Clinical Coverage Guidelines – Vision Therapy

**Current Effective Date:** 03/23/12  
**Original Effective Date:** 03/07/06*  
**Policy Number:** OCA 3.40  
**Product Applicability:**  
✓ MassHealth  
✓ Commonwealth Care  
✓ Commercial

**Summary:** Vision therapy (up to 24 visits within 6 months) is considered medically necessary for the following clinical conditions: accommodative insufficiency, amblyopia, convergence insufficiency, and esotropia, acquired (prior to surgery).

**Description of Item or Service:** Vision Therapy (VT) as broadly defined by the American Optometric Association: vision therapy is a treatment plan used to correct or improve specific dysfunctions of the vision system. Treatment plans encompass lenses, prisms, occlusion (eye patching), and other appropriate materials, modalities, and equipment and procedures including eye exercises and behavioral modalities that are used for eye movement and fixation training. (Vision therapy can also be called visual training or therapy or vision training, orthoptics, optometric vision therapy, orthoptic vision therapy, eye training, or eye exercises.)

**Clinical Guideline Statement:**

1. The Plan considers the use of vision therapy (up to 24 visits within 6 months of initiating the treatment program) medically necessary as a standard treatment option for the following clinical conditions:
   - Accommodative Insufficiency
   - Amblyopia
   - Convergence Insufficiency
   - Esotropia, acquired (prior to surgery)

   **When all of the following criteria are met:**

2. The initial evaluation must include quantifiable measurements to support the diagnosis to establish the baseline against which follow-up evaluations can be measured.
3. There must be a comprehensive plan of treatment that includes the projected period of treatment.

4. There must be reasonable expectation that vision therapy will produce measurable improvement in a reasonable period of time.

5. A measurable improvement must be demonstrated within the first two months of treatment. If there is no improvement, the vision therapy services will no longer be considered medically necessary.

6. Follow-up evaluations thereafter should be conducted at least monthly and should include quantifiable measurements and the percentage of improvement from the initial evaluation. The service will no longer be considered medically necessary once further improvement cannot be documented.

7. The provider should document all progress and any changes in the treatment plan. Those receiving treatment are expected to have a home program in addition to office visual therapy, and documentation of compliance should be included in the records.

8. The number of visits per week and the total number of visits varies depending upon the nature and severity of the problem being treated and the needs of the individual receiving treatment. Generally, maximum improvement will require no more than 24 treatments (one to two times weekly for 4-6 months), and may be achieved more quickly.

9. Vision therapy may include any of the following treatments:
   - Lenses
   - Prisms
   - Filters
   - Occlusion or patching; and
   - Eye exercises/vision training/orthoptics/pleoptics, which are used for eye movement and fixation training.

The Plan considers the use of vision therapy experimental and not covered for the following clinical conditions that include but are not limited to:

- Learning Disabilities including attention deficit hyperactivity disorder (ADHD), dyslexia and reading disabilities
- Language disorders including developmental delay
- Strabismus with the exception of acquired esotropia
- Visual field defects following stroke and traumatic brain injury
- Any other diagnoses where there is not adequate authoritative evidence of effectiveness

Additional Definitions:
Accommodation: The eye's ability to adjust its focus by the action of the ciliary muscle, which increases the lens focusing power. When this accommodation skill is working properly, the eye can focus and refocus quickly and effortlessly, which is similar to an automatic focus feature on a camera.

Accommodative Insufficiency: A lack of focusing ability at a near distance. Symptoms include eyestrain, blurred vision, occasional or constant when doing near work (such as reading or using a computer), occasional unusual sensitivity to light, excess tearing, headaches, and general fatigue. Vision therapy is an effective treatment option.

Amblyopia: (Lazy Eye), Poor vision in an eye that did not develop normal sight during early childhood. It is usually marked by blurred vision in one eye and favoring one eye over the other. Treatment options for functional amblyopia are eye patching, prescription lenses, prisms, and vision therapy.

Convergence Insufficiency (CI): The inability of the eyes to turn inward and/or sustain an inward turn. Symptoms include eyestrain with reading and using a computer, headaches, loss of comprehension, difficulty concentrating, blurred or double vision, and eye fatigue. Vision therapy is an effective treatment option.

Esotropia (ET): Conditions in which an eye is turned inward toward the nose. Esotropia is a type of strabismus. It is caused by a reduction in visual acuity, reduced visual function, high refractive error, traumatic brain injury, oculomotor nerve lesion, or eye muscle injury. Acquired esotropia is defined as crossed eyes that develop after a child reaches the age of 6 months.

Esophoria: Conditions in which when both eyes are open each eye points accurately at the target. However, upon covering one eye the covered eye turns inwards. Also known as over-convergence.

Exophoria: Conditions in which when both eyes are open each eye points accurately at the target. However, upon covering one eye the covered eye turns outwards. Also known as under-convergence.

Exotropia (XT): Conditions in which an eye is turned outward toward the ear. Exotropia is a type of strabismus. It may also be called divergent strabismus, wandering eye, or wall eye(s). It is caused by a reduction in visual acuity, reduced visual function, high refractive error, traumatic brain injury, oculomotor nerve lesion, or eye muscle injury.

Hypertropia: A type of Strabismus where one eye turns upward.

Hypotropia: A type of Strabismus where one eye turns downward.
**Learning Disability:** A disorder that affects individual’s ability to either interpret what they see and hear or to link information from different parts of the brain. Learning disabilities can be divided into five broad categories: speech and language disorders, reading disorder, arithmetic disorder, writing disorder, and attention disorders.

**Orthoptics:** A system of eye exercises to improve eye movement and visual tracking by strengthening eye muscles. Orthoptics is a limited form of optometric vision therapy and usually administered by an orthoptist who is a specialist that works under the supervision of an ophthalmologist.

**Pleoptics:** A method of eye exercises created to stimulate and train an amblyopic eye.

**Strabismus:** (Squint), A condition in which the two eyes are directed to different points when looking at an object in space. Normally, in the absence of strabismus, the two eyes are directed to the same point when fixating on an object. This deviation of one eye may cause double vision and/or the suppression of vision in one eye. Strabismus is more common in children between the ages of 6 to 17 years, but it may also appear later in life.

**Applicable Coding:** Codes may not be all inclusive as the American Medical Association (AMA) code updates may occur more frequently or at different intervals than policy updates. These codes are not intended to be used for coverage determinations.

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<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
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<tr>
<td>92065</td>
<td>Orthoptic and/or pleoptic training with continuing medical direction and evaluation</td>
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**ICD9 Diagnosis Codes Covered without prior authorization**

<table>
<thead>
<tr>
<th>ICD9 Diagnosis Codes</th>
<th>Covered without prior authorization</th>
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<tbody>
<tr>
<td>367.51-367.53</td>
<td>Accommodative Insufficiency</td>
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<tr>
<td>368.00-368.03</td>
<td>Amblyopia</td>
</tr>
<tr>
<td>378.83</td>
<td>Convergence Insufficiency</td>
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<tr>
<td>378.00-378.08</td>
<td>Esotropia, acquired</td>
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**Limitations:**
The Plan considers the use of vision therapy experimental and not covered because of the lack of evidence in peer-reviewed medical literature for the following clinical conditions that include but are not limited to:

- Learning Disabilities including attention deficit hyperactivity disorder (ADHD), dyslexia and reading disabilities
- Language disorders including developmental delay
- Strabismus with the exception of acquired esotropia
- Visual field defects following stroke and traumatic brain injury
- Any other diagnoses where there is not adequate authoritative evidence of effectiveness
Clinical Background Information and References:
Vision Therapy is sometimes called visual training, visual therapy, vision training, orthoptics, orthoptic vision therapy or optometric vision therapy and is a nonsurgical clinical approach for treating functional visual deficiencies. Vision therapy includes a wide range of optometric treatment modalities such as lenses, prisms, filters, occluders, and specialized computer programs or instruments. Other modalities include eye exercise and behavioral modalities that are used for eye movement and fixation training with the overall goal to correct or improve specific dysfunctions of the vision system. Vision therapy is administered in an office setting under the guidance of an optometrist and requires a number of office visits with the length of the program varying from a few weeks to several months depending upon the severity of the visual condition being treated. Typically, patients are taught home exercises and activities to be done in conjunction with vision therapy to reinforce visual skills.

There have been many studies that have evaluated the efficacy of vision therapy for a variety of visual disorders, however; in general, the data is weak and derived from poorly controlled studies. There is some evidence from the available studies that vision therapy may improve certain visual impairments such as amblyopia, acquired esotropia, convergence insufficiency and accommodative deficiencies.

Vision therapy is a controversial topic as there is no complete consensus between the opinions of specialists. Some ophthalmologists believe that eye exercises, lenses, prisms, and occlusion may benefit individuals with specific visual disorders; most do not believe that vision therapy is an effective treatment option for individuals with dyslexia and learning disabilities. Some optometrists advocate vision therapy for individuals with learning disabilities including dyslexia. A joint policy statement of the American Academy of Ophthalmologists, the American Academy of Pediatrics (AAP), and the American Association for Pediatric Ophthalmology and Strabismus (AAPOS) states that visual problems are rarely responsible for learning difficulties, and there is no scientific evidence supporting the use of vision therapy for learning disabilities. Therefore, vision therapy is not recommended for patients with learning disabilities including dyslexia.

References:


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This guideline provides information on BMC HealthNet Plan claims adjudication processing guidelines. The use of this guideline is not a guarantee of payment and will not determine how a specific claim(s) will be paid. Reimbursement is based on member benefits and eligibility, medical necessity review, where applicable, coordination of benefits, adherence to Plan policies, clinical coding criteria, and the BMC HealthNet Plan agreement with the rendering or dispensing provider. Reimbursement policies may be amended at BMC HealthNet Plan’s discretion. BMC HealthNet Plan will always use the most recent CPT and HCPCS coding guidelines. All Plan policies are developed in accordance with state, federal and accrediting organization guidelines and requirements, including NCQA.
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IMPORTANT NOTE: Not all services are covered for all products or employer groups. This medical policy expresses the Plan’s determination of whether certain services or supplies are medically necessary, experimental or investigational or cosmetic. The Plan has reached these conclusions based upon the regulatory status of the technology and a review of clinical studies published in peer-reviewed medical literature. Even though this policy may indicate that a particular service or supply is considered covered or not covered, this conclusion is not based upon the terms of a member’s particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all services that are determined to be medically necessary will necessarily be covered services under the terms of a member’s benefit plan. Members and their providers need to consult the applicable benefit plan document (e.g., Evidence of Coverage) to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this medical policy and the benefit plan document, the provisions of the benefit plan document will govern. In addition, this policy and the benefit plan document are subject to applicable state and federal laws that may mandate coverage for certain services and supplies.