Policy Name	Clinical Policy – Low Vision Evaluation and Rehabilitation
Policy Number	1318.00
Department	Clinical Strategy/Product
Subcategory	Medical Management
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Current Effective Date	10/01/2023

Company Entities Supported (Select All that Apply)
_X_ Superior Vision Benefit Management
_X_ Superior Vision Services
_X_ Superior Vision of New Jersey, Inc.
_X_ Block Vision of Texas, Inc. d/b/a Superior Vision of Texas
_X_ Davis Vision
(Collectively referred to as 'Versant Health' or 'the Company')

ACRONYMS / DEFINITIONS	
n/a	

PURPOSE

To provide clinical criteria to support the indication(s) for low vision evaluation and rehabilitation. Applicable procedure codes are also defined.

POLICY

A. Description

Low vision can be a deficit in acuity or limitations in the visual field. No specific level of acuity is excluded if it otherwise meets the criteria in visual fields limitations as defined by the World Health Organization and the American Academy of Ophthalmology.

B. Medically Necessary

Low vision evaluation, treatment, and rehabilitation services are indicated when the following criteria are met using the WHO and the AAO Preferred Practice Pattern definitions.

1. The World Health Organization defines low vision:

a. “Low vision is visual acuity less than 6/18 (Snellen equivalent is 20/70) and equal to or better than 3/60 (Snellen equivalent is 20/400) in the better eye with best correction.
b. (Low Vision Services or Care) a person with low vision is one who has impairment of visual functioning even after treatment and/or standard refractive correction and has a visual acuity of less than 6/18 to light perception, or a visual field less than 10 degrees from the point of fixation, but who uses, or is potentially able to use, vision for the planning and/or execution of a task for which vision is essential.”
c. The World Health Organization (WHO) has additionally formalized a severity index of visual loss into categories of mild, moderate, severe and blindness. The details of this methodology are referenced in Sources.

2. The American Academy of Ophthalmology Preferred Practice Pattern (PPP)[1] defines low vision requiring vision rehabilitation as:

“Low vision is the term for vision impairment that cannot be corrected by standard eyeglasses or by medical or surgical treatment. Low vision may result from many different ocular diseases or from neurological disorders such as cerebral vascular accidents. The ICD-10 CM definitions of low vision are based on visual acuity and visual field … but other aspects of visual function also contribute to visual impairment … Even with visual acuity better than 20/70, the ability to perform visual tasks can be affected … In addition, modest levels of vision loss may be a greater disability when they co-exist with other health problems . . . as in a patient who has a hearing impairment requires good vision to lip read … Although some patients with low vision successfully minimize the impact of their vision loss without formal rehabilitation, most are unable to read standard print, many are unable to maintain their safety and independence in daily activities, and some require extensive assistance …”

The PPP also says, “Even early or moderate vision loss may result in disability, which can affect visual performance, cause anxiety, and interfere with everyday activities … There is evidence that vision rehabilitation improves reading and visual ability.”

3. Low Vision Aids

a. Low vision aids may be optical or non-optical devices, which are indicated when conventional refractive means do not achieve an improvement in the vision impairment. Such devices are indicated when the presence of low vision as described in section B is documented. Examples of low vision aids include the following: (Due to the continuing innovation of new devices, this is not a comprehensive list of all the devices that are indicated for the improvement of vision impairment/function.)

i. Handheld low vision aids and other non-spectacle mounted aids;
ii. Single lens spectacle mounted low vision aids;
iii. Telescopic and other compound lens systems, including distance vision;
iv. Telescopic, near vision telescopes and compound microscopic lens system;

[1] AAO Preferred Practice Pattern 2017

v. Electronic magnifier, desktop and portable digital magnifier

b. The devices require the following to meet low vision indications:
   i. Diagnosis of low vision as described in section B above; and,
   ii. Current low vision effects on daily life; and,
   iii. Anticipation of further or changed impacts on daily life; and,
   iv. Patient and/or family is willing and able to participate in the plan of care to learn and use the recommended devices.

4. Implantable intraocular Telescope

   An implantable intraocular telescope is medically indicated for patients with end-stage macular degeneration defined as:

   a. Best corrected visual acuity of 20/160 to 20/800; and,
   b. Bilateral central scotomas; and,
   c. Untreatable macular disease.

C. Not Medically Necessary

1. Low vision rehabilitation does not include eye exercises, orthoptics, vision therapy, vision training, visual training, behavioral optometry, or similar descriptions for non-surgical treatments of phorias and tropias.
2. Low vision rehabilitation does not include mobility and gait training rehabilitation as these services are not specific to eye treatment.
3. Low vision rehabilitation is not indicated when:

   a. An impairment to lifestyle has not been demonstrated; or,
   b. The impairment is temporary; or,
   c. The impairment is amenable to treatment by other optical, medical, or surgical therapy; or,
   d. There is no documentation of a desire for improvement by the beneficiary.

4. The medical necessity for low vision rehabilitation may end when the patient demonstrates no additional progress. Maintenance sessions, after the patient has reached a steady state, may not be medically necessary. Once the maximal improvement has been made, the attending physician must review and sign a discharge summary describing the extent to which each goal in the care plan was achieved.

D. Documentation

Low Vision evaluation and treatments must be supported by adequate and complete documentation in the member's medical record, describing the treatments or procedures and the medical rationale. Documentation should include, at a minimum, all the following items for both initial and subsequent medical review. For all retrospective reviews, a full surgical report or clinical care plan is required.

Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, date(s) of service) and the visits must meet the appropriate provider signature requirements, handwritten or electronic signature or the provider. Stamped signatures are not acceptable

1. Initiation of Services

    a. Eye exam with description of medical justification for initial or subsequent low vision treatment.
    b. Documentation of low vision based on best-corrected visual acuity and/or field restriction findings.
    c. Allied diagnostic testing that supports the findings and plan. Chart notes must include an interpretation and report for each test.

    d. Detailed low vision care plan that incorporates:
        i. Indications for low vision therapy including ADL effects
        ii. Goals of low vision therapy, including schedule of visits, devices evaluated (spectacles or other) for various tasks
        iii. Documented observation of the devices in use by the patient with an assessment of the device(s) suitability and recommended changes.
        iv. Quantitative measurements of baseline performance
        v. Once a steady state is reached with therapy, the medical record must describe the goals which were completed, met or unment, and/or require changes. At this point, unless there are new or changed treatment goals, the need for further low vision therapy is ended.

2. Continuation of Services

    Requests for additional vision rehab services should evidence the indications for ongoing treatment and include the following documentation of the initial episode of care.

    a. Documentation for each completed vision rehab session to include a progress note that states the start and end times for each session.
    b. Treatment goals and current performance measurements for each session, measured against the baseline.
    c. The need for on-going services must be assessed and noted at the conclusion of each session, with justification compared to care goals.
    d. Once a steady state is reached with therapy, the medical record must describe it. At this point, the medical necessity for further low vision therapy is ended.

3. Professional and rehabilitation services for low vision are provided by a multidisciplinary team. For both initial and continued services, the following documentation is required. Care coordination notes should include:

    a. Planned rehabilitation training, with initial evaluation visit notes, goals, and care plan, provided by an occupational therapist; and,

b. Follow up treatment visit notes and ongoing evaluation visit notes incorporating the goals, measurements of progress towards the goals, current status and plan, and future visit/treatment plan.

4. Low vision devices

Requests for low vision devices should include documentation of low vision treatment plan as in 1. and 3. above, plus:

a. Documented presence of low vision as described in section B above; and,
b. Documented low vision onset and effects on daily life; and,
c. Documentation of manifest refraction exam with best corrected visual acuity; and,
d. Documentation of visual field testing results; and,
e. Description of selected vision aids related to vision and functioning goals; and,
f. Documented or planned instruction in use of the devices; and,
g. Plan to manage correct use of devices and reinforcement of new vision tasks.

5. Implants

Requests for implantable telescopic procedures should include documentation of other treatments trialed, as in 1-3 above, plus:
a. Progress notes describing the need for surgery; and,
b. Surgical report; and,
c. Post-surgical evaluation to include stated goals of low vision rehab therapy.

E. Procedural Details

92354	Fitting of spectacle mounted low vision aid, single element system
92355	Fitting of spectacle mounted low vision aid, telescopic or other compound lens system
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training … direct one-on-one contact by provider, each 15 minutes
V2600	Handheld low vision aids and other non spectacle mounted aids
V2610	Single lens spectacle mounted low vision aids
V2615	Telescopic and other compound lens systems, including distance vision telescopic, near vision telescopes and compound microscopic lens system

Subject to applicable law, compliance with this clinical policy is not a guarantee of coverage or payment. Coverage is based on the terms of an individual's particular coverage plan document, which may not cover the service(s) or procedure(s) addressed in this clinical policy the individual's specific coverage plan are always determinative. Every effort has been made to ensure that the information in this clinical policy is accurate. The Company does not guarantee that there are no errors in this policy or that the display of this file on a website is without error. The company and its employees are not liable for any errors, omissions, or other inaccuracies in the information, product, or processes disclosed herein. Neither the Company nor the employees represent that the use of such information, products, or processes will not infringe on privately owned rights. In no event shall the Company be liable for direct, indirect, special, incidental, or consequential damages arising out of the use of such information, product, or process.

RELATED POLICIES AND PROCEDURES	
1337	Vision Therapy and Orthoptics

Approval Dates	***Revision***	***Effective Dates***
03/29/2019	Initial policy	03/29/2019
10/18/2019	Revise policy for all Versant Health entities	11/01/2019
10/28/2020	Annual Review: two CPT codes removed from medical exam group.	03/01/2021
10/06/2021	No criteria changes; restated documentation requirements for initial and subsequent services.	04/01/2022
04/06/2022	Added criteria for implantable telescopes	09/01/2022
04/12/2023	Added magnifying devices and criteria.	10/01/2023

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