



Clinical Medical Policy Vision Care

Benefit Coverage:

Covered Benefits:

- 1) For members under 21, eye examination and glasses covered as medically necessary with no other limits.
- 2) For members age 21 and older, benefit is limited to examinations that include refractions and provision of eyeglasses once every 2 years, or if medically necessary.
- 3) For members over age 21 with diabetes, annual eye exams are covered.
- 4) Other medically necessary treatment for illness or injury to the eye is covered

Description:

Vision care involves the diagnosis and treatment of eye diseases, disorders and injuries. Services include routine eye exams, special ophthalmological services, and surgeries related to the eye and ocular adnexa.

Coverage Determination:

Table I

Coverage	Prior Auth Y/N
Members under 21 years old, eye examination and glasses	N
Members age 21 and older, examinations that include refractions and provision of eyeglasses once every 2 years, or if medically necessary.	N
Members over age 21 with diabetes, annual eye exams	N
Treatment for illness or injury to the eye	N (unless performed in ambulatory surgery or hospital setting. In ER, no auth required.)
Replacement lenses for members under 21	N
Replacement lenses/frames	See Table II

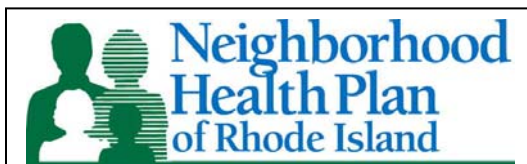


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for members 21 and older	
Special frames, lenses, contact lenses, punctal plugs, special procedures (see Table II.)	See Table II

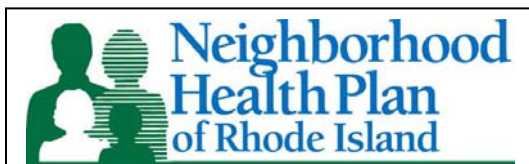
Table II - Criteria:

Service	Criteria	Prior Auth Y/N
Eye Exam Routine Under Age 21yo	Eye examinations that include refractions covered as medically necessary with no other limits.	N
Eye Exam Over age 21yo	Eye examinations that include refractions, once every 2 years.	N
Eye Exam - Diabetic	Members over age 21 with diabetes, annual eye exams	N
Replacement lenses/frames under 21 years old	For members under age 21, lenses and frames are covered as medically necessary with no other limits.	N
Replacement lenses/frames age 21 years old and over	For members age 21 and older, lenses covered more than once in 2 years if there is a change in refraction of at least 0.5 diopter (lens spherical equivalent). Eyeglass frames are covered only every 2 years.	Y
Polycarb Lenses	Approved for children. For adults, considered medically necessary for patients with severely impaired eye requiring prescription lenses.	Y (for adults only)
Plastic Frames (metal allergy)	Medically necessary if a skin reaction/allergy is notable and attributable to metal frames. Non-allergenic metal not approved.	Y
Punctal Plugs (for dry eye syndrome)	Medically necessary if the following criteria are met: <ul style="list-style-type: none"> • History of using artificial tears without success • Trial use of collagen plugs which dissolve in 7-12 days with success, i.e. symptom relief 	Y
Contact Lenses	Medically necessary for high myopia (> -6.00) or for keratoconus that cannot be corrected with glasses. Medically necessary for anisometropia if diopter difference is > 3. (Difference in the power of required lens power of the two eyes of greater than a spherical equivalent of 3 diopters.)	Y



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Service	Criteria	Prior Auth Y/N
Aphakic Contact Lenses	Medically necessary to correct aphakia with either contact lenses or glasses	Y
High Index Lenses	Medically necessary when prescription is (-10) or above and lens does not fit into frame.	N
Special Small Size Frames with Temple Cables	Medically necessary for infants and small children when covered frames do not fit.	N
Progressive spectacle lens	Only in lieu of 2 pairs of glasses for non-presbyopic (young) monocular pseudophake or monocular aphakic contact lens wearer.	Y
Polychromic lenses	Medical conditions that cause defects of the iris, which clearly cause an excess of light to enter the eye (i.e. trauma, aniridia, polycoria). NOT considered medically necessary, for a diagnosis of cataracts or light sensitivity secondary to medication use.	Y
Topography	In mild cases of keratoconus, a cone may not be obvious and yet spectacle correction may not correct vision. Topography is the best diagnostic test to identify the condition, to allow contact lens fitting and coverage. Retrospective medical review required if payment requested when results of the topography identified ocular surface irregularities which prove to be the cause of otherwise unexplained decreased vision.	Y
Fundus Photography	<ul style="list-style-type: none"> • Necessary to document a retinal finding that must be followed over time to look for subtle changes (i.e. a pigmented lesion that has the potential of being or becoming a melanoma rather than a mere nevus), and NOT for diagnostic purposes in lieu of careful fundus examination. • Also required for the performance of fluorescein angiography. • Appropriate in stereoscopic disc photography on an annual basis to follow optic nerve cupping in glaucoma. 	Y



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Service	Criteria	Prior Auth Y/N
	When used for documentation of a condition where the presence of change over time in the photographed lesion is not specific (as in following changes after a vein or artery occlusion, or to document presence of diabetic retinopathy), it is NOT considered medically necessary.	

Exclusions:

Additional prescriptive eyewear for computer use, sports, and driving are not covered.

CMP Number: CMP-010.00

CMP Cross Reference:

References:

American Academy of Ophthalmology, O.N.E. Network Clinical Statements, Screening for Diabetic Retinopathy

http://one.aao.org/CE/PracticeGuidelines/ClinicalStatements_Content.aspx?cid=ed55ed3c-b34b-4f10-ae13-09e063d8d773

emedicine from WebMD, “Keratoconus,” Barry A. Weissman, OD, PhD, FAAO, and Karen K. Yeung, OD, FAAO, 1/8/07

<http://emedicine.medscape.com/article/1194693-overview>

Created:

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