in combination with cataract surgery (e.g. iStent Trabecular Micro-Bypass stent) are a covered benefit.

H. General Exclusions
The following are not covered benefits:
- Refractive services unless covered by a vision rider
- Routine glaucoma screening
- Low vision aids
- Refractive keratoplasty (see medical policy #91529)
- Replacement for loss, damage, misuse or abuse is not a covered benefit.
- Coverage is not provided for: sunglasses, scratch resistant coating, transition/progressive lenses, or contact lens supplies (e.g. wetting and cleaning solutions, carrying cases).
- Artificial retina devices (e.g., the Argus™ II) are considered experimental and investigational and not a covered benefit because there is insufficient scientific evidence of the safety and effectiveness of these devices in restoring vision.

These devices provide electrical stimulation of the retina to induce visual perception in blind patients with severe to profound retinitis pigmentosa and bare light or no light perception in both eyes. The effectiveness of these devices has not been demonstrated.

*For Medicaid/Healthy Michigan Plan members, please refer to medical policy #91500 Orthoptic and Pleoptic Training for Medicaid Members.

II. MEDICAL NECESSITY REVIEW
III. APPLICATION TO PRODUCTS

Coverage is subject to member’s specific benefits. Group specific policy will supersede this policy when applicable.

- **HMO/EPO:** This policy applies to insured HMO/EPO plans.
- **POS:** This policy applies to insured POS plans.
- **PPO:** This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.
- **ASO:** For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.
- **INDIVIDUAL:** For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.
- **MEDICARE:** Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.
- **MEDICAID/HEALTHY MICHIGAN PLAN:** For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: [http://www.michigan.gov/mdch/0,1607,7-132-2945-42543-42546-42551-139815--,00.html](http://www.michigan.gov/mdch/0,1607,7-132-2945-42543-42546-42551-139815--,00.html). If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: [http://www.michigan.gov/mdch/0,1607,7-132-2945-5100-87572--,00.html](http://www.michigan.gov/mdch/0,1607,7-132-2945-5100-87572--,00.html), the Michigan Medicaid Provider Manual will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.
- **MICHILD:** For MICHILD members, this policy will apply unless MICHILD certificate of coverage limits or extends coverage.

IV. DESCRIPTION

A. A comprehensive eye evaluation is performed to detect and diagnose ocular, visual and systemic disease. The following elements are normally included in a comprehensive eye exam:

- Member’s family and personal health history
- Visual acuity with present correction (the power of the present correction recorded) at distance and at near
- Ocular alignment and motility
- Pupillary function
- Intraocular pressure measurement
- Visual fields by confrontation when indicated
- External examination: lids, lashes and lacrimal apparatus, orbit and pertinent facial features
Slit-lamp examination: eyelid margins and lashes, tear film, conjunctiva, sclera, cornea, anterior chamber and assessment of peripheral anterior chamber depth, iris, lens and anterior vitreous
Examination of the fundus: vitreous, retina (including posterior pole and periphery), vasculature and optic nerve

B. The following are considered to be common vision conditions:
   - Myopia (nearsightedness) - A vision condition in which near objects are seen clearly, but distant objects do not come into proper focus. Nearsightedness is very common.
   - Presbyopia - A condition in which the crystalline lens of the eye loses its flexibility, making it difficult to focus on close objects. Presbyopia, usually becomes noticeable in the early to mid-forties, and is a natural part of the aging process of the eye. It is not a disease and it cannot be prevented.
   - Hyperopia (farsightedness) - A condition in which distant objects are usually seen clearly, but close objects do not come into proper focus.
   - Astigmatism - A condition that occurs when the front surface of the eye, the cornea, is slightly irregular in shape. This irregular shape prevents light from focusing properly on the retina. Almost all levels of astigmatism can be optically corrected with eyeglasses and/or contact lenses.

C. The following are considered to be medical disorders:
   - Strabismus - A condition when one or both eyes turns in, out, up or down. Poor eye muscle control usually causes misalignment of the eyes.
   - Amblyopia (lazy eye) - A loss or lack of development of central vision in one eye that is unrelated to any eye health problem and not correctable with lenses. It can result from a failure to use both eyes together. Lazy eye is often associated with crossed-eyes or a large difference in the degree of nearsightedness or farsightedness between the two eyes.
   - Cataract - The clouding of all or part of the normally clear lens within the eye, which results in blurred or distorted vision.

D. The following are ophthalmic diseases:
   - Glaucoma - A disease in which the internal pressure of the eyes increase enough to damage the nerve fibers in the optic nerve and cause vision loss. The increase in pressure occurs when the passages that normally allow fluid in the eyes to drain become blocked. Glaucoma cannot be prevented, but if diagnosed and treated early, can be controlled. Vision lost to glaucoma cannot be restored.
   - Macular degeneration - A condition that results from changes to the macula, a portion of the retina that is responsible for clear, sharp vision.
   - Diabetic retinopathy - A condition occurring as a result of diabetes which causes weakening and changing of the small blood vessels that nourish the
eye’s retina. Early treatment is important to avoid permanent damage and blindness.
- **Keratoconus** - A vision disorder that occurs when the cornea becomes thin and irregularly shaped. This abnormal shape prevents the light entering the eye from being focused correctly on the retina and causes distortion of vision. Treatment can be divided into three tiers: correction with glasses, correction with rigid gas permeable contact lenses for more progressive cases and possibly corneal transplantation.

V. **CODING INFORMATION:**

**Routine Vision diagnoses:**

_Services billed with the following diagnoses are subject to Vision Rider_

**ICD-10 Codes** that apply to this policy:

- H52.00 - H52.03  Hypermetropia
- H52.10 - H52.13  Myopia
- H52.201 - H52.209  Astigmatism, Unspecified
- H52.211 - H52.219  Irregular Astigmatism
- H52.221 - H52.229  Regular astigmatism
- H52.31  Anisometropia
- H52.32  Aniseikonia
- H52.4  Presbyopia
- H52.6  Other disorders of refraction
- H52.7  Unspecified disorder of refraction
- Z01.00 - Z01.01  Encounter for examination of eyes and vision

**CPT/HCPCS Codes:**

_Listing of code does not guarantee coverage for all plans and provider specialties; some services are covered with optional vision benefits. List is not inclusive of all possible vision services_

_Services that may be payable to Optometrists_

- 0190T  Placement of intraocular radiation source applicator (List separately in addition to primary procedure) (Not covered for Priority Health Medicare)
- 0191T  Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach
- 0253T  Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach, into the suprachoroidal space (Not covered for Priority Medicaid)
- 0376T  Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; each additional device insertion (List separately in addition to code for primary procedure)
- 0402T  Collagen cross-linking of cornea (including removal of the corneal epithelium and intraoperative pachymetry when performed) (Not covered for Medicaid)
- 0449T  Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device (Not covered for Medicaid)
0450T  Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; each additional device (List separately in addition to code for primary procedure)  *(Not covered for Medicaid)*

0474T  Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space  *(Not covered for Medicaid)*

65205  Remove foreign body, external eye; conjunctival superficial

65210  Removal of foreign body, external eye; conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating  *(Not covered for Optometrist for Medicaid)*

65220  Removal of foreign body, external eye; corneal, without slit lamp

65222  Removal of foreign body, external eye; corneal, with slit lamp

65235  Removal of foreign body, intraocular; from anterior chamber of eye or lens

65260  Removal of foreign body, intraocular; from posterior segment, magnetic extraction, anterior or posterior route

65265  Removal of foreign body, intraocular; from posterior segment, nonmagnetic extraction

65430  Scraping of cornea, diagnostic, for smear and/or culture

65435  Removal of corneal epithelium; with or without chemocauterization (abrasion, curettage)

65436  Removal of corneal epithelium; with application of chelating agent (eg, EDTA)

65600  Multiple punctures of anterior cornea (eg, for corneal erosion, tattoo)

65778  Placement of amniotic membrane on the ocular surface; without sutures

66174  Transluminal dilation of aqueous outflow canal; without retention of device or stent

66175  Transluminal dilation of aqueous outflow canal; with retention of device or stent

66179  Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft

66183  Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach

66184  Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft

66185  Revision of aqueous shunt to extraocular equatorial plate reservoir; with graft

*(Cataract surgical codes subject to CoManagement billing rules – see Provider Manual)*

66982  Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage

66983  Intracapsular cataract extraction with insertion of intraocular lens prosthesis (1 stage procedure)

66984  Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)
66985 Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal
67820 Correction of trichiasis; epilation, by forceps only
67938 Removal of embedded foreign body, eyelid
67938 Removal of embedded foreign body, eyelid
68020 Incision of conjunctiva, drainage of cyst
68040 Expression of conjunctival follicles (eg, for trachoma)
68760 Closure of the lacrimal punctum; by thermocauterization, ligation, or laser surgery
68761 Closure of the lacrimal punctum; by plug, each
68801 Dilation of lacrimal punctum, with or without irrigation

76510 Ophthalmic ultrasound, diagnostic; b-scan and quantitative a-scan performed during the same patient encounter
76511 Ophthalmic ultrasound, diagnostic; quantitative A-scan only
76512 Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan)
76513 Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) b-scan or high resolution biomicroscopy
76514 Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)
76516 Ophthalmic biometry by ultrasound echography, A-scan;
76519 Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation
76529 Ophthalmic ultrasonic foreign body localization

92002 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
92004 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits
92012 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
92014 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits
92015 Determination of refractive state (Vision benefit only)
92018 Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete
92019 Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; limited
92020 Gonioscopy with medical diag eval
92025 Computerized corneal topography, unilateral or bilateral, with interpretation and report 92060 Sensorimotor examination with multiple measurements of
ocular deviation (eg, restrictive or paretic muscle with diplopia) with interpretation and report

**92065** Orthoptic/pleoptic training
*Coverage for commercial plans for children 0-18 years for this indication only:*

**ICD-10 Codes** that apply to this policy:
H51.11 Convergence insufficiency
*Note: Coverage is subject to physical and occupational therapy benefit limits and applicable copays.*

---

92071 Fitting of contact lens for treatment of ocular surface disease
92072 Fitting of contact lens for management of keratoconus, initial fitting
92081 Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, autoplot, arc perimeter, or single stimulus level automated test, such as octopus 3 or 7 equivalent)
92082 Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on goldmann perimeter, or semiquantitative, automated suprathreshold screening program, humphrey suprathreshold automatic diagnostic test, octopus program 33)
92083 Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, goldmann visual fields with at least 3 isopters plotted and static determination within the central 30°, or quantitative, automated threshold perimetry, octopus program g-1, 32 or 42, humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)
92100 Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure)
92132 Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral 92133 Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve
92134 Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina
92136 Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation
92225 Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; initial
92226 Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; subsequent
92227 Remote imaging for detection of retinal disease (eg, retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral
92228 Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral
92230 Fluorescein angioscopy with interpretation and report
92235  Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral
92240  Indocyanine-green angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral
92250  Fundus photography with interpretation and report
92260  Ophthalmodynamometry
92265  Needle oculoelectromyography, one or more extraocular muscles, one or both eyes, with interpretation and report
92270  Electro-oculoelectromyography with interpretation and report
92275  Electroretinography with interpretation and report
92283  Color vision examination, extended, eg, anomaloscope or equivalent
92284  Dark adaptation examination with interpretation and report
92285  External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)
92286  Special anterior segment photography with interpretation and report; with specular endothelial microscopy and cell count
92287  Special anterior segment photography with interpretation and report; with fluorescein angiography (*Not Covered for Priority Health Medicare*)
92310  Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia (*Vision only for Priority Health Medicare*)
92340  Fitting of spectacles, except aphakia, monofocal (*Vision only for Priority Health Medicare*)
92341  Fitting of spectacles, except aphakia, bifocal (*Vision only for Priority Health Medicare*)
92342  Fitting of spectacles, except aphakia, multifocal (*Vision only for Priority Health Medicare*)
92352  Fitting of spectacle prosthesis for aphakia, monofocal (*Vision only for Optometrist for Priority Health Medicare*)
92353  Fitting of spectacle prosthesis for aphakia, multifocal (*Not Covered for Optometrist for Priority Health Medicare*)
92358  Eye prosthesis service  (*Not Covered for Priority Health Medicaid*)
92370  Repair and refitting spectacles; except for aphakia (*Not Covered for Priority Health Medicare*)
92371  Spectacle prosthesis for aphakia
95060  Ophthalmic mucous membrane tests
95930  Visual evoked potential (vem) testing central nervous system, checkerboard or flash
99172  Visual function screening, automated or semi-automated bilateral quantitative determination of visual acuity, ocular alignment, color vision by pseudoisochromatic plates, and field of vision (may include all or some screening of the determination(s) for contrast sensitivity, vision under glare) (*Not Covered for Priority Health Medicaid or Medicare*)
99173  Screening test of visual acuity, quantitative, bilateral (*Not Covered for Priority Health Medicaid or Medicare*)
G0117  Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist
G0118  Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or

S0620  Routine ophthalmological examination including refraction; new patient
(Covered as vision benefit with routine vision dx only for Priority Health Medicaid and Medicare)
S0621  Routine ophthalmological examination including refraction; established patient
(Covered as vision benefit with routine vision dx only for Priority Health Medicaid and Medicare)

Supplies
V2020  Frames,purchases
V2100  Sphere, single vision, plano to plus or minus 4.00,per lens
V2101  Sphere, single vision, plus/minus 4.12 to plus/minus 7.00d,per lens
V2102  Sphere, single vision, plus/minus 7.12 to plus/minus 20.00d,per lens
V2103  Spherocyl, sgl vision, plano to plus/minus 4.00d sphere, 2.12 to 4.00d cyl, per lens
V2104  Spherocyl, sgl vision, plano to plus/minus 4.00d sph, 2.12 to 400d cyl, per lens
V2105  Spherocyl, sgl vision, plano to plus/minus 4.00d sph, 4.25-6.00d cyl, per lens
V2106  Spherocyl, sgl vision, plano to plus/minus 4.00d sph, over 6.00d cyl, per lens
V2107  Spherocyl, sgl vision, plus/minus 4.25-plus/minus 7.00 sph, 0.12-2.00d cyl, per lens
V2108  Spherocyl, sgl vis, plus/minus 4.25d-plus/minus 7.00d sph, 2.12-4.00d cyl, per lens
V2109  Spherocyl, sgl vis, plus/minus 4.25-plus/minus 7.00d sph, 4.25-6.00d cyl, per lens
V2110  Spherocyl, sgl vis, plus/minus 4.25-7.00d sph, over 6.00d cylinder, per lens
V2111  Spherocyl, sgl vis, plus/minus 7.25-plus/minus 12.00d sph, 0.25-2.25d cyl, per lens
V2112  Spherocyl, sgl vis, plus/minus 7.25-plus/minus 12.00d sph, 2.25d-4.00d cyl, per lens
V2113  Spherocyl, sgl vis, plus/minus 7.25-plus/minus 12.00d sph, 4.25-6.00d cyl, per lens
V2114  Spherocyl, sgl vision sphere over plus/minus 12.00d, per lens
V2115  Lenticular (myodisc), per lens, single vision
V2118  Aniseikonic lens, single vision (Not Covered for Priority Health Medicaid)
V2121  Lenticular lens, per lens, single

V2200  Sphere, bifocal, plano to plus/minus 4.00d, per lens
V2201  Sphere, bifocal, plus/minus 4.12-plus/minus 7.00d, per lens
V2202  Sphere, bifocal, plus/minus 7.12-plus/minus 20.00d, per lens
V2203  Spherocyl, bifocal, plano to plus/minus 4.00d sph, 0.12-2.00d cyl, per lens
V2204  Spherocyl, bifocal, plano to plus/minus 4.00d sph, 2.12-4.00d cyl, per lens
V2205  Spherocyl, bifocal, plano to plus/minus 4.00d sph, 4.25-6.00d cyl, per lens
V2206  Spherocyl, bifocal, plano to plus/minus 4.00d sph, over 6.00d cyl, per lens
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2207</td>
<td>Spherocyl, bifocal, plus/minus 4.25-plus/minus 7.00d sph,0.12-2.00d cyl, per lens</td>
</tr>
<tr>
<td>V2208</td>
<td>Spherocyl, bifocal, plus/minus 4.25-plus/minus 7.00d sph,2.12-4.00d cyl, per lens</td>
</tr>
<tr>
<td>V2209</td>
<td>Spherocyl, bifocal, plus/minus 4.25-plus/minus 7.00d sph,4.25-6.00d cyl, per lens</td>
</tr>
<tr>
<td>V2210</td>
<td>Spherocyl, bifocal, plus/minus 4.25-plus/minus 7.00d sph,over 6.00d cyl, per lens</td>
</tr>
<tr>
<td>V2211</td>
<td>Spherocyl, bifocal, plus/minus 7.25-plus/minus 12.00d sph,0.25-2.25d cyl, per lens</td>
</tr>
<tr>
<td>V2212</td>
<td>Spherocyl, bifocal, plus/minus 7.25-plus/minus 12.00d sph,2.25-4.00d cyl, per lens</td>
</tr>
<tr>
<td>V2213</td>
<td>Spherocyl, bifocal, plus/minus 7.25-plus/minus 12.00d sph,over 6.00d cyl, per lens</td>
</tr>
<tr>
<td>V2214</td>
<td>Spherocylinder, bifocal, sphere over plus/minus 12.00d,per lens</td>
</tr>
<tr>
<td>V2215</td>
<td>Lenticular (myodisc), per lens, bifocal  <em>(Not Covered for Priority Health Medicaid)</em></td>
</tr>
<tr>
<td>V2218</td>
<td>Aniseikonic, per lens, bifocal  <em>(Not Covered for Priority Health Medicaid)</em></td>
</tr>
<tr>
<td>V2219</td>
<td>Bifocal seg width over 28mm</td>
</tr>
<tr>
<td>V2220</td>
<td>Bifocal add over 3.25d</td>
</tr>
<tr>
<td>V2221</td>
<td>Lenticular lens, per lens, bifocal</td>
</tr>
<tr>
<td>V2229</td>
<td>Specialty bifocal (by report)</td>
</tr>
<tr>
<td>V2300</td>
<td>Sphere, trifocal, plano to plus/minus 4.00d,per lens</td>
</tr>
<tr>
<td>V2301</td>
<td>Sphere, trifocal, plus/minus 4.12 to plus/minus 7.00d per lens</td>
</tr>
<tr>
<td>V2302</td>
<td>Sphere, trifocal, plus/minus 7.12 to plus/minus 20.00,per lens</td>
</tr>
<tr>
<td>V2303</td>
<td>Spherocyl, trifocal, plano to plus/minus 4.00d sph,0.12-2.00d cyl, per lens</td>
</tr>
<tr>
<td>V2304</td>
<td>Spherocyl, trifocal, plano to plus/minus 4.00d sph,2.25-4.00d cyl,per lens</td>
</tr>
<tr>
<td>V2305</td>
<td>Spherocyl, trifocal, plano to plus/minus 4.00d sph,4.25-6.00 cyl, per lens</td>
</tr>
<tr>
<td>V2306</td>
<td>Spherocyl, trifocal, plano to plus/minus 4.00d sph,over 6.00d cyl, per lens</td>
</tr>
<tr>
<td>V2307</td>
<td>Spherocyl, trifocal, plus/minus 4.25-plus/minus 7.00d sph,0.12-2.00d cyl, per lens</td>
</tr>
<tr>
<td>V2308</td>
<td>Spherocyl, trifocal, plus/minus 4.25-plus/minus 7.00d sph,2.12-4.00d cyl, per lens</td>
</tr>
<tr>
<td>V2309</td>
<td>Spherocyl, trifocal, plus/minus 4.25-plus/minus 7.00d sph,4.25-6.00d cyl, per lens</td>
</tr>
<tr>
<td>V2310</td>
<td>Spherocyl, trifocal, plus/minus 4.25-plus/minus 7.00d sph,over 6.00d cyl,per lens</td>
</tr>
<tr>
<td>V2311</td>
<td>Spherocyl, trifocal, plus/minus 7.25-plus/minus 12.00d sph,0.25-2.25d cyl,per lens</td>
</tr>
<tr>
<td>V2312</td>
<td>Spherocyl, trifocal, plus/minus 7.25-plus/minus 12.00d sph,2.25-4.00d cyl, per lens</td>
</tr>
<tr>
<td>V2313</td>
<td>Spherocyl, trifocal, plus/minus 7.25-plus/minus 12.00d sph,over 6.00d cyl, per lens</td>
</tr>
<tr>
<td>V2314</td>
<td>Spherocylinder, trifocal, sphere over plus/minus 12.00d,per lens</td>
</tr>
<tr>
<td>V2315</td>
<td>Lenticular (myodisc), per lens, trifocal  <em>(Not Covered for Priority Health Medicaid)</em></td>
</tr>
<tr>
<td>V2318</td>
<td>Aniseikonic lens, trifocal  <em>(Not Covered for Priority Health Medicaid)</em></td>
</tr>
<tr>
<td>V2319</td>
<td>Trifocal seg width over 28mm  <em>(Not Covered for Priority Health Medicaid)</em></td>
</tr>
<tr>
<td>V2320</td>
<td>Trifocal add of 3.25d</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>V2321</td>
<td>Lenticular lens, per lens, trifocal</td>
</tr>
<tr>
<td>V2410</td>
<td>Variable asphericity lens, single vision, full field, glass/plastic, per lens</td>
</tr>
<tr>
<td>V2430</td>
<td>Variable asphericity lens, bifocal, full field, glass/plastic, per lens</td>
</tr>
<tr>
<td>V2500</td>
<td>Contact lens, pmma, spherical, per lens</td>
</tr>
<tr>
<td>V2501</td>
<td>Contact lens, pmma, toric or prism ballast, per lens</td>
</tr>
<tr>
<td>V2502</td>
<td>Contact lens, pmma, bifocal, per lens</td>
</tr>
<tr>
<td>V2503</td>
<td>Contact lens, pmma, color vision deficiency, per lens</td>
</tr>
<tr>
<td>V2510</td>
<td>Contact lens, gas permeable, spherical, per lens</td>
</tr>
<tr>
<td>V2511</td>
<td>Contact lens, gas permeable, toric, prism ballast, per lens</td>
</tr>
<tr>
<td>V2512</td>
<td>Contact lens, gas permeable, bifocal, per lens</td>
</tr>
<tr>
<td>V2513</td>
<td>Contact lens, gas permeable, extended wear, per lens</td>
</tr>
<tr>
<td>V2520</td>
<td>Contact lens, hydrophilic, spherical, per lens</td>
</tr>
<tr>
<td>V2521</td>
<td>Contact lens, hydrophilic, toric, prism ballast, per lens</td>
</tr>
<tr>
<td>V2522</td>
<td>Contact lens, hydrophilic, bifocal, per lens</td>
</tr>
<tr>
<td>V2523</td>
<td>Contact lens, hydrophilic, extended wear, per lens</td>
</tr>
<tr>
<td>V2530</td>
<td>Contact lens, scleral, per lens</td>
</tr>
<tr>
<td>V2531</td>
<td>Contact lens, scleral, gas permeable, per lens</td>
</tr>
<tr>
<td>V2600</td>
<td>Hand held low vision aids &amp; other nonspect. mounted aids.</td>
</tr>
<tr>
<td>V2610</td>
<td>Single lens spectacle mounted low vision aids.</td>
</tr>
<tr>
<td>V2615</td>
<td>Telescopic/other comp lens sys, incl dist visn, near visn &amp; comp micro lens sys</td>
</tr>
<tr>
<td>V2623</td>
<td>Prosthetic eye, plastic, custom</td>
</tr>
<tr>
<td>V2624</td>
<td>Polishing/resurfacing of ocular prosthesis</td>
</tr>
<tr>
<td>V2625</td>
<td>Enlargement of ocular prosthesis</td>
</tr>
<tr>
<td>V2626</td>
<td>Reduction of ocular prosthesis</td>
</tr>
<tr>
<td>V2627</td>
<td>Scleral cover shell</td>
</tr>
<tr>
<td>V2628</td>
<td>Fabrication/fitting of ocular conformer</td>
</tr>
<tr>
<td>V2630</td>
<td>Anterior chamber intraocular lens (payable in physician office only)</td>
</tr>
<tr>
<td>V2631</td>
<td>Iris supported intraocular lens (payable in physician office only)</td>
</tr>
<tr>
<td>V2632</td>
<td>Posterior chamber intraocular lens (payable in physician office only)</td>
</tr>
<tr>
<td>V2700</td>
<td>Balance lens, per lens</td>
</tr>
<tr>
<td>V2710</td>
<td>Slab off prism, glass/plastic, per lens</td>
</tr>
<tr>
<td>V2715</td>
<td>Prism, per lens</td>
</tr>
<tr>
<td>V2718</td>
<td>Press-on lens, fresnell prism, per lens</td>
</tr>
<tr>
<td>V2730</td>
<td>Special base curve, glass/plastic, per lens</td>
</tr>
<tr>
<td>V2744</td>
<td>Tint, photochromatic, per lens (Not Covered for Priority Health Medicaid)</td>
</tr>
<tr>
<td>V2745</td>
<td>Addition to lens; tint, any color, solid, gradient or equal, excludes</td>
</tr>
</tbody>
</table>

*(Not Covered for Priority Health Medicaid)*
<table>
<thead>
<tr>
<th>HPC Code</th>
<th>Description</th>
<th>Coverage Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2755</td>
<td>U-v lens, per lens (Not Covered for Priority Health Medicaid)</td>
<td></td>
</tr>
<tr>
<td>V2760</td>
<td>Scratch resistant coating, per lens (Not Covered for Priority Health Medicaid or Medicare)</td>
<td></td>
</tr>
<tr>
<td>V2761</td>
<td>Mirror coating, any type, solid, gradient or equal, any lens material, per lens</td>
<td>(Not Covered for Priority Health Medicaid)</td>
</tr>
<tr>
<td>V2762</td>
<td>Polarization, any lens material, per lens (Not Covered for Priority Health Medicaid)</td>
<td></td>
</tr>
<tr>
<td>V2770</td>
<td>Occluder lens, per lens (Not Covered for Priority Health Medicaid)</td>
<td></td>
</tr>
<tr>
<td>V2780</td>
<td>Oversize lens, per lens (Not Covered for Priority Health Medicaid)</td>
<td></td>
</tr>
<tr>
<td>V2781</td>
<td>Progressive lens, per lens (Not Covered for Priority Health Medicaid)</td>
<td></td>
</tr>
<tr>
<td>V2782</td>
<td>Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate, per lens (Not Covered for Priority Health Medicaid)</td>
<td></td>
</tr>
<tr>
<td>V2783</td>
<td>Lens, index greater than or equal to 1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate, per lens</td>
<td>(Not Covered for Priority Health Medicaid)</td>
</tr>
<tr>
<td>V2784</td>
<td>Lens, polycarbonate or equal, any index, per lens (Not Covered for Priority Health Medicaid)</td>
<td></td>
</tr>
<tr>
<td>V2785</td>
<td>Processing, preserving, transporting corneal tissue</td>
<td></td>
</tr>
<tr>
<td>V2786</td>
<td>Specialty occupational multifocal lens, per lens</td>
<td></td>
</tr>
<tr>
<td>V2790</td>
<td>Amniotic membrane for surgical reconstruction, per procedure (Not separately payable for Priority Health Medicare and Medicaid)</td>
<td></td>
</tr>
<tr>
<td>V2797</td>
<td>Vision supply, accessory and/or service component of another hpcs vision code</td>
<td></td>
</tr>
</tbody>
</table>

“S” Codes are not covered for Priority Medicaid and Medicare plans except where noted:
- S0500 Contact lens, disposable
- S0504 Single vision prescription lens (safety, athletic, or sunglass), per lens
- S0506 Bifocal vision prescription lens (safety, athletic, or sunglass), per lens
- S0508 Trifocal vision prescription lens (safety, athletic, or sunglass), per lens
- S0515 Scleral lens, liquid bandage device, per lens
- S0516 Safety eyeglass frames
- S0581 Non-standard lens code (Covered for Priority Health Medicaid only)
- S0592 Comprehensive contact lens evaluation (Covered for Priority Health Medicaid only)

Modifiers for Medicaid Use Only:
- Mod U1 Polycarbonate lenses
- Mod U1 Industrial Thickness Lenses
- Mod U2 High Index Lenses

Not Covered for all products:
- 0100T Placement of a subconjunctival retinal prosthesis receiver and pulse generator, and implantation of intra-ocular retinal electrode array, with vitrectomy
- C1841 Retinal prosthesis, includes all internal and external components
- 0198T Measurement of ocular blood flow by repetitive intraocular pressure sampling, with interpretation and report
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
</table>
| 0290T | Corneal incisions in the recipient cornea created using a laser, in preparation for penetrating or lamellar keratoplasty (List separately in addition to code for primary procedure)  
(Not separately payable)                                                        |
| 0329T | Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral, with interpretation and report                                                                                          |
| 0330T | Tear film imaging, unilateral or bilateral, with interpretation and report                                                                                                                                    |
| 0333T | Visual evoked potential, screening of visual acuity, with report                                                                                                                                            |
| 0378T | Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional |
| 0379T | Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days; technical support and patient instructions, surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional |
| 0380T | Computer-aided animation and analysis of time series retinal images for the monitoring of disease progression, unilateral or bilateral, with interpretation and report  
(Not separately payable)                                                        |
| 0464T | Visual evoked potential, testing for glaucoma, with interpretation and report                                                                                                                                |
| 0465T | Suprachoroidal injection of a pharmacologic agent (does not include supply of medication)                                                                                                                    |
| 0469T | Retinal polarization scan, ocular screening with on-site automated results, bilateral                                                                                                                      |
| 0472T | Device evaluation, interrogation, and initial programming of intraocular retinal electrode array (eg, retinal prosthesis), in person, with iterative adjustment of the implantable device to test functionality, select optimal permanent programmed values with analysis, including visual training, with review and report by a qualified health care professional |
| 0473T | Device evaluation and interrogation of intra-ocular retinal electrode array (eg, retinal prosthesis), in person, including reprogramming and visual training, when performed, with review and report by a qualified health care professional |
| 0474T | Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space                                                                   |
| 92015 | Determination of refractive state  
(Vision benefit only)                                                                            |
| 92145 | Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report                                                                                     |
| 92354 | Fitting of spectacle mounted low vision aid; single element system                                                                           |
| 92355 | Fitting of spectacle mounted low vision aid; telescopic or other compound lens system                                                        |
| S0510 | Nonprescription lens (safety, athletic, or sunglass), per lens                                                                                 |
| S0512 | Daily wear specialty contact lens, per lens                                                                                                   |
| S0514 | Color contact lens, per lens                                                                                                                  |
| S0518 | Sunglasses frames                                                                                                                             |
| S0580 | Polycarbonate lens (list this code in addition to the basic code for the lens)                                                                  |
| S0581 | Non-standard lens code  
(Covered for Priority Health Medicaid only)                                                                     |
| S0590 | Integral lens service, miscellaneous services reported separately                                                                              |
S0592    Comprehensive contact lens evaluation
S0595    Dispensing new spectacle lenses for patient supplied frame

V2025    Deluxe frame
V2600    Hand held low vision aids & other nonspectacle mounted aids (Covered for Priority Health Medicaid only)
V2610    Single lens spectacle mounted low vision aids (Covered for Priority Health Medicaid only)
V2615    Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens system (Covered for Priority Health Medicaid only)

V2702    Deluxe lens feature
V2750    Antireflective coating, per lens
V2756    Eye glass case

V2787    Astigmatism correcting function of intraocular lens
V2788    Presbyopia correcting function of intraocular lens

G9041    Low vision rehabilitation services, qualified occupational therapist, direct face-to-face one-on one, each 15 minutes
G9042    Low vision rehabilitation services, certified orientation and mobility specialist, direct face-to-face one-on-one, each 15 minutes
G9043    Low vision rehabilitation services, certified low vision therapist, direct face-to-face one-on-one, each 15 minutes
G9044    Low vision rehabilitation services, qualified rehabilitation teacher, direct face-to-face one-on-one, each 15 minutes

ICD-10 Codes that codes that support medical necessity for contact lenses and the procedures below:
A18.52    Tuberculous keratitis
B09       Unspecified viral infection characterized by skin and mucous membrane lesions
H16.001 - H16.009    Unspecified corneal ulcer
H16.011 - H16.019    Central corneal ulcer
H16.021 - H16.029    Ring corneal ulcer
H16.031 - H16.039    Corneal ulcer with hypopyon
H16.041 - H16.049    Marginal corneal ulcer
H16.051 - H16.059    Mooren's ulcer
H16.061 - H16.069    Mycotic corneal ulcer
H16.071 - H16.079    Perforated corneal ulcer
H16.101 - H16.109    Unspecified superficial keratitis
H16.111 - H16.119    Macular keratitis
H16.121 - H16.129    Filamentary keratitis
H16.131 - H16.139    Photokeratitis
H16.141 - H16.149    Punctate keratitis
H16.201 - H16.209    Unspecified keratoconjunctivitis
H16.211 - H16.219    Exposure keratoconjunctivitis
H16.221 - H16.229    Keratoconjunctivitis sicca, not specified as Sjogren's
H16.231 - H16.239    Neurotrophic keratoconjunctivitis
Phlyctenular keratoconjunctivitis
Vernal keratoconjunctivitis, with limbar and corneal involvement
Other keratoconjunctivitis
Unspecified interstitial keratitis
Corneal abscess
Diffuse interstitial keratitis
Sclerosing keratitis
Other interstitial and deep keratitis
Keratoconus, unspecified
Keratoconus, stable
Keratoconus, unstable
Recurrent erosion of cornea
Anisometropia (Contact lens for Priority Health Medicare & Medicaid only)
Congenital cataract (over age 6 only – for Medicaid)
Congenital displaced lens
Congenital lens malformation, unspecified

CPT Codes:
92311 Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye
92312 Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes
92313 Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens
92314 Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens (Not Covered for Priority Health Medicaid)
92315 Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens for aphakia, one eye (Not Covered for Priority Health Medicaid)
92316 Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens for aphakia, both eyes (Not Covered for Priority Health Medicaid)
92317 Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneoscleral lens (Not Covered for Priority Health Medicaid)
92325 Modification of contact lens (Not Covered for Priority Health Medicaid)
92326 Replacement of contact lens

ICD-10 Codes that codes that support medical necessity for the procedures below:
H18.21 - H18.629 Keratoconus, unstable
H18.40 Unspecified corneal degeneration
H18.601 - H18.609  Keratoconus, unspecified
H18.611 - H18.619  Keratoconus, stable
Q13.4  Other congenital corneal malformations

CPT Codes:
65785  Implantation of intrastromal corneal ring segments

Special Note: Vision care, services, and supplies may be covered with a rider, group contract language or a stand-along vision policy.

VI. REFERENCES


Food and Drug Administration (FDA) Website. CDRH consumer information – new humanitarian device approval. Available at: http://www.fda.gov


Food and Drug Administration (FDA) Website. CDRH consumer information – new humanitarian device approval. Available at: http://www.fda.gov


Artificial Retina, Aetna Clinical Policy Bulletin @

Hayes, Inc. iStent Trabecular Micro-Bypass (Glaukos Corp.) in Combination with Cataract Surgery for Treatment of Open-Angle Glaucoma March 17, 2016.
AMA CPT Copyright Statement:
All Current Procedure Terminology (CPT) codes, descriptions, and other data are copyrighted by the American Medical Association.

This document is for informational purposes only. It is not an authorization, certification, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of coverage. Eligibility and benefit coverage are determined in accordance with the terms of the member’s plan in effect as of the date services are rendered. Priority Health’s medical policies are developed with the assistance of medical professionals and are based upon a review of published and unpublished information including, but not limited to, current medical literature, guidelines published by public health and health research agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Priority Health reserves the right to review and update its medical policies at its discretion.

Priority Health’s medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan’s ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.

The name “Priority Health” and the term “plan” mean Priority Health, Priority Health Managed Benefits, Inc., Priority Health Insurance Company and Priority Health Government Programs, Inc.