QUESTION: Does Medicare cover low vision rehabilitation (LVR)?

ANSWER: Yes, effective May 29, 2002, Medicare extended its coverage of rehabilitation services to include low vision (LV) such that, "A Medicare beneficiary with vision loss may be eligible for rehabilitation services designed to improve functioning, by therapy, to improve performance of activities of daily living, including self-care and home management skills."1

QUESTION: Who is eligible to receive these services?

ANSWER: LVR services are considered reasonable and necessary only for patients with a visual impairment, a clear medical need, and the potential to improve significantly from the services. This excludes impairments that can be otherwise corrected (e.g., by surgery or eyeglasses). "Medicare beneficiaries who are blind or visually impaired are eligible for physician-prescribed rehabilitation services from approved health care professionals on the same basis as beneficiaries with other medical conditions that result in reduced physical functioning." 2 A Technology Assessment 3 estimated the rate of vision impairment for Medicare beneficiaries was >3% and would likely grow.

QUESTION: Who may provide LVR services?

ANSWER: LVR services may be personally provided by ophthalmologists and optometrists 4 or by certified occupational therapists (OT) or physical therapists (PT) under the direct supervision of an optometrist or ophthalmologist. 5 Note that some states prohibit optometrists from supervising OT services.

QUESTION: What services are included in LVR?

ANSWER: Covered services include the initial evaluation by a physician as well as a series of therapy sessions. Weekly sessions lasting about an hour each are common. Medical necessity for LVR ends when the patient demonstrates no progress. Maintenance sessions, after the patient has reached a steady state, are not covered. 6 Low vision devices, such as spectacle-mounted telescopic lenses, are not included in LVR nor covered by Medicare. Teaching patients to modify their behavior and mobility training while using the devices is included in LVR and covered by Medicare.

The LCD on Outpatient Rehabilitation by WPS notes: “Evaluation of the patient’s level of functioning in activities of daily living, followed by implementation of a therapeutic plan of care aimed at safe and independent living, is critical…”

QUESTION: How must the initial low vision assessment be documented?

ANSWER: The initial assessment must document the visual impairment, the functional deficits, and the ability to benefit from LVR. Coverage is absent when there is no potential to improve, the patient is unable to cooperate, or when there are no definable goals.

A written plan of care is required. It defines the specific, measurable goals to be fulfilled by ameliorating the functional deficits, the criteria by which the goals will be measured, the rehabilitative services to be directed toward each goal, and an estimate of the time required to reach the goals.

March 29, 2016

The reader is strongly encouraged to review federal and state laws, regulations, code sets (including ICD-9 and ICD-10), and official instructions promulgated by Medicare and other payers. This document is not an official source nor is it a complete guide on reimbursement. The reader is reminded that this information, including references and hyperlinks, changes over time, and may be incorrect at any time following publication.

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6 **QUESTION:** What documentation is required for LVR?

**ANSWER:** Each session must include a progress note that states the actual time spent in LVR services. Monthly reports are required describing progress towards the stated goals. Quantitative measurements of baseline performance should be compared to current performance measurements at each session. The need for on-going services must be assessed.

The attending physician must promptly review and sign the progress notes of the low vision specialist and see the patient at least every 30 days during therapy to review progress and modify the Plan of Care as needed.

Finally, the attending physician must review and sign a discharge summary describing the extent to which each goal in the Plan of Care was achieved.

7 **QUESTION:** How should claims be submitted?

**ANSWER:** Use E/M (992xx) or eye exam (920xx) codes for the initial evaluation. Therapy sessions are most commonly reported using CPT code 97535 (Self care/management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes).

There are other CPT codes that may apply including: 97110, 97116, 97532, 97533, or 97535. If the physician is working with a therapist in private practice, there are unique therapist evaluation codes (G904x).

8 **QUESTION:** What does Medicare allow for these services?

**ANSWER:** The 2016 national Medicare Physician Fee Schedule includes the values below. These amounts are adjusted locally.

<table>
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<tr>
<th>CPT Code</th>
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<td>$33</td>
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</tbody>
</table>

9 **QUESTION:** Are diagnostic tests covered at the same time as the exam?

**ANSWER:** Yes, medically necessary diagnostic tests may be performed and reimbursed at the time of the initial evaluation or re-evaluation. Some examples include SCODI-P (92133 or 92134), perimetry (9208x), extended color vision examination (92283), electroretinography (92275), or electro-oculography (92270). As always, refraction (92015) is never covered by Medicare for any reason.

March 29, 2016

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All links accessed 03/17/16.


2 FY 2002 Labor/HHS/Education appropriations bill.


4 [Medicare Benefit Policy Manual, Chapter 15, §220.2.](#)

5 [Medicare Benefit Policy Manual, Chapter 15, §230.5B.](#)

6 WPS. LCD L28531 (Retired) Visual Rehabilitation (In: Outpatient Rehabilitation Therapy Services Billed to Medicare Part B). Rev eff. 03/01/2014.

7 [Medicare Benefit Policy Manual, Chapter 15, §220-230.](#)