PriorityHealth

MEDICAL POLICY
No. 91538-R6

*VISION CARE

Effective Date: July 29, 2016	**Review Dates: 7/07, 4/08, 4/09, 4/10, 4/11, 4/12, 4/13, 5/14, 5/15, 5/16**
Date Of Origin: July 2007	**Status: Current**

Note this policy incorporates the previously separate policy Contact Lenses/Eyeglasses #91425 and the title of this policy changed from Vision Care/Eye Exam to Vision Care.

Summary of Changes

Clarifications:

- Pg. 4, Section I, 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.

Deletions:

-

Additions:

-

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

☐ Required ☒ Not Required ☐ Not Applicable

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_42542_42543_42546_42551-159815--,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, 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)*

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
92140 Provocative tests for glaucoma, with interpretation and report, without tonography *(Not Covered for Priority Health Medicaid)*

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 92240 Indocyanine-green angiography (includes multiframe imaging) with interpretation and report 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-oculography 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 (vep) 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 plu/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
V2207 Spherocyl, bifocal, plus/minus 4.25-plus/minus 7.00d sph,0.12-2.00d cyl, per lens
V2208 Spherocyl, bifocal, plus/minus 4.25-plus/minus 7.00d sph,2.12-4.00d cyl, per lens
V2209 Spherocyl, bifocal, plus/minus 4.25-plus/minus 7.00d sph,4.25-6.00d cyl, per lens
V2210 Spherocyl, bifocal, plus/minus 4.25-plus/minus 7.00d sph,over 6.00d cyl, per lens
V2211 Spherocyl, bifocal, plus/minus 7.25-plus/minus 12.00d sph,0.25-2.25d cyl, per lens
V2212 Spherocyl, bifocal, plus/minus 7.25-plus/minus 12.00d sph,2.25-4.00d cyl, per lens
V2213 Spherocyl, bifocal, plus/minus 7.25-plus/minus 12.00d sph,4.25-6.00d cyl, per lens
V2214 Spherocylinder, bifocal, sphere over plus/minus 12.00d,per lens
V2215 Lenticular (myodisc), per lens, bifocal *(Not Covered for Priority Health Medicaid)*
V2218 Aniseikonic, per lens, bifocal *(Not Covered for Priority Health Medicaid)*
V2219 Bifocal seg width over 28mm
V2220 Bifocal add over 3.25d
V2221 Lenticular lens, per lens, bifocal
V2299 Specialty bifocal (by report)

V2300 Sphere, trifocal, plano to plus/minus 4.00d,per lens
V2301 Sphere, trifocal, plus/minus 4.12 to plus/minus 7.00d per lens
V2302 Sphere, trifocal, plus/minus 7.12 to plus/minus 20.00,per lens
V2303 Spherocyl, trifocal, plano to plus/minus 4.00d sph,0.12-2.00d cyl, per lens
V2304 Spherocyl, trifocal, plano to plus/minus 4.00d sph,2.25-4.00d cyl,per lens
V2305 Spherocyl,trifocal,plano to plus/minus 4.00d sph,4.25-6.00 cyl, per lens
V2306 Spherocyl,trifocal,plano to plus/minus 4.00d sph,over 6.00d cyl, per lens
V2307 Spherocyl,trifocal,plus/minus 4.25-plus/minus 7.00d sph,0.12-2.00d cyl, per lens
V2308 Spherocyl,trifocal,plus/minus 4.25-plus/minus 7.00d sph,2.12-4.00d cyl, per lens
V2309 Spherocyl,trifocal,plus/minus 4.25-plus/minus 7.00d sph,4.25-6.00d cyl, per lens
V2310 Spherocyl,trifocal,plus/minus 4.25-plus/minus 7.00d sph,over 6.00d cyl,per lens
V2311 Spherocyl,trifocal,plus/minus 7.25-plus/minus 12.00d sph,0.25-2.25d cyl,per lens
V2312 Spherocyl, trifocal,plus/minus 7.25-plus/minus 12.00d sph,2.25-4.00d cyl, per lens
V2313 Spherocyl, trifocal,plus/minus 7.25-plus/minus 12.00d sph,4.25-6.00d cyl, per lens
V2314 Spherocylinder, trifocal,sphere over plus/minus 12.00d,per lens
V2315 Lenticular (myodisc), per lens, trifocal *(Not Covered for Priority Health Medicaid)*

V2318 Aniseikonic lens, trifocal *(Not Covered for Priority Health Medicaid)*
V2319 Trifocal seg width over 28mm *(Not Covered for Priority Health Medicaid)*
V2320 Trifocal add of 3.25d
V2321 Lenticular lens, per lens, trifocal *(Not Covered for Priority Health Medicaid)*
V2410 Variable asphericity lens,single vision,full field,glass/plastic, per lens
V2430 Variable asphericity lens,bifocal,full field,glass/plastic, per lens

V2500 Contact lens, pmma, spherical,per lens
V2501 Contact lens, pmma, toric or prism ballast, per lens
V2502 Contact lens, pmma, bifocal, per lens *(Not Covered for Priority Health Medicaid)*
V2503 Contact lens, pmma, color vision deficiency, per lens *(Not Covered for Priority Health Medicaid)*
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 *(Not Covered for Priority Health Medicaid)*
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 *(Not Covered for Priority Health Medicaid)*
V2523 Contact lens,hydrophilic,extended wear,per lens
V2530 Contact lens,scleral,per lens *(Not Covered for Priority Health Medicaid)*
V2531 Contact lens,sclearl,gas permeable,per lens *(Not Covered for Priority Health Medicaid)*
V2600 Hand held low vision aids & other nonspect.mounted aids. *(Covered for Priority Health Medicaid only)*
V2610 Single lens spectacle mounted low vision aids. *(Covered for Priority Health Medicaid only)*
V2615 Telescopic/other comp lens sys,incl dist visn ,near visn & comp micro lens sys *(Covered for Priority Health Medicaid only)*
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/fitting of ocular conformer

V2630 Anterior chamber intraocular lens (*payable in physician office only)*
V2631 Iris supported intraocular lens (*payable in physician office only)*
V2632 Posterior chamber intraocular lens (*payable in physician office only)*

V2700 Balance lens, per lens
V2710 Slab off prism, glass/plastic, per lens
V2715 Prism, per lens
V2718 Press-on lens, fresnell prism, per lens
V2730 Special base curve, glass/plastic, per lens *(Not Covered for Priority Health Medicaid)*
V2744 Tint, photochromatic, per lens *(Not Covered for Priority Health Medicaid)*

V2745 Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens *(Not Covered for Priority Health Medicaid)*
V2755 U-v lens, per lens *(Not Covered for Priority Health Medicaid)*
V2760 Scratch resistant coating, per lens *(Not Covered for Priority Health Medicaid or Medicare)*
V2761 Mirror coating, any type, solid, gradient or equal, any lens material, per lens *(Not Covered for Priority Health Medicaid)*

V2762 Polarization, any lens material, per lens *(Not Covered for Priority Health Medicaid)*
V2770 Occluder lens, per lens *(Not Covered for Priority Health Medicaid)*
V2780 Oversize lens, per lens *(Not Covered for Priority Health Medicaid)*
V2781 Progressive lens, per lens *(Not Covered for Priority Health Medicaid)*
V2782 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)*
V2783 Lens, index greater than or equal to 1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate, per lens *(Not Covered for Priority Health Medicaid)*
V2784 Lens, polycarbonate or equal, any index, per lens *(Not Covered for Priority Health Medicaid)*
V2785 Processing, preserving, transporting corneal tissue
V2786 Specialty occupational multifocal lens, per lens
V2790 Amniotic membrane for surgical reconstruction, per procedure *(Not separately payable forPriority Health Medicare and Medicaid)*
V2797 Vision supply, accessory and/or service component of another hcpcs vision code

"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
0289T	Corneal incisions in the donor cornea created using a laser, in preparation for penetrating or lamellar keratoplasty (List separately in addition to code for primary procedure) *(Not separately payable*)
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*)
0291T	Intravascular optical coherence tomography (coronary native vessel or graft) during diagnostic evaluation and/or therapeutic intervention, including imaging supervision, interpretation, and report; initial vessel (List separately in addition to primary procedure) (*Not separately payable*)
0292T	Intravascular optical coherence tomography (coronary native vessel or graft) during diagnostic evaluation and/or therapeutic intervention, including imaging supervision, interpretation, and report; each additional vessel (List separately in addition to 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,
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)*
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 lenses for patient supplied frame	Dispensing new spectacle
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-9 Codes that codes that support medical necessity for contact lenses and the procedures below (*for dates of service on or before September 30, 2015):*

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 hypoyon
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 keratiti
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
H16.251 - H16.259	Phlyctenular keratoconjunctivitis
H16.261 - H16.269	Vernal keratoconjunctivitis, with limbar and corneal involvement
H16.291 - H16.299	Other keratoconjunctivitis
H16.301 - H16.309	Unspecified interstitial keratitis
H16.311 - H16.319	Corneal abscess
H16.321 - H16.329	Diffuse interstitial keratitis
H16.331 - H16.339	Sclerosing keratitis
H16.391 - H16.399	Other interstitial and deep keratitis
H18.601 - H18.609	Keratoconus, unspecified
H18.611 - H18.619	Keratoconus, stable
H18.621 - H18.629	Keratoconus, unstable
H18.831 - H18.839	Recurrent erosion of cornea
H52.31	Anisometropia (*Contact lens for Priority Health Medicare & Medicaid only*)
Q12.0	Congenital cataract *(over age 6 only – for Medicaid)*
Q12.1	Congenital displaced lens
Q12.9	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

American Academy of Ophthalmology. (2005) Policy Statement-definition of Primary Eye Care. Retrieved on 2/22/2007 from: http://www.aao.org/education/library/statements/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=11889

Centers for Medicare and Medicaid (CMS), Medicare Coverage database, AdminiaStar Federal, Inc (Region B), Local Coverage Decision (LCD), Eye Prosthesis, L11529, DME Region A/B, Original effective date: 10/01/1993. Revision effective date: 03/01/2006. Retrieved on 02/22/2007 from: http://www.cms.hhs.gov/mcd/viewlcd.asp?lcd_id=11529&lcd_version=11&basket=lcd%3A11529%3A11%3AEye+Prosthesis%3ADME+PSC%3ATriCenturion+%2877011%29%3A

HAYES Alert. Intrastromal Corneal Ring Segments (ICRS) for Vision Correction. Vol. VIII, No. 7. Lansdale, PA: HAYES Inc, July 2005.

Wisconsin Physicians Services (WPS), Region V, Local Coverage Decision (LCD) #OPHTH-003, Optometrist Services, Original effective date Michigan: 12/01/2000, Revision effective date: 01/01/2007, Retrieved on 2/22/2007 from: http://www.wpsic.com/medicare/policies/wisconsin/ophth003.pdf

Wisconsin Physicians Services (WPS), Region V, National Coverage Provision (NCP), Glaucoma Screening, #OPHTH-024, Original effective date: 0101/2002, Effective date: 0101/2006, Retreived on 2/23/2007 from: http://www.wpsic.com/medicare/policies/wisconsin/ophth024.pdf

Hayes, Winfred S. Literature Search. Intacs for keratoconus. March 1, 2010.

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

National Institute for Health and Clinical Excellence (NICE). Corneal implants for keratoconus. Interventional Procedure Guidance 227. London, UK: NICE; July 2007.

Medical Advisory Secretariat. Intrastromal corneal ring segments for corneal thinning disorders: An evidence-based analysis. Pre-edit Draft. Ontario Health Technology Assessment Series. April 2009;9(TBA):1-92. Available

at: http://www.health.gov.on.ca/english/providers/program/mas/tech/reviews/pdf/rev

Regence Group. Vision Therapy for the Treatment of Learning Disabilities. Policy No. 19. Effective March 1, 2011. Available at: http://blue.regence.com/trgmedpol/alliedHealth/ah19.html. Accessed September 23, 2011.

Scheiman M, Cotter S, Kulp MT, et al.; the Convergence Insufficiency Treatment Trial Study Group. Treatment of accommodative dysfunction in children: results from a randomized clinical trial. *Optom Vis Sci*. 2011a. Epub ahead of print. August 25, 2011. Available at: http://journals.lww.com/optvissci

Scheiman M, Gwiazda J, Li T. Non-surgical interventions for convergence insufficiency. *Cochrane Database Syst Rev*. 2011b;(3):CD006768.

Shin HS, Park SC, Maples WC. Effectiveness of vision therapy for convergence dysfunctions and long-term stability after vision therapy. *Ophthalmic Physiol Opt*. 2011;31(2):180-189.

UnitedHealthcare (UHC). Visual Information Processing Evaluation and Orthoptic and Vision Therapy. Medical Policy No. 2011T0072I. Effective February 3, 2011. Available at: https://www.unitedhealthcareonline.com

Wallace DK. Treatment options for symptomatic convergence insufficiency. *Arch Ophthalmol*. 2008;126(10):1455-1456

Hayes, Inc. Argus II Retinal Prosthesis System Prognosis Overview, February 2013, update 2014.

Humayun MS(1), Dorn JD, da Cruz L, Dagnelie G, Sahel JA, Stanga PE, Cideciyan AV, Duncan JL, Eliott D, Filley E, Ho AC, Santos A, Safran AB, Arditi A, Del Priore LV, Greenberg RJ; Argus II Study Group. Interim results from the international trial of Second Sight's visual prosthesis. Ophthalmology. 2012 Apr;119(4):779-88.

Artificial Retina, Aetna Clinical Policy Bulletin @ http://www.aetna.com/cpb/medical/data/700_799/0713.html (Retrieved March 13, 2015 & March 31, 2016)

Hayes, Inc. iStent Trabecular Micro-Bypass (Glaukos Corp.) in Combination with Cataract Surgery for Treatment of Open-Angle Glaucoma March 17, 2016.
