Clinical Review Criteria
Low Vision Aides and Devices

Kaiser Permanente Clinical Review Criteria are developed to assist in administering plan benefits. These criteria neither offer medical advice nor guarantee coverage. Kaiser Permanente reserves the exclusive right to modify, revoke, suspend or change any or all of these Review Criteria, at Kaiser Permanente's sole discretion, at any time, with or without notice. Member contracts differ in their benefits. Always consult the patient's Medical Coverage Agreement or call Kaiser Permanente Customer Service to determine coverage for a specific medical service.

Criteria
For Medicare Members
Per Noridian 2013 Jurisdiction List for DMEPOS HCPCS Codes - Low Vision Aides and Devices are not covered.

For Non-Medicare Members
A. To qualify for low vision aides or devices a member must have best corrected vision of 20/70 or worse in the better eye with glasses or contacts on.
   1. The following codes are identified and coverable per contract for low vision aides and devices:
      a. V2600 – Hand held low vision aids and other non-specific mounted aids.
      b. V2610 – Single Lens Spectacles mounted low vision aids
      c. V2615 – Telescope and other compound lens system, including distance vision telescopic, near vision telescopic and compound microscopic lens system.
      d. 92354 – Fitting of spectacle mounted low vision aid: single element system
      e. 92355 – Fitting of spectacle mounted low vision aid: Telescopic or compound lens system

Background
A wide variety of rehabilitation options are available to help people with low vision live and/or work more effectively, efficiently, and safely. Most people can be helped with one or more low vision treatment options. The more commonly prescribed devices are: Hand held low vision aids and other non-spectacle mounted aids, Single lens spectacle mounted low vision aids, Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens system.

The following information was used in the development of this document and is provided as background only. It is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

Date Created |
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12/03/2013

Date Reviewed |
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12/03/2013\(\text{MPC}\), 09/16/2014\(\text{MPC}\), 08/04/2015\(\text{MPC}\), 06/07/2016\(\text{MPC}\), 04/04/2017\(\text{MPC}\), 09/16/2014

Date Last Revised |
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09/16/2014

MPC Medical Policy Committee

Revision History
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08/04/2015
Editorial changes were made to criteria.

Codes
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CPT: 92354; 92355
HCPCS: V2600; V2610; V2615