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Vision Services
Corporate Medical Policy

File name: Vision Services
Origination: 12/1992
Last Review: 09/2015 (ICD-10 remediation)
Effective Date: 10/01/15

Description/Summary

An eye exam is not a covered medical benefit for common vision conditions, such as myopia, presbyopia, hyperopia, and 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. Routine eye exams/care may be covered under the members benefit for vision services should the member have that benefit in their contract.

Policy

Coding Information

Click the links below for attachments, coding tables & instructions.
Attachment I- Eligible diagnosis code list
Attachment II- CPT List & Instructions
Attachment III- HCPCS Code List & Instructions
Attachment IV- Eligible Diagnoses for 92133 & 92134 OCT/SCODI List

When a service may be considered medically necessary

Routine eye exams (CPT 92002-92014) may be considered medical necessary under the medical benefit only when a disease condition of the eye is found or reasonably suspected. See attachment I for a list of eligible diagnoses.

A screening test for defective vision in conjunction with a preventive medicine evaluation and management service when done in accordance with current American Academy of Pediatrics, American Academy of Family Practice, and/or Bright Futures guidelines by a physician, physician assistant, or advanced practice nurse clinician.

Visual examination without refraction (CPT 92002 - 92014) may be considered medically necessary when a disease state of the eye or known to affect the eye is present or reasonably suspected (see attachment I) or when an individual is undergoing long term treatment (greater than 30 days) with a high risk medication.

The medical record must clearly document the specific condition or the high risk medication.
Visual examination with refraction (CPT 92015) may be considered medically necessary only in the treatment of aphakia, keratoconus or for specific eye injuries as listed in attachment II.

Analysis of the retinal nerve fiber layer may be considered medically necessary in the diagnosis and evaluation of patients with glaucoma (see Attachment IV for a list of covered diagnoses).

92133-Scanning computerized ophthalmic diagnostic imaging, posterior segment, unilateral or bilateral; optic nerve

92134-Scanning computerized ophthalmic diagnostic imaging, posterior segment, unilateral or bilateral; retina

Scanning computerized ophthalmic diagnostic imaging (SCODI) may be accomplished by various devices, among them Optical Coherence Tomography (OCT).

When used in diagnosing and monitoring glaucoma, nerve fiber layer, and optic nerve conditions, OCT testing may be allowed every year. If the testing is done more frequently than every year, the testing may be subject to review for medical necessity.

Prescription glasses and contact lenses are covered only with (and subject to the limitations of) a vision materials rider except for Aphakia or Keratoconus.

Fundus photography (CPT 92250) is covered.

Therapeutic keratotomy (66999, S0812) is a covered medical benefit for recurrent erosion of the cornea (371.42) and anterior corneal dystrophies (371.52).

When a service is considered not medically necessary

Non-computer-assisted corneal topography is considered part of the evaluation/and management services of general ophthalmological services (CPT codes 92002–92014) and reimbursement for Plan contracted providers is set accordingly. Separate reimbursement is not appropriate for this procedure.

Computer-assisted corneal topography (CPT 92025) is considered **not medically necessary** to detect or monitor diseases of the cornea.

A screening test for defective vision in conjunction with an evaluation and management service other than with a preventive medicine service done in accordance with current American Academy of Pediatrics, American Academy of Family Practice, and/or Bright Futures guidelines by a physician, physician assistant, or advanced practice nurse clinician is considered inclusive to the office visit or preventive medicine service, and separate reimbursement is not authorized.

When a service or procedure may not be covered

Routine eye exams are not covered for conditions not listed in attachment I, including for confirmation of defective vision identified on a covered screening examination. This does not apply when the member's contract specifies they have the vision care benefit.

Routine eye examinations and corrective eye wear required by an employer as a condition of employment is not eligible for coverage.

Orthoptic and/or pleoptic training, with continuing medical direction and evaluation (92065) is not covered.

Contact lenses and eyeglasses are only eligible when the member has a vision materials rider or to treat aphakia and keratoconus. For aphakia and keratoconus, benefits for one set of eyeglasses or contact lenses for the original evaluation and one set for each new prescription may be eligible.

Glaucoma Pressure Tests (CPT codes 92100, 92120, 92130, 92140, 92136) are only eligible when billed with a diagnosis from attachment I.

When a service is considered non-covered because it is considered a benefit exclusion

Refractive Keratoplasty is a generic term, which includes all surgical procedures on the cornea to improve vision by changing the refractive index of the corneal surface.

Refractive keratoplasty procedures (CPT codes 65760, 65765, 65767, and 65771) are excluded under all certificates.

- Radial Keratotomy (RK)
- Photorefractive Keratectomy (PRK)
- Automated Lamellar Keratoplasty (ALK)
- Minimally Invasive Radial Keratotomy (mini-RK)
- Hexagonal Keratotomy
- Keratomileusis
- Keratophakia
- Epikeratophakia (lamellar Keratoplasty)

When a service is considered investigational

Retinal nerve fiber analysis is considered **investigational** as a screening tool for glaucoma in individuals who are not at high risk for glaucoma and for all other diagnoses not listed in Attachment IV. Techniques used in the analysis of the retinal nerve fiber layer include:

- Scanning Laser Ophthalmoscopy (SLO)
- Scanning Laser Polarimetry, and
- Optical Coherence Tomography (OCT)

Optical coherence tomography (OCT) is a high resolution method of imaging the ocular structures. OCT for the anterior eye segment is being evaluated as a rapid and non-invasive diagnostic and screening tool for the detection of angle closure glaucoma.

Scanning computerized ophthalmic (e.g. OCT) imaging of the anterior eye segment (92132) is considered **investigational**.

The measurement of pulsatile ocular blood flow or blood flow velocity with Doppler ultrasonography is considered **investigational** in the diagnosis and follow-up of patients with glaucoma, and is therefore not covered.

New technology intraocular lenses are considered investigational as long term safety and efficacy is unproven and not medically necessary as standard lenses are available to provide normal vision.

Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract language, the member's contract language takes precedence.

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non-compliant payments.

Eligible Providers

Allopathic Physicians (M.D.)
Osteopathic Physicians (D.O)
Naturopathic Physicians (N.D)
Advanced Practice Nurse Clinician (APRN)
Optometrists (O.D.)

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval is required for services as outlined in the policy. **B**enefits are subject to all terms, limitations and conditions of the subscriber contract.

An approved referral authorization for members of the New England Health Plan (NEHP) is required. A prior approval for Access Blue New England (ABNE) members is required. NEHP/ABNE members may have different benefits for services listed in this

policy. To confirm benefits, please contact the customer service department at the member's health plan.

Federal Employee Program (FEP) members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through a self-funded (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's plan documents or contact the customer service department.

Policy Implementation/Update information

05/2003	Clarified managed care and indemnity benefit
01/2003	Updated to address CPT codes 92250 and 92135; supersedes policy/procedure Memo 86-35 and 86-36
11/2001	Updated to reflect current codes; added 92250 to coverage list; updated to include benefits for CPT 92135 and additional covered diagnoses for refraction benefits
04/1006	Updated to clarify vision services as a medical benefit and to include additional CPT and diagnosis codes. Input received from BCBSVT Network ophthalmologists, including Michelle Young, MD; Julie Larson, MD; David Lawlor, MD; Gordon Kelly, MD; Alan Irwin, MD; Robert Millay, MD; and Christopher Chapman, MD
02/2007	Annual review; minor diagnosis code additions. To be reviewed by the CAC 3/08
11/2009	Addition of benefits for vision screening during a preventive medicine service when done in accordance with national guidelines; new technology intraocular lenses added to appendix as not covered.
01/2001	Annual review, clarified OCT eligible diagnoses codes. Added new language relating to vision service coverage in standard contracts.
09/2015	ICD-10 remediation. Updated section headers and updated standard language added.

Health Care Procedure Coding System (HCPCS) codes related to chemotherapy drugs, drugs administered other than oral method, and enteral/parenteral formulas may be subject to National Drug Code (NDC) processing and pricing. The use of NDC on medical claims helps facilitate more accurate payment and better management of drug costs based on what was dispensed and may be required for payment. For more information on BCBSVT requirements for billing of NDC please refer to the provider portal http://www.bcbsvt.com/provider-home latest news and communications.

Approved by BCBSVT Medical Directors Date Approved

Joshua Plavin, MD
Senior Medical Director
Chair, Medical Policy Committee

Robert Wheeler MD
Chief Medical Officer

Attachment I
For best performance, please use Mozilla Firefox or Google Chrome
Eligible Diagnoses List

Attachment II
CPT List & Instructions

Code Type	Number	Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
CPT	65756	Keratoplasty (corneal transplant); endothelial	H18.10-H18.13, H18.51, T85.318A, T85.318D, T85.318S, T85.328A, T85.328D, T85.328S, T85.398A, T85.398D, T85.398S, T86.840, T86.841
CPT	65757	Backbench preparation of corneal endothelial allograft prior to transplantation (List separately in addition to code for primary procedure)	

CPT	65770	Keratoprosthesis	H17.10, H17.11, H17.12, H17.13, H54.0, H54.10, H54.11, H54.12, H54.40, H54.41, H54.42, L51.1, T26.60xA, T26.60xD, T26.60xS, T26.61xA, T26.61xD, T26.61xS, T26.62xA, T26.62xD, T26.62xS, T85.318A, T85.318D, T85.318S, T85.328A, T85.328D, T85.328S, T85.398A, T85.398D, T85.398S, T85.79xA, T85.79xD, T85.79xS, T85.81xA, T85.81xD, T85.81xS, T85.82xA, T85.82xD, T85.82xS, T85.83xA, T85.83xD, T85.83xS, T85.84xA, T85.84xD, T85.84xS, T85.85xA, T85.85xD, T85.85xS, T85.86xA, T85.86xD, T85.86xS, T85.89xA, T85.89xD, T85.89xS, T86.840, T86.841, T86.842, T86.848, T86.849
CPT	66999	Unlisted procedure, anterior segment of eye	Allowable with the following conditions: H18.59- Other hereditary corneal dystrophies & H18.83X codes associated with Recurrent erosion of cornea.
CPT	76514	Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)	Attachment I for eligible diagnoses.
CPT	92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient	Attachment I for eligible diagnoses.
CPT	92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits	Attachment I for eligible diagnoses.

CPT	92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient	Attachment I for eligible diagnoses.
CPT	92014	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits	Attachment I for eligible diagnoses.

CPT	92015	Determination of refractive state	Eligible for aphakia, keratoconus and eye injuries: S00.10xA, S00.10xD, S00.10xS, S00.11xA, S00.11xD, S00.11xS, S00.12xA, S00.12xD, S00.12xS, S04.011A, S04.011D, S04.011S, S04.012A, S04.012D, S04.012S, S04.019A, S04.019D, S04.019S, S04.02xA, S04.02xD, S04.02xS, S04.031A, S04.031D, S04.031S, S04.032A, S04.032D, S04.032S, S04.039A, S04.039D, S04.039S, S04.041A, S04.041D, S04.041S, S04.042A, S04.042D, S04.042S, S04.049A, S04.049D, S04.049S, S05.10xA, S05.10xD, S05.10xS, S05.11xA, S05.11xD, S05.11xS, S05.12xA, S05.12xD, S05.12xS, S05.20xA, S05.20xD, S05.20xS, S05.21xA, S05.21xD, S05.21xS, S05.22xA, S05.22xD, S05.22xS, S05.30xA, S05.30xD, S05.30xS, S05.50xA, S05.50xD, S05.50xS, S05.51xA, S05.51xD, S05.51xS, S05.52xA, S05.52xD, S05.52xS, S05.60xA, S05.60xD, S05.60xS, S05.61xA, S05.61xD, S05.61xS, S05.62xA, S05.62xD, S05.62xS, S05.70xA, S05.70xD, S05.70xS, S05.71xA, S05.71xD, S05.71xS, S05.72xA, S05.72xD, S05.72xS, S05.8x1A, S05.8x1D, S05.8x1S, S05.8x2A, S05.8x2D, S05.8x2S, S05.8x9A, S05.8x9D, S05.8x9S, S05.90xA, S05.90xD, S05.90xS, S05.91xA, S05.91xD, S05.91xS, S05.92xA, S05.92xD, S05.92xS, T26.00xA, T26.00xD, T26.00xS, T26.01xA, T26.01xD, T26.01xS, T26.02xA, T26.02xD, T26.02xS, T26.10xA, T26.10xD, T26.10xS, T26.11xA, T26.11xD, T26.11xS, T26.12xA, T26.12xD, T26.12xS, T26.20xA, T26.20xD, T26.20xS, T26.21xA, T26.21xD, T26.21xS, T26.22xA, T26.22xD, T26.22xS, T26.30xA, T26.30xD, T26.30xS, T26.31xA, T26.31xD, T26.31xS, T26.32xA, T26.32xD, T26.32xS, T26.40xA, T26.40xD, T26.40xS, T26.41xA, T26.41xD, T26.41xS, T26.42xA,

			T26.42xD, T26.42xS, T26.50xA, T26.50xD, T26.50xS, T26.51xA, T26.51xD, T26.51xS, T26.52xA, T26.52xD, T26.52xS, T26.60xA, T26.60xD, T26.60xS, T26.61xA, T26.61xD, T26.61xS, T26.62xA, T26.62xD, T26.62xS, T26.70xA, T26.70xD, T26.70xS, T26.71xA, T26.71xD, T26.71xS, T26.72xA, T26.72xD, T26.72xS, T26.80xA, T26.80xD, T26.80xS, T26.81xA, T26.81xD, T26.81xS, T26.82xA, T26.82xD, T26.82xS, T26.90xA, T26.90xD, T26.90xS, T26.91xA, T26.91xD, T26.91xS, T26.92xA, T26.92xD, T26.92xS
CPT	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	Attachment I for eligible diagnoses.
CPT	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	Attachment I for eligible diagnoses.
CPT	92020	Gonioscopy (separate procedure)	Attachment I for eligible diagnoses.

CPT	92060	Sensorimotor examination with multiple measurements of ocular deviation (eg, restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)	Attachment I for eligible diagnoses.
CPT	92071	Fitting of contact lens for treatment of ocular surface disease	Eligible for aphakia or keratoconus only.
CPT	92072	Fitting of contact lens for management of keratoconus, initial fitting	Eligible for aphakia or keratoconus only.
CPT	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)	Attachment I for eligible diagnoses.
CPT	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)	Attachment I for eligible diagnoses.
CPT	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 degrees 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)	Attachment I for eligible diagnoses.

CPT	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)	Attachment I for eligible diagnoses.
CPT	92133	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve	Attachment IV for eligible diagnoses.
CPT	92134	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina	Attachment IV for eligible diagnoses.
CPT	92136	Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation	Attachment I for eligible diagnoses.
CPT	92140	Provocative tests for glaucoma, with interpretation and report, without tonography	Attachment I for eligible diagnoses.
CPT	92225	Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; initial	Attachment I for eligible diagnoses.
CPT	92226	Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; subsequent	Attachment I for eligible diagnoses.
CPT	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	Attachment I for eligible diagnoses.

CPT	92228	Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral	Attachment I for eligible diagnoses.
CPT	92230	Fluorescein angioscopy with interpretation and report	Attachment I for eligible diagnoses.
CPT	92235	Fluorescein angiography (includes multiframe imaging) with interpretation and report	Attachment I for eligible diagnoses.
CPT	92240	Indocyanine-green angiography (includes multiframe imaging) with interpretation and report	Attachment I for eligible diagnoses.
CPT	92250	Fundus photography with interpretation and report	Attachment I for eligible diagnoses.
CPT	92260	Ophthalmodynamometry	Attachment I for eligible diagnoses.
CPT	92265	Needle oculoelectromyography, 1 or more extraocular muscles, 1 or both eyes, with interpretation and report	Attachment I for eligible diagnoses.
CPT	92270	Electro-oculography with interpretation and report	Attachment I for eligible diagnoses.
CPT	92275	Electroretinography with interpretation and report	Attachment I for eligible diagnoses.
CPT	92283	Color vision examination, extended, eg, anomaloscope or equivalent	Attachment I for eligible diagnoses.
CPT	92284	Dark adaptation examination with interpretation and report	Attachment I for eligible diagnoses.
CPT	92285	External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)	Attachment I for eligible diagnoses.

CPT	92286	Anterior segment imaging with interpretation and report; with specular microscopy and endothelial cell analysis	Attachment I for eligible diagnoses.
CPT	92287	Anterior segment imaging with interpretation and report; with fluorescein angiography	Attachment I for eligible diagnoses.
CPT	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	Eligible for keratoconus only.
CPT	92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, 1 eye	Eligible for aphakia only
CPT	92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes	Eligible for aphakia only
CPT	92313	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens	Eligible for aphakia or keratoconus only.
CPT	92314	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes except for aphakia	Eligible for keratoconus only.

CPT	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, 1 eye	Eligible for aphakia only
CPT	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	Eligible for aphakia only.
CPT	92317	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneoscleral lens	Eligible for aphakia or keratoconus only.
CPT	92325	Modification of contact lens (separate procedure), with medical supervision of adaptation	Eligible for aphakia or keratoconus only.
CPT	92326	Replacement of contact lens	Eligible for aphakia or keratoconus only.
CPT	92340	Fitting of spectacles, except for aphakia; monofocal	Eligible for keratoconus only.
CPT	92341	Fitting of spectacles, except for aphakia; bifocal	Eligible for keratoconus only.
CPT	92342	Fitting of spectacles, except for aphakia; multifocal, other than bifocal	Eligible for keratoconus only.
CPT	92352	Fitting of spectacle prosthesis for aphakia; monofocal	Eligible for aphakia only.
CPT	92353	Fitting of spectacle prosthesis for aphakia; multifocal	Eligible for aphakia only.
CPT	92354	Fitting of spectacle mounted low vision aid; single element system	Eligible for aphakia or keratoconus only.

CPT	92355	Fitting of spectacle mounted low vision aid; telescopic or other compound lens system	Eligible for aphakia or keratoconus only.
CPT	92358	Prosthesis service for aphakia, temporary (disposable or loan, including materials)	Eligible for aphakia or keratoconus only.
CPT	92370	Repair and refitting spectacles; except for aphakia	Eligible for keratoconus only.
CPT	92371	Repair and refitting spectacles; spectacle prosthesis for aphakia	Eligible for aphakia only.
CPT	99173	Screening test of visual acuity, quantitative, bilateral	Eligible when rendered in conjunction with a preventive visit in accordance with national guidelines.
The following codes will be denied as Not Medically Necessary, Non-Covered, Contract Exclusions or Investigational			
CPT	92025	Computerized corneal topography, unilateral or bilateral, with interpretation and report	Non-Covered
CPT	92065	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation	
CPT	65760	Keratomileusis	
CPT	65765	Keratophakia	
CPT	65767	Epikeratoplasty	
CPT	65771	Radial keratotomy	
CPT	92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral	Investigational

Attachment III
HCPCS Code List & Instructions

HCPCS code	Description	Policy Instructions
The following HCPCS are considered medically necessary when applicable criteria outlined in the medical policy is met.		
C1818	Integrated keratoprosthesis	Eligible diagnoses: H17.10, H17.11, H17.12, H17.13, H54.0, H54.10, H54.11, H54.12, H54.40, H54.41, H54.42, L51.1, T26.60xA, T26.60xD, T26.60xS, T26.61xA, T26.61xD, T26.61xS, T26.62xA, T26.62xD, T26.62xS, T85.318A, T85.318D, T85.318S, T85.328A, T85.328D, T85.328S, T85.398A, T85.398D, T85.398S, T85.79xA, T85.79xD, T85.79xS, T85.81xA, T85.81xD, T85.81xS, T85.82xA, T85.82xD, T85.82xS, T85.83xA, T85.83xD, T85.83xS, T85.84xA, T85.84xD, T85.84xS, T85.85xA, T85.85xD, T85.85xS, T85.86xA, T85.86xD, T85.86xS, T85.89xA, T85.89xD, T85.89xS, T86.840, T86.841, T86.842, T86.848, T86.849
L8609	Artificial cornea	
S0812	Phototherapeutic keratectomy (PTK)	Eligible diagnoses: recurrent erosion of the cornea (H18.831-H18.839) and anterior corneal dystrophies (H18.59).
V2020	Frames, purchases	Eligible for aphakia or keratoconus only.
V2025	Deluxe frame	
V2100	Sphere, single vision, plano to plus or minus 4.00, per lens	
V2101	Sphere, single vision, plus or minus 4.12 to plus or minus 7.00d, per lens	

V2102	Sphere, single vision, plus or minus 7.12 to plus or minus 20.00d, per lens	
V2103	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens	
V2104	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens	
V2105	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens	
V2106	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens	
V2107	Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00 sphere, 0.12 to 2.00d cylinder, per lens	
V2108	Spherocylinder, single vision, plus or minus 4.25d to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens	
V2109	Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens	
V2110	Spherocylinder, single vision, plus or minus 4.25 to 7.00d sphere, over 6.00d cylinder, per lens	
V2111	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens	
V2112	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25d to 4.00d cylinder, per lens	

V2113	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens	
V2114	Spherocylinder, single vision, sphere over plus or minus 12.00d, per lens	
V2115	Lenticular (myodisc), per lens, single vision	
V2118	Aniseikonic lens, single vision	
V2121	Lenticular lens, per lens, single	
V2199	Not otherwise classified, single vision lens	
V2200	Sphere, bifocal, plano to plus or minus 4.00d, per lens	Eligible for aphakia or keratoconus only.
V2201	Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00d, per lens	
V2202	Sphere, bifocal, plus or minus 7.12 to plus or minus 20.00d, per lens	
V2203	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens	
V2204	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens	
V2205	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens	
V2206	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens	
V2207	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens	

V2208	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens	
V2209	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens	
V2210	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens	
V2211	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens	
V2212	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens	
V2213	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens	
V2214	Spherocylinder, bifocal, sphere over plus or minus 12.00d, per lens	
V2215	Lenticular (myodisc), per lens, bifocal	
V2218	Aniseikonic, per lens, bifocal	
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 or minus 4.00d, per lens	Eligible for aphakia or keratoconus only.
V2301	Sphere, trifocal, plus or minus 4.12 to plus or minus 7.00d per lens	

V2302	Sphere, trifocal, plus or minus 7.12 to plus or minus 20.00, per lens	
V2303	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens	
V2304	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 2.25 to 4.00d cylinder, per lens	
V2305	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00 cylinder, per lens	
V2306	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens	
V2307	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens	
V2308	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens	
V2309	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens	
V2310	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens	
V2311	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens	
V2312	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens	

V2313	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens	
V2314	Spherocylinder, trifocal, sphere over plus or minus 12.00d, per lens	
V2315	Lenticular, (myodisc), per lens, trifocal	
V2318	Aniseikonic lens, trifocal	
V2319	Trifocal seg width over 28 mm	
V2320	Trifocal add over 3.25d	
V2321	Lenticular lens, per 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	
V2499	Variable sphericity lens, other type	
V2500	Contact lens, PMMA, spherical, per lens	Eligible for aphakia or keratoconus only.
V2501	Contact lens, PMMA, toric or prism ballast, per lens	
V2502	Contact lens PMMA, bifocal, per lens	
V2503	Contact lens, PMMA, color vision deficiency, per lens	
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	
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	
V2530	Contact lens, scleral, gas impermeable, per lens (for contact lens modification, see 92325)	
V2531	Contact lens, scleral, gas permeable, per lens (for contact lens modification, see 92325)	
V2599	Contact lens, other type	
V2623	Prosthetic eye, plastic, custom	Prior Approval Required Eligible Diagnoses: Acquired absence of eye (Z90.01) and Other anophthalmos (Q11.1) only.
V2624	Polishing/resurfacing of ocular prosthesis	
V2625	Enlargement of ocular prosthesis	
V2626	Reduction of ocular prosthesis	
V2627	Scleral cover shell	
V2628	Fabrication and fitting of ocular conformer	
V2629	Prosthetic eye, other type	
V2745	Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens	Eligible for aphakia or keratoconus only.
The following HCPCS will deny as Not Medically Necessary, Non-Covered, Contract Exclusion, or Investigational		
Q1005	New technology, intraocular lens, category 5 as defined in Federal Register notice	Not Covered
V2788	Presbyopia correcting function of intraocular lens	Not Covered

Attachment IV
For best performance, please use Mozilla Firefox or Google Chrome
Eligible Diagnoses for 92133 & 92134 OCT/SCODI List