



**Covered Benefit: Vision Care**

CMP Published:  Yes  No

CMP Link: [Vision Care](#)

CPG Published:  Yes  No

Definitions:

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

Routine Vision Care:

Routine vision care refers to those services rendered by a contracted optometrist or ophthalmologist in an office or outpatient setting (see table 1 for CPT codes).

The frequency of routine vision exams is:

- Child: annually
- Adult: every two-years (biannually)
- Adult with Diabetes: annually
- Additional vision exams as medically necessary are covered; see attached.
- The vision benefits follow a rolling year not a calendar year; where the 12 month timeframe is measured from the last date of service.

Special Ophthalmological Services:

Additional exams and eyeglasses beyond the limit noted above; specialty lenses; contact lenses; and covered special ophthalmological services, are listed by code or code ranges on table 1.

Eye Surgery:

Covered surgical procedures, either outpatient or inpatient, are listed by code ranges on the attached table.

Benefit Packages: RItE Care, Substitute Care, Children with Special Health Care Needs, and Rhody Health Partners

Coverage Limitations:

Children:

For members under 21, eye examination and glasses are covered as medically necessary with no other limits.

Adults:

1. 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.<sup>1</sup>
2. For members over age 21 with diabetes, annual eye exams are covered.
3. Other medically necessary treatment for illness or injury to the eye is covered

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<sup>1</sup> For the vision benefit, child is defined as a member under the age of 21



Exclusions:

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

Non-covered Services Include: See Table below

Coverage Includes:

- Eye Exam Routine
- Eye Exam Diabetic
- Eye Exam Medically Necessary
- Routine Fitting of Eyewear
- Fitting of Contact Lenses
- Lenses Routine
- Lenses Medically Necessary
- Contact Lenses
- Frames Routine
- Ophthalmological Surgery
- Ophthalmological Surgery Auth Required
- Special Ophthalmological Services

Episodes of care can occur across multiple settings:

Inpatient (POS 21); requires prior authorization as do all inpatient admissions

Outpatient (POS 22)

Office (POS 11)

Community Health Centers-CHCs (POS 50)



**Non-covered Services**

<u>CPT/HCPCS Code</u>	<u>Description</u>
65760	Keratomileusis
65771	Radial keratotomy
65781	Ocular surface reconstruction; limbal stem cell allograft
S0800	Laser In Situ Keratomileusis
S0810	Photorefractive Keratectomy
V2025	Deluxe Frames
V2530	Contact Lens Scleral Gas Impermeable Per Lens
V2531	Contact Lens Scleral Gas Permeable Per Lens
V2599	Contact Lens Other Type
V2702	Deluxe Lens Feature
V2710	Slab Off Prism Glass Or Plastic Per Lens
V2718	Press-On Lens Fresnell Prism Per Lens
V2730	Special Base Curve Glass Or Plastic Per Lens
V2756	Eye Glass Case
V2760	Scratch Resistant Coating Per Lens
V2761	Mirror Coat Type Solid Gradient/= Lens Matl-Lens
V2762	Polarization Any Lens Material Per Lens
V2770	Occluder Lens Per Lens
V2780	Oversize Lens Per Lens
V2786	Specialty Occupational Multifocal Lens Per Lens
V2787	Astigmatism Correcting Function Intraocular Lens
V2788	Presbyopia Correction Function Intraocular Lens
V2790	Amniotic Membrane Surgical Reconstruct Per Proc

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