Criteria:

*Subnormal visual 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 are 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 2. Colenbrander chart, or the Berkeley Rudimentary Vision Test at 25 cm (10 inches).
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 therapy (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.
**CPT Code:**
92065
92499 (when used with definition vision therapy examination)

**HCPS Code:**

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**References Used:**

Medicaid Provider Manual
IAC 441-78.28 (3)


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


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


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.
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<th>Change Date</th>
<th>Changed By</th>
<th>Description of Change</th>
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<td>4/19/13</td>
<td>CAC</td>
<td>Re-number of 1-5 under coverage of contact lens</td>
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<tr>
<td>5/14/13</td>
<td>Policy staff</td>
<td>Added rule changes from 11/1/12</td>
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<tr>
<td>4/2/14</td>
<td>Ophthalmology and Optometry Review Consultants</td>
<td>Under Criteria, paragraph 4 removed “amblyopia” as approved diagnosis and added “and is covered when provided by ophthalmologists, orthoptists, and optometrists”.</td>
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<td>6/2/14</td>
<td>Medical Director</td>
<td>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 this criteria.</td>
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<td>Under subnormal visual aids, added measurement narrative to #1. Added references.</td>
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<td>Medical Director</td>
<td>Added last paragraph in References Used.</td>
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C. David Smith, MD