# Clinical Policy: Low Vision Evaluation, Rehabilitation and Aids

Reference Number: CP.VP.71
Last Review Date: 08/2025

Coding Implications
Revision Log

**See Important Reminder at the end of this policy for important regulatory and legal information.**

## Description

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. This policy describes the medical necessity requirements for low vision evaluations, rehabilitation and aids.

## Policy/Criteria

**I.** It is the policy of health plans affiliated with Centene Corporation® (Centene) and Envolve Vision, Inc.® (Envolve) that low vision evaluations, rehabilitation and aids are **medically necessary** when all of the following indications are met:

A. Moderate or severe visual impairment, one of the following:
   1. Best-corrected visual acuity is worse than 20/60 in the better eye;
   2. Visual field of 20 degrees or less in the better seeing eye;

B. A reasonable expectation exists that evaluation, rehabilitation and/or aids will make a meaningful contribution to the improvement of the patient's ability to perform activities of daily living.

## Background

Patients with severe, profound, near-total, or total visual impairment meet the criteria for the status of legal blindness or "statutory visual impairment," a designation that has traditionally been used to determine eligibility for disability benefits in the United States. The Social Security Administration's definition of legal blindness is visual acuity 20/200 or less with the use of a correcting lens or visual field diameter 20 degrees or less in the better-seeing eye using both automated visual fields and visual acuity charts that measure lower levels of acuity. Low vision is a visual impairment that is not correctable by standard eyeglasses, contact lenses, medicine, or surgery, that interferes with a patient's ability to perform activities of daily living. Low vision is not the same as blindness, as patients with low vision have useful vision that may be optimized by the use of low vision aids. Eye care providers who subspecialize in providing vision rehabilitation should aim to optimize patients' reading, activities of daily living, safety, participation in their community despite vision loss, and psychosocial well-being.

The vast majority of patients with low vision present later in life due to increased risk of macular degeneration, glaucoma, diabetes or other causes. Visual deficits are common with acquired brain injury, and they frequently mix with motor, language, and cognitive deficits to create a complex disability picture that requires a multidisciplinary approach to rehabilitation, including occupational therapy. The rehabilitative needs of patients vary considerably: some patients simply require an increase in reading add and others benefit from a wide range of interventions that include training to use adaptive devices. In general, objects at near can be enlarged or magnified for viewing at a closer distance. Objects at distance can be enlarged by moving closer or by viewing them with a telescopic device. Peripheral visual field defects may be addressed with the use of peripheral sector prisms. Adaptive, non-optical devices may be used to address

some goals. The effectiveness, ergonomics, appropriateness and cost effectiveness of the devices should be considered with respect to improving patient participation in activities of daily living.

**Coding Implications**

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

**Low Vision Evaluation & Rehabilitation**

| CPT® Codes | Description |
|---|---|
| 92002 | Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient |
| 92004 | Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new |
| 92012 | Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient |
| 92014 | Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits |
| 97165 | Occupational therapy evaluation, low complexity, requiring these components: an occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; an assessment(s) that identifies 1-3 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family. |
| 97166 | Occupational therapy evaluation, moderate complexity, requiring these components: an occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; an assessment(s) that identifies 3-5 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and clinical decision |

| CPT® Codes | Description |
|---|---|
| | making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family. |
| 97167 | Occupational therapy evaluation, high complexity, requiring these components: an occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; an assessment(s) that identifies 5 or more performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family. |
| 99202 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. |
| 99203 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. |
| 99204 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity |
| 99205 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A |

| CPT® Codes | Description |
|---|---|
| | comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity |
| 99212 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. |
| 99213 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. |
| 99214 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. |
| 99215 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. |

**Low Vision Aids**

| HCPCS Codes | Description |
|---|---|
| V2600 | Hand held low vision aids and other non-spectacle mounted aids |
| V2610 | Single lens spectacle mounted low vision aids |
| V2615 | Telescopic and other compound lens system, including distance vision telescopic, near vison telescopes and compound microscopic lens system |

**ICD-10-CM Diagnosis Codes that Support Coverage Criteria**

+ Indicates a code requiring an additional character

| ICD-10-CM Code | Description |
|---|---|
| H53.411 | Scotoma involving central area, right eye |
| H53.412 | Scotoma involving central area, left eye |
| H53.413 | Scotoma involving central area, bilateral |
| H53.461 | Homonymous bilateral field defects, right side |
| H53.462 | Homonymous bilateral field defects, left side |
| H53.47 | Heteronymous bilateral field defects |
| H53.481 | Generalized contraction of visual field, right eye |
| H53.482 | Generalized contraction of visual field, left eye |
| H53.483 | Generalized contraction of visual field, bilateral |
| H54.0X33 | Blindness right eye category 3, blindness left eye category 3 |
| H54.0X34 | Blindness right eye category 3, blindness left eye category 4 |
| H54.0X35 | Blindness right eye category 3, blindness left eye category 5 |
| H54.0X43 | Blindness right eye category 4, blindness left eye category 3 |
| H54.0X44 | Blindness right eye category 4, blindness left eye category 4 |
| H54.0X45 | Blindness right eye category 4, blindness left eye category 5 |
| H54.0X53 | Blindness right eye category 5, blindness left eye category 3 |
| H54.0X54 | Blindness right eye category 5, blindness left eye category 4 |
| H54.0X55 | Blindness right eye category 5, blindness left eye category 5 |
| H54.1131 | Blindness right eye category 3, low vision left eye category 1 |
| H54.1132 | Blindness right eye category 3, low vision left eye category 2 |
| H54.1141 | Blindness right eye category 4, low vision left eye category 1 |
| H54.1142 | Blindness right eye category 4, low vision left eye category 2 |
| H54.1151 | Blindness right eye category 5, low vision left eye category 1 |
| H54.1152 | Blindness right eye category 5, low vision left eye category 2 |
| H54.1213 | Low vision right eye category 1, blindness left eye category 3 |
| H54.1214 | Low vision right eye category 1, blindness left eye category 4 |
| H54.1215 | Low vision right eye category 1, blindness left eye category 5 |
| H54.1223 | Low vision right eye category 2, blindness left eye category 3 |
| H54.1224 | Low vision right eye category 2, blindness left eye category 4 |
| H54.1225 | Low vision right eye category 2, blindness left eye category 5 |
| H54.2X11 | Low vision right eye category 1, low vision left eye category 1 |
| H54.2X12 | Low vision right eye category 1, low vision left eye category 2 |
| H54.2X21 | Low vision right eye category 2, low vision left eye category 1 |
| H54.2X22 | Low vision right eye category 2, low vision left eye category 2 |
| H54.8 | Legal blindness, as defined in USA |

| Reviews, Revisions, and Approvals | Date | Approval Date |
|---|---|---|
| Original approval date | 12/2019 | 12/2019 |

| Reviews, Revisions, and Approvals | Date | Approval Date |
|---|---|---|
| Converted to new template | 08/2020 | 10/2020 |
| Annual Review | 12/2020 | 12/2020 |
| Annual Review | 12/2021 | 01/2022 |
| Annual Review | 11/2022 | 12/2022 |
| Updated criteria to include best corrected visual acuity worse than 20/60 in the better seeing eye; Updated references. | 11/2023 | 12/2023 |
| Annual Review | 11/2024 | 12/2024 |
| Annual Review | 08/2025 | 10/2025 |

**References**

1. American Academy of Ophthalmology Vision Rehabilitation Committee, Preferred Practice Pattern® Guidelines, Vision Rehabilitation, San Francisco, CA: American Academy of Ophthalmology, 2022, https://www.aao.org/education/preferred-practice-pattern/vision-rehabilitation-ppp-2022
2. World Health Organization, "Blindness and Vision Impairment". Updated: 8 Oct 2019. https://www.who.int/news-room/fact-sheets/detail/blindness-and-visual-impairment.
3. Ecosse L. Lamoreux; Elaine Chong; Jie Jin Wang; Seang Mei Saw; Tin Aung; Paul Mitchell; Tien Yin Wong. Visual Impairment, Causes of Vision Loss, and Falls: The Singapore Malay Eye Study. Investigative Ophthalmology & Visual Science February 2008, Vol.49, 528-533.

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or

regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at https://www.cms.gov for additional information.

©2025 Centene Corporation. All rights reserved. All materials are exclusively owned by Centene Corporation and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Centene Corporation. You may not alter or remove any trademark, copyright or other notice contained herein. Centene® and Centene Corporation® are registered trademarks exclusively owned by Centene Corporation.

©2025 Envolve, Inc. All rights reserved. All materials are exclusively owned by Envolve and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Envolve. You may not alter or remove any trademark, copyright or other notice contained herein.