Priority Health

MEDICAL POLICY
No. 91538-R10

VISION CARE

Effective Date: December 1, 2025	**Review Dates: 7/07, 4/08, 4/09, 4/10, 4/11, 4/12, 4/13, 5/14, 5/15, 5/16, 5/17, 5/18, 5/19, 5/20, 5/21, 2/22, 2/23, 2/24, 11/24, 11/25**
Date Of Origin: July 2007	**Status: Current**

Summary of Changes

Additions:

- Home intraocular pressure monitoring devices (e.g., The iCare device for measurement of intraocular pressure) are considered not medically necessary and therefore excluded. There is limited evidence to suggest that home intraocular pressure monitoring improves clinical outcomes.

Clarifications:

- Eyelid thermal pulsation therapy, vectored thermal pulsation, or thermal-activated restorative gland expression therapy (e.g., LipiFlow, TearCare) is considered not medically necessary as a treatment for chronic dry eye and meibomian gland dysfunction. There is inconsistent evidence that these therapies may benefit patients more than standard at-home warm compress treatments.

Related policies:

No. 91529 Refractive Keratoplasty
No. 91306 Prosthetics – External
No. 91645 Digital Therapeutics

I. MEDICAL NECESSITY 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 specific plan documents 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. FDA-approved bypass stents for the treatment of open-angle glaucoma in combination with cataract surgery 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.

- Artificial iris devices (e.g., the CUSTOM*FLEX*® ARTIFICAL *IRIS* by Human Optics Holding AG) for congenital aniridia are considered experimental and investigational and not a covered benefit because available guidance confers strong support against their use for the treatment of aniridia. Evidence on the safety and efficacy of artificial implant insertion for congenital aniridia is inadequate in quantity and quality.
- Treatment of amblyopia using an online digital program (e.g., RevitalVision Perceptual Learning Vision Training Program (Talshir medical Technologies Ltd). Findings do not evaluate impact on social or academic function or quality of life. The available studies are few in number and are limited by weak study designs, lack of follow-up beyond treatment completion, lack of statistical comparisons with standard care, and/or unknown generalizability to typical amblyopia populations. No practice guidelines were identified that addressed the use of RevitalVision or vision training software using perceptual learning principles.
- Home intraocular pressure monitoring devices (e.g., The iCare device for measurement of intraocular pressure). There is limited evidence to suggest that home intraocular pressure monitoring improves clinical outcomes.
- Eyelid thermal pulsation therapy, vectored thermal pulsation, or thermal-activated restorative gland expression therapy (e.g., LipiFlow, TearCare) is considered not medically necessary as a treatment for chronic dry eye and meibomian gland dysfunction. There is inconsistent evidence that these therapies may benefit patients more than standard at-home warm compress treatments.

II. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) COVERAGE DETERMINATION

Any applicable federal or state mandates will take precedence over this medical coverage policy.

Medicare: Refer to the CMS Online Manual System (IOMs) and Transmittals. For the most current applicable CMS National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA) refer to CMS Medicare Coverage Database.

The information below is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. MAC jurisdiction for purposes of local coverage determinations is governed by the geographic service area where the Medicare Advantage plan is contracted to provide the service. Please refer to the Medicare Coverage Database website for the most current applicable NCD, LCD, LCA, and CMS Online Manual System/Transmittals.

National Coverage Determinations (NCDs)	
None identified.	
Local Coverage Determinations (LCDs)	
CGS Administrators, LLC	Capsule Opacification Following Cataract Surgery: Discission and YAG Laser Capsulotomy L33946 Cataract Extraction L33954 Computerized Corneal Topography L34008 Electroretinography (ERG) L38992 Micro-Invasive Glaucoma Surgery L37578 MolDX: DecisionDx-UM (Uveal Melanoma) L37130 Ophthalmic Biometry for Intraocular Lens Power Calculation L34181 Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) L34061 Visual Fields Testing L34394 Refractive Lenses L33793
First Coast Service Options, Inc.	Cataract Extraction (including Complex Cataract Surgery) L38926 Electroretinography (ERG) L37398 Micro-Invasive Glaucoma Surgery (MIGS) L38233 Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) L33751 Visual Field Examination L33766
National Government Services, Inc.	Cataract Extraction L33558 Corneal Hysteresis L38014 Micro-Invasive Glaucoma Surgery (MIGS) L37244

	Ophthalmic Biometry for Intraocular Lens Power Calculation L33621 Ophthalmology: Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography) L33567 Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) L34380 Visual Electrophysiology Testing L36831 Visual Fields Testing L33574
Noridian Healthcare Solutions	Cataract Surgery in Adults L34203 Micro-Invasive Glaucoma Surgery (MIGS) L38299 L38301 MolDX: DecisionDx-UM (Uveal Melanoma) L37070 L37072
Novitas Solutions, Inc.	Cataract Extraction (including Complex Cataract Surgery) L35091 Electroretinography (ERG) L37371 Micro-Invasive Glaucoma Surgery (MIGS) L38223 Scanning Computerized Ophthalmic Diagnostic Imaging L35038
Palmetto GBA	Cataract Surgery L34413 Corneal Hysteresis L38026 Dexamethasone Intracanalicular Ophthalmic Insert (Dextenza®) L38792 Micro-Invasive Glaucoma Surgery (MIGS) L37531 MolDX: DecisionDx-UM (Uveal Melanoma) L37033 Ophthalmology: Extended Ophthalmoscopy and Fundus Photography L33467 Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) L34431 Voretigene Neparvovec-rzyl (Luxturna®) L37863 YAG Capsulotomy L37644
WPS Insurance Corporation	Cataract Surgery L39905 Corneal Hysteresis L38211 Micro-Invasive Glaucoma Surgery (MIGS) L39907 MolDX: Decision Dx-UM (Uveal Melanoma) L37210 Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) L34760 Visual Electrophysiology Testing L37015

	Visual Fields L34615

III. BACKGROUND

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.

Home Intraocular Pressure Monitoring

Management of intraocular pressure (IOP) is the only readily modifiable risk factor known to slow the development and progression of glaucoma and visual disability. As glaucoma is a leading cause of permanent blindness worldwide, efforts to accurately monitor IOP changes over time are of paramount importance. The Icare HOME (TA022, Icare Oy, Vanda, Finland) is a rebound tonometer approved by the US Food and Drug Administration in March 2017 designed for self-measurement of intraocular pressure (IOP). IOP remains a major modifiable risk factor for glaucoma progression; however IOP measurements typically occur through single office measurements on Goldmann applanation tonometry (GAT) and do not always reveal the complete picture of patient's IOP patterns and daily fluctuations, which are important for accurate diagnosis and evaluation. (Nayak et al., 2023)

In a 2023 study by Nayak and colleagues, 83 eligible patients underwent iCare HOME training through guided demonstration (verbal, pictorial, video) and practiced self-tonometry measures using iCare HOME. Certification for

independent iCare HOME measure was provided if first iCare HOME intraocular pressure (IOP) measurement fell within ± 5 mmHg of Goldmann applanation tonometer (GAT) measurement which was measured by the trained clinician (principal investigator). Certified participants underwent simulated home self-tonometry measurements using iCare HOME, and agreement with GAT IOP measurements was assessed. Seven of 83 participants (8.43%) failed to complete the study due to difficulty in performing the task, leading to non-certification. Patients who could use the iCare HOME had a mean age of 53 ± 15.55years (53% males; 46% females). Only one in 12 subjects did not qualify to use iCare HOME. The overall mean difference between iCare HOME and GAT was 0.83 mmHg (95%, 3.92 and -2.25). At various pressure ranges, 7-16 mmHg, 17-23 mmHg and >23 mmHg, the mean difference between iCare HOME and GAT was 1.22 mmHg (95%, 4.32 and -1.86), 0.77 mmHg (95%,3.69 and -2.19), -0.11 mmHg (95%, 2.52 and -2.74) respectively. The intra-class correlation coefficient of the iCare HOME device was 0.997(95% CI,0.995-0.998). The authors concluded that patients were able to perform self- tonometry using iCare HOME with good reliability and safety.

Another 2022 study compared intraocular pressure (IOP) readings obtained with Perkins tonometry, iCare Home, iCare 200, and Tonopen to IOP readings obtained with the manometer of a perfusion system to assess the accuracy and reproducibility of each method of tonometry at set pressures. The IOP of human cadaveric eyes (n=2) was measured using a manometer inserted into the eye through the optic nerve. IOP measurements were obtained using a Perkins tonometer, iCare Home, iCare 200, and Tonopen. These measurements were compared to set point IOP measurements of a manometer to determine accuracy and reproducibility of each device. Mean IOP readings obtained with the Perkins tonometer compared to manometer readings demonstrated a difference of -1.0±5.0 mm Hg (P=0.45), indicating a lower reading on average than manometery although not significant. Mean IOP difference between iCare 200 and manometer was 5.3±2.2 mm Hg (P<0.0001). Mean difference in IOP between iCare Home and manometer was 3.5±2.4 mm Hg (P=0.0004). Mean IOP difference compared to manometer was 4.6±4.0 mm Hg for the Tonopen (P<0.0001). IOP measurements obtained with the Perkins tonometer demonstrated a standard deviation of 5.0 mm Hg while the Tonopen measurements demonstrated a 4.0 mm Hg standard deviation. In comparison, iCare 200 and iCare Home demonstrated 2.2 and 2.4 mm Hg standard deviation, respectively. The authors concluded that applanation tonometry produces more accurate IOP readings than rebound tonometry or Tonopen, however it demonstrates greater variability than the other forms of tonometry. Rebound tonometry is more reproducible but tends to over-estimate IOP. (Ertel et al., 2022)

Thermal pulsation therapy, vectored thermal pulsation, thermal-activated restorative gland expression therapy for chronic dry eye and meibomian gland dysfunction

This group of therapies is intended to provide prolonged relief of dry eye by unclogging the lipid-producing meibomian glands in the eyelids, restoring normal

lipid secretion, which keeps tear fluid from drying too quickly. This treatment heats and massages eyelids to melt and extrude deposits of lipid that can plug the glands, and if successful, reduces tear evaporation. This therapy may enable reduction or elimination of other treatments that must be performed daily such as eye drops or warm compresses. The available studies provide inconsistent evidence that such therapy may benefit patients more than standard at-home warm compress treatments for dry eye disease and meibomian gland dysfunction.

IV. GUIDELINES / POSITION STATEMENTS

Medical/Professional Society	Guideline
American Academy of Ophthalmology (AAO)	Practice Guidelines Clinical Statements: Definition of Primary Eye Care – 2014 (April 2014) Preferred Practice Patterns®: Amblyopia is a Medical Condition – 2017 (April 2017) Primary Open-Angle Glaucoma Preferred Practice Pattern guidelines (2020)
National Institute for Health and Clinical Excellence (NICE)	Corneal implants for keratoconus (July 25 2007) Artificial iris insertion for acquired aniridia (July 22, 2020) Artificial iris insertion for congenital aniridia (July 22, 2020)
American Optometric Association (AOA)	Care of the Patient With Primary Open-Angle Glaucoma (2024)
European Glaucoma Society (EGS)	European Glaucoma Society Terminology and Guidelines for Glaucoma, 5th Edition (2021)

V. REGULATORY (US FOOD & DRUG ADMINISTRATION)

See U.S. Food & Drug Administration (FDA) Medical Device Databases for the most current information.

Classification Product Code	Device Classification Name (Examples)
HKI	*Camera, Ophthalmic, AC-Powered* (numerous devices)
HJT	Haploscope

	(RevitalVision; AA-1 System; Aniseikonia Inspector)
HKY	*Tonometer, manual* (iCare HOME2)
QQU	*Digital Therapy Device for Amblyopia* (CureSight-CS100; Luminopia)
OGO	*Intraocular pressure lowering implant* (iStent inject® Trabecular Micro-Bypass Device; Hydrus® Microstent)
KYF	*Implant, Eye Valve* (XEN® Glaucoma Treatment System)
LQE	*Implant, Corneal, Refractive* (Intacs® Corneal Implants)
NBF	*Prosthesis, Retinal* (Argus™ II Retinal Prosthesis System)
QBT	*Artificial Iris* (CUSTOMFLEX® ARTIFICALIRIS)

Device	Premarket Approval 513(f)(2)(De Novo), or 510(k) Number	Decision Date
Luminopia Luminopia One (Luminopia, Inc.)	K243819 K233720 K221659	April 9, 2025 August 8, 2024 November 4, 2022
CureSight-CS100 (NovaSight Ltd.)	K221375	September 29, 2022
iCare HOME2 (Icare Finland Oy)	K211355	January 25, 2022
Hydrus® Microstent (Alcon Inc.)	P170034 S015 P170034	May 30, 2025 August 10, 2018
CyPass Micro-Stent (Alcon Inc.)	Withdrawn from market	August 2018
CUSTOM*FLEX*® ARTIFICAL*IRIS* (Human Optics Holding AG)	P170039 S003 P170039	September 4, 2020 May 30, 2018
XEN® Glaucoma Treatment System (AbbVie)	K161457	November 21, 2016
Argus™ II Retinal Prosthesis System (Cortigent™)[1]	H110002 S033 H110002	August 13, 2021 February 13, 2013
iStent *inject*® Trabecular Micro-Bypass Device (Glaukos Corp.)	P170043 S020 P170043 P080030 S026 P080030	January 1, 2025 June 21, 2018 March 28, 2024 June 25, 2012
Aniseikonia Inspector (Optical Diagnostics, Inc.)	K013110	December 19, 2001

RevitalVision Perceptual Learning Vision Training Program (Talshir medical Technologies Ltd) Originally: AA-1 System (Neurovision, Inc.)	K012530	August 31, 2001
Intacs® Corneal Implants (Addition Technology Inc.)	P980031 S014 P980031	May 2, 2025 April 9, 1999

[1]Argus II has been discontinued due to the small population of patients with retinitis pigmentosa (RP) (Cortigent, Inc.)

VI. CODING

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
* = Medical services that *may* be payable to Optometrists

0253T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach, into the suprachoroidal space
0308T	Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis *(Not covered for Medicaid)*
0402T	Collagen cross-linking of cornea including removal of the corneal epithelium and intraoperative pachymetry when performed (Report medication separately) *(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)* [includes XEN® Gel Stent/Glaucoma Treatment System]
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)* [includes XEN® Gel Stent/Glaucoma Treatment System]

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

0671T Insertion of anterior segment aqueous drainage device into the trabecular meshwork, without external reservoir, and without concomitant cataract removal, one or more *(Not covered for Medicaid)*

0699T Injection, posterior chamber of eye, medication *(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 (e.g., EDTA)

65600 Multiple punctures of anterior cornea (e.g., for corneal erosion, tattoo)

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

65855 Trabeculoplasty by laser surgery

66174 Transluminal dilation of aqueous outflow canal; (eg, canaloplasty); 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

66683 Implantation of iris prosthesis, including suture fixation and repair or removal of iris, when performed *(Not covered for commercial products)*

(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 (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., 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 (e.g., irrigation and aspiration or phacoemulsification)
66985	Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal
66987	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with endoscopic cyclophotocoagulation
66988	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification); with endoscopic cyclophotocoagulation
66989	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more
66991	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more
67820 *	Correction of trichiasis; epilation, by forceps only
67938 *	Removal of embedded foreign body, eyelid
68020	Incision of conjunctiva, drainage of cyst
68040	Expression of conjunctival follicles (e.g., 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
68841	Insertion of drug-eluting implant, including punctal dilation when performed, into lacrimal canaliculus, each
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 (e.g., restrictive or paretic muscle with diplopia) with interpretation and report

92065 * Orthoptic/pleoptic training
92066* Orthoptic training; under supervision of a physician or other qualified health care professional
Coverage for commercial plans limitedto 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 (e.g., 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 (e.g., 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 (e.g., 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 (e.g., diurnal curve or medical treatment of acute elevation of intraocular pressure)

92132 * Computerized ophthalmic diagnostic imaging (eg, optical coherence tomography [OCT]), anterior segment, with interpretation and report, unilateral or bilateral

92133 * Computerized ophthalmic diagnostic imaging (eg, optical coherence tomography [OCT]), posterior segment, with interpretation and report, unilateral or bilateral; optic nerve

92134 * Computerized ophthalmic diagnostic imaging (eg, optical coherence tomography [OCT]), posterior segment, with interpretation and report, unilateral or bilateral; retina

92136 * Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation

92137* Computerized ophthalmic diagnostic imaging (eg, optical coherence tomography [OCT]), posterior segment, with interpretation and report, unilateral or bilateral; retina, including OCT angiography

92201 * Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (eg, for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral

92202 * Ophthalmoscopy, extended; with drawing of optic nerve or macula (eg, for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral

92227 * Imaging of retina for detection or monitoring of disease; with remote clinical staff review and report, unilateral or bilateral

92228 * Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral

92229 * Imaging of retina for detection or monitoring of disease; point-of-care automated analysis 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-oculography with interpretation and report
92273 * Electroretinography (ERG), with interpretation and report; full field (i.e., ffERG, flash ERG, Ganzfeld ERG)
92274 * Electroretinography (ERG), with interpretation and report; multifocal (mfERG)
92283 * Color vision examination, extended, e.g., anomaloscope or equivalent
92284 * Dark adaptation examination with interpretation and report
92285 * External ocular photography with interpretation and report for documentation of medical progress (e.g., 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

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 *(Not Covered for Priority Health Medicare)*
92341 * Fitting of spectacles, except aphakia, bifocal *(Not Covered for Priority Health Medicare)*
92342 * Fitting of spectacles, except aphakia, multifocal *(Not Covered 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 ophthalmologist

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
V2523 Contact lens,hydrophilic,extended wear,per lens
V2524 Contact lens, hydrophilic, spherical, photochromic additive, per lens
V2530 Contact lens,scleral,per lens *(Not Covered for Priority Health Medicaid)*
V2531 Contact lens,sclearl,gas permeable, per lens
V2600 Hand held low vision aids & other nonspect.mounted aids.
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
V2745 Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per
V2750 Antireflective coating, per lens (*covered for Priority Medicare only)*
V2755 U-v lens, per lens
V2760 Scratch resistant coating, per lens *(Not Covered for Priority Health Medicaid)*
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 for Priority Health Medicare and Medicaid)*
V2797 Vision supply, accessory and/or service component of another HCPCS vision code

"S" Codes are not covered for any Priority Health Commercial, 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 for medical contact lens services 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
0207T Evacuation of meibomian glands, automated, using heat and intermittent pressure, unilateral
C1839 Iris prosthesis

L8608 Miscellaneous external component, supply or accessory for use with the Argus II retinal prosthesis system

0198T Measurement of ocular blood flow by repetitive intraocular pressure sampling, with interpretation and report
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

0444T Initial placement of a drug-eluting ocular insert under one or more eyelids, including fitting, training, and insertion, unilateral or bilateral

0445T Subsequent placement of a drug-eluting ocular insert under one or more eyelids, including re-training, and removal of existing insert, unilateral or bilateral

0464T Visual evoked potential, testing for glaucoma, with interpretation and report

0469T Retinal polarization scan, ocular screening with on-site automated results, bilateral

0472T Device evaluation, interrogation, and initial programming of intraocular retinal electrode array (e.g., 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 *(Covered for Medicare Only)*

0473T Device evaluation and interrogation of intra-ocular retinal electrode array (e.g., retinal prosthesis), in person, including reprogramming and visual training, when performed, with review and report by a qualified health care professional *(Covered for Medicare Only)*

0506T Macular pigment optical density measurement by heterochromatic flicker photometry, unilateral or bilateral, with interpretation and report

0507T Near-infrared dual imaging (i.e., simultaneous reflective and trans-illuminated light) of meibomian glands, unilateral or bilateral, with interpretation and report

0509T Electroretinography (ERG) with interpretation and report, pattern (PERG) *(Covered for Medicare Only)*

0563T Evacuation of meibomian glands, using heat delivered through wearable, open-eye eyelid treatment devices and manual gland expression, bilateral

0621T Trabeculostomy ab interno by laser

0622T Trabeculostomy ab interno by laser; with use of ophthalmic endoscope

0687T Treatment of amblyopia using an online digital program; device supply, educational set-up, and initial session [includes RevitalVision]

0688T Treatment of amblyopia using an online digital program; assessment of patient performance and program data by physician or other qualified health care professional, with report, per calendar month [includes RevitalVision]

0704T Remote treatment of amblyopia using an eye tracking device; device supply with initial set-up and patient education on use of equipment

0705T Remote treatment of amblyopia using an eye tracking device; surveillance center technical support including data transmission with analysis, with a minimum of 18 training hours, each 30 days

0706T Remote treatment of amblyopia using an eye tracking device; interpretation and report by physician or other qualified health care professional, per calendar month

0730T Trabeculotomy by laser, including optical coherence tomography (OCT) guidance

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
95919	Quantitative pupillometry with physician or other qualified health care professional interpretation and report, unilateral or bilateral
C1818	Integrated keratoprosthesis
L8609	Artificial cornea (Not separately payable)
L8610	Ocular implant (Not separately payable)
L8612	Aqueous shunt (Not separately payable) [includes XEN® Gel Stent/Glaucoma Treatment 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
V2526	Contact lens, hydrophilic, with blue-violet filter, per lens
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

ICD-10 Codes that codes that support medical necessity for <u>contact lenses and the procedures below:</u>

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
H27.00 - H27.03	Aphakia
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 procedure 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-alone vision policy.

VII. MEDICAL NECESSITY REVIEW

Prior authorization for certain drugs, devices, services, and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service, or procedure is medically necessary. For more information, please refer to the Priority Health Provider Manual.

VIII. 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) and/or the Evidence of Coverage (EOC); 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. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.***

IX. REFERENCES

1. Hayes, Inc. Evolving Evidence Review. CustomFlex Artificial Iris (HumanOptics AG, Clinical Research Consultants Inc.) for Aniridia. Hayes, Inc. March 10, 2022. Annual Review April 15, 2025.
2. Hayes, Inc. Evolving Evidence Review. Luminopia One (Luminopia Inc.) for Treatment of Amblyopia in Children. Hayes, Inc. April 14, 2023. Annual Review August 27, 2024.
3. Hayes, Inc. Evolving Evidence Review. RevitalVision Perceptual Learning Vision Training Program (Talshir Medical Technologies LTD) for Treatment of Amblyopia. Hayes, Inc. May 8, 2024. Annual Review June 17, 2025.
4. Hayes, Inc. Evidence Analysis Research Brief. iStent infinite Trabecular Micro-Bypass System Model iS3 (Glaukos Corp.) for Treatment of Open-Angle Glaucoma. Hayes, Inc. October 25, 2024.
5. Hayes, Inc. Health Technology Assessment. iStent inject Trabecular Micro-Bypass Stent (Glaukos Corp.) as a Standalone Procedure for Open-Angle Glaucoma. Hayes, Inc. September 17, 2019. Annual Review November 10, 2022.
6. Hayes, Inc. Health Technology Assessment. iStent inject Trabecular Micro-Bypass (Glaukos Corp.) in Combination with Cataract Surgery for Management of Open-Angle Glaucoma. July 2, 2019. Annual Review July 6, 2022.
7. Hayes, Inc. Health Technology Assessment. iStent Trabecular Micro-Bypass Stent (Glaukos Corp.) in Combination with Cataract Surgery for Treatment of Open-Angle Glaucoma. Hayes, Inc. March 17, 2016. Annual Review March 30, 2018.
8. Hayes, Inc. Health Technology Assessment. Vision Therapy for Accommodative Dysfunction. Hayes, Inc. August 2, 2023. Annual Review August 27, 2024.Hayes, Inc. Health Technology Assessment. XEN Glaucoma Treatment System (Allergan) for Treatment of Open-Angle Glaucoma. December 19, 2019. Annual Review April 4, 2023.
9. Humayun MS, 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. doi: 10.1016/j.ophtha.2011.09.028. Epub 2012 Jan 11. PMID: 22244176; PMCID: PMC3319859.
10. Medical Advisory Secretariat. Intrastromal corneal ring implants for corneal thinning disorders: an evidence-based analysis. Ont Health Technol Assess Ser. 2009;9(1):1-90. Epub 2009 Apr 1. PMID: 23074513; PMCID: PMC3385416.
11. Scheiman M, Cotter S, Kulp MT, Mitchell GL, Cooper J, Gallaway M, Hopkins KB, Bartuccio M, Chung I; Convergence Insufficiency Treatment Trial Study Group. Treatment of accommodative dysfunction in children: results from a randomized clinical trial. Optom Vis Sci. 2011 Nov;88(11):1343-52. doi: 10.1097/OPX.0b013e31822f4d7c. PMID: 21873922; PMCID: PMC3204163.
12. Scheiman M, Gwiazda J, Li T. Non-surgical interventions for convergence insufficiency. Cochrane Database Syst Rev. 2011 Mar 16;(3):CD006768. doi: 10.1002/14651858.CD006768.pub2. Update in: Cochrane Database Syst Rev. 2020 Dec 2;12:CD006768. doi: 10.1002/14651858.CD006768.pub3. PMID: 21412896; PMCID: PMC4278667.
13. Shin HS, Park SC, Maples WC. Effectiveness of vision therapy for convergence dysfunctions and long-term stability after vision therapy. Ophthalmic Physiol Opt. 2011 Mar;31(2):180-9. doi: 10.1111/j.1475-1313.2011.00821.x. PMID: 21309805.
14. Wallace DK. Treatment options for symptomatic convergence insufficiency. Arch Ophthalmol. 2008 Oct;126(10):1455-6. doi: 10.1001/archopht.126.10.1455. PMID: 18852426.

Home Intraocular Pressure Monitoring

15. Nayak, A., Ramesh, S. V., Kuzhuppilly, N. I. R., Pai, V. H., & Chaitanya, A. (2023). Performance of home-based self-tonometry (iCare HOME (TA022)) for measuring intraocular pressure among healthy and glaucoma patients. *F1000Research*, *12*, 128. https://doi.org/10.12688/f1000research.123104.2
16. Ertel, M. K., Seibold, L. K., Patnaik, J. L., & Kahook, M. Y. (2022). Comparison of intraocular pressure readings with Perkins, Tonopen, iCare 200, and iCare Home to manometry in cadaveric eyes. *International journal of ophthalmology*, *15*(12), 2022–2027. https://doi.org/10.18240/ijo.2022.12.19
17. Cvenkel, B., & Atanasovska Velkovska, M. (2019). Self-monitoring of intraocular pressure using Icare HOME tonometry in clinical practice. *Clinical ophthalmology (Auckland, N.Z.)*, *13*, 841–847. https://doi.org/10.2147/OPTH.S198846

Thermal pulsation therapy (vectored thermal pulsation) for chronic dry eye and meibomian gland dysfunction

18. Hayes, Inc. Health Technology Assessment. Thermal Pulsation for Chronic Dry Eye Syndrome and Meibomian Gland Dysfunction. Hayes, Inc. December 31, 2019. Annual Review May 2, 2023.

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.