STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Visual Aids and Vision Therapy
OPH-002

Iowa Medicaid Program:	Prior Authorization	**Effective Date:**	4/13/2012
Revision Number:	9	**Last Rev Date:**	1/19/2024
Reviewed By:	Medicaid Medical Director	**Next Rev Date:**	1/17/2024
Approved By:	Medicaid Clinical Advisory Committee	**Approved Date:**	11/22/2017

Criteria

Prior authorization is required.

Subnormal Vision Aids

Subnormal vision aids include, but are not limited to, hand magnifiers, stand magnifiers, loupes, telescopic spectacles, or projection screens.

Subnormal visual aids are considered medically necessary if **ONE** of the following is met:

1. Best corrected visual acuity of 20/200 or worse visual acuity for distance or near vision in the best-seeing eye measured with a standardized instrument, such as the Retinopathy Study, ETDRS chart, Colenbrander chart, or the Berkeley Rudimentary Vision Test at 25 cm (10 inches); **OR**
2. Best corrected visual acuity of 20/50 in the best-seeing eye along with documented scotoma, restrictions of visual field, or loss of contrast sensitivity requiring low vision aids for activities of daily life.

Vision/Visual Therapy

Vision therapy is defined as an attempt to develop or improve visual skills and abilities; improve visual comfort, ease, and efficiency; and change visual processing or interpretation of visual information. There are three main categories of vision therapy:

1. Orthoptic vision therapy - eye exercises to improve binocular function. Orthoptic eye exercises are used by pediatric ophthalmologists and orthoptists, while optometrists call it orthoptic vision therapy. When pediatric ophthalmologists and orthoptists prescribe orthoptic eye exercises, the exercises are taught in the office and carried out at home.
2. Behavioral/perceptual vision therapy - eye exercises to improve visual processing and visual perception.
3. Vision therapy for prevention or correction of myopia (nearsightedness).

Only orthoptic vision therapy is covered when prior authorized.

Vision therapy may be authorized, when warranted, by case history **AND** diagnosis for a period not greater than 90 days. Should continued therapy beyond 90 days be warranted, the prior approval should be resubmitted, accompanied by a report showing satisfactory progress.

Approved diagnoses are amblyopia, convergence insufficiency, convergence excess, accommodation deficiencies, and strabismus. Vision therapy is covered when provided by pediatric ophthalmologists, orthoptists, and optometrists. Vision therapy is not covered when provided by opticians.

Coding

The following lists of codes are provided for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment, nor does the exclusion of a code imply that its association to the HCPCS/CPT code is inappropriate.

HCPCS	Description
V2115	Lenticular, (myodisc), per lens, single vision.
V2218	Aniseikonic lens, single vision.
V2315	Lenticular, (myodisc), per lens, trifocal.
V2318	Aniseikonic lens, trifocal.
V2399	Specialty trifocal (by report).
V2410	Variable asphericity lens, single vision, full field, glass or plastic, per lens.
V2430	Variable asphericity lens, bifocal, full field, glass or plastic, per lens.
V2600	Hand held low vision AIDS and other nonspectacle mounted AIDS.
V2610	Single lens spectacle mounted low vision AIDS.
V2615	Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens system.

CPT	Description
92065	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation.

Compliance

1. Should conflict exist between this policy and applicable statute, the applicable statute shall supersede.
2. Federal and State law, as well as contract language, including definitions and specific contract provisions or exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage.
3. Medical technology is constantly evolving, and Iowa Medicaid reserves the right to review and update medical policy on an annual and as-needed basis.

Medical necessity guidelines have been developed for determining coverage for member benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by

national accreditation organizations. Criteria are revised and updated annually, or more frequently if new evidence becomes available that suggests needed revisions.

References

Medicaid Provider Manual.

Iowa Administrative Code 441-78.28 (3).

American Academy of Ophthalmology, Vision Rehabilitation Preferred Practice Pattern, May 2013, http://www.aao.org/ppp.

American Association for Pediatric Ophthalmology and Strabismus. http://www.aapos.org/terms/conditions/108. Accessed 6/25/2014 (Vision therapy definition).
CITT. Long-term effectiveness of treatments for symptomatic convergence insufficiency in children. Optom Vis Sci 2009, 86: 1096-103.

The Pediatric Eye Disease Investigator Group. Randomized trial treatment of amblyopia in childred aged 7 to 17 years. Arch Opthalmol 2005; 123: 437-47.

A binocular approach to treating amblyopia: antisuppression therapy. Hess, RF, Mansouri, B., Thompson, B. Optom Vis Sci 2010 Sep; 87(9): 697-704.

Rouse, MW "Management of binocular anomalies: efficacy of vision therapy in the treatment of accommodative deficiencies." Am J Optom Physiol Optics, (64): 415-420, 1987.

Vision Rehabilitation Preferred Practice Pattern - 2013 AAO. AAO Vision Rehabilitation Committee, Hoskins Center for Quality Eye Care.

Joint Statement Learning Disabilities, Dyslexia, and Vision - Reaffirmed 2014.

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

Criteria Change History

Change Date	Changed By	Description of Change	Version

Signature

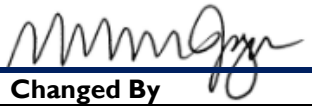
Change Date	Changed By	Description of Change	Version

Signature

Change Date	Changed By	Description of Change	Version
1/19/2024	CAC	Annual review.	9

Signature
William Jagiello, DO 

Change Date	Changed By	Description of Change	Version
1/20/2023	CAC	Annual review.	8

Signature
William Jagiello, DO 

Change Date	Changed By	Description of Change	Version
10/15/2021	Medical Director	Annual review. Formatting changes.	7

Signature
William Jagiello, DO 

Change Date	Changed By	Description of Change	Version
4/17/2015	Medical Director	Added last paragraph in References.	6

Signature
C. David Smith, MD  William Jagiello, DO 

Change Date	Changed By	Description of Change	Version
3/10/2015	Ophthalmology and Optometry Review Consultants	Under subnormal visual aids, added measurement narrative to #1. Added references.	5

Signature

Change Date	Changed By	Description of Change	Version
6/2/2014	Medical Director	Added references. Added new diagnoses and changed "visual therapy" to "vision therapy", the more generally used term. Clarified wording around Subnormal Visual Aids. Removal of eyeglass lens and contact lenses from these criteria.	4

Signature

Change Date	Changed By	Description of Change	Version
4/2/2014	Ophthalmology and Optometry Review Consultants	Under Criteria, paragraph 4 removed "amblyopia" as approved diagnosis and added "and is covered when provided by ophthalmologists, orthoptists, and optometrists".	3

Signature

Criteria Change History

Change Date	Changed By	Description of Change	Version
5/14/2013	Policy	Added rule changes from 11/1/2012.	2
Signature			

Change Date	Changed By	Description of Change	Version
4/19/2013	CAC	Re-number of 1-5 under coverage of contact lens.	1
Signature			