

**Medical Necessity Guidelines: Vision Therapy**
*Effective: March 18, 2020*

<b>Prior Authorization Required</b> If <u>REQUIRED</u> , submit supporting clinical documentation pertinent to service request.	<b>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></b>
<p><b>Applies to:</b></p> <p><b>COMMERCIAL Products</b></p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Tufts Health Plan Commercial products; Fax: 617.972.9409</li> <li><input checked="" type="checkbox"/> Tufts Health Freedom Plan products; Fax: 617.972.9409</li> <li>• CareLink<sup>SM</sup> – Refer to <a href="#">CareLink Procedures, Services and Items Requiring Prior Authorization</a></li> </ul> <p><b>TUFTS HEALTH PUBLIC PLANS Products</b></p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 888.415.9055</li> <li><input checked="" type="checkbox"/> Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055</li> <li><input checked="" type="checkbox"/> Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404</li> <li><input checked="" type="checkbox"/> Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304</li> <li>*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.</li> </ul> <p><b>SENIOR Products</b></p> <ul style="list-style-type: none"> <li>• Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the <a href="#">Tufts Health Plan SCO Prior Authorization List</a></li> <li>• Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the <a href="#">Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List</a></li> </ul>	

**Note:** While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

**Overview**

Vision Therapy is an individualized therapeutic program provided by ophthalmologists and optometrists to treat a variety of visual problems. This therapy is effective in treating conditions that affect binocular vision, including convergence insufficiency disorders. Vision therapy involves participation of the patient in a sequence of controlled visual tasks or procedures that modify visual function. The program may consist of specialized equipment, such as lenses, prisms, or filters, to stimulate changes in vision. The therapy sessions are a component of a program that includes home-based eye exercises. Duration of treatment varies depending on the severity of the condition and presence of complicating factors. Consistent monitoring of the patient's progress and reinforcement of home-based exercises is essential. It is expected patients will progress to a point where home-based exercises are sufficient to treat the visual dysfunction.

**CLINICAL COVERAGE CRITERIA**

- Tufts Health Plan may authorize coverage of vision therapy for confirmed symptomatic convergence insufficiency disorder. Initial authorization covers 12 sessions. Subsequent authorization is dependent on patient progress and compliance with home exercise as demonstrated by clinical documentation submitted by the treating optometrist and/or ophthalmologist.

**NOTE:** Vision Therapy Services may include but are not limited to computer orthoptics if/when used for the treatment of convergence insufficiency in the office or home setting

**LIMITATIONS**

Tufts Health Plan will not cover vision therapy when requested for any of the following diagnoses:

- Dyslexia and other reading or learning disabilities
- Attention deficit disorder
- Strabismic Amblyopia
- Deprivation Amblyopia

- Psychological Disturbances
- General Binocular Vision Dysfunction
- Suppression of Binocular Vision
- Simultaneous Vision without Fusion
- Fusion with Defective Stereopsis
- Anomalous (Retinal) Correspondence
- Monocular Comitant Esotropia
- Monocular Comitant Exotropia
- Hypertropia
- Hypotropia
- Cyclotropia
- Microtropia
- Accommodative Esotropia
- Basic Esophoria
- Basic Exophoria
- Vertical Heterophoria
- Cyclophoria
- Dissociated Vertical Deviation
- Third Cranial Nerve Palsies, total or partial
- Fourth Cranial Nerve Palsies
- Sixth Cranial Nerve Palsies
- External Ophthalmoplegia
- Total Ophthalmoplegia
- Brown’s Tendon Sheath Syndrome
- Limited Ductions
- Duane’s Syndrome
- Chronic Progressive Ophthalmoplegia
- Convergence Excess
- Divergence Insufficiency
- Congenital Nystagmus
- Latent Nystagmus
- Visual Deprivation Nystagmus
- Ocular Motor Dysfunction-Deficiencies of Saccadic Eye Movement
- Ocular Motor Dysfunction-Deficiencies of Pursuit Eye Movements
- Ocular Motor Dysfunction-Abnormal Oculomotor Studies

## CODES

Table 1 contains the CPT code that requires prior authorization:

**Table 1: CPT Codes**

CPT Code	Description
92065	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation

Table 2 contains the ICD-10 diagnosis code(s) associated with the procedure in Table 1:

**Table 2: ICD-10 Codes**

ICD-10 Code	Description
H51.11	Convergence insufficiency

## REFERENCES

1. Hayes, Inc. Vision therapy for visual dysfunction and dyslexia and other reading disabilities. Hayes Directory. October 16, 2002.
2. Hayes, Inc. Vision therapy for visual dysfunction and dyslexia and other reading disabilities. Hayes Directory. Update Search. July 10, 2006.
3. American Academy of Pediatrics, American Association for Pediatric Ophthalmology and Strabismus, American Academy of Ophthalmology. Policy Statement: Learning disabilities, dyslexia, and vision. Pediatrics. 1992; 90:124-6.
4. Coates DK, Paysse EA, et.al. Causes of horizontal strabismus in children. In: UpToDate® Post TW, ed. UpToDate® Waltham, MA: [uptodate.com/home](http://uptodate.com/home)(Accessed on January 30, 2018.)

5. Scheiman M, Mitchell GL, et. al. A randomized clinical trial of treatments for symptomatic convergence insufficiency in children. Arch Ophthalmol 2005; 123: 14-24.
6. Cotter S, Kulp M, et. al. Response to editorial about the convergence insufficiency treatment trial. Arch Ophthalmol. 2009; 127 (9): 1229-1230.
7. Wallace DK. Treatment options for symptomatic convergence insufficiency. Arch Ophthalmol. 2008; 126(10):1455-1456.
8. American Association for Pediatric Ophthalmology and Strabismus. Convergence Insufficiency. Accessed on November, 12, 2019 at <https://aapos.org/glossary/convergence-insufficiency>.
9. Scheiman MM, Hoover DL, et.al. Home-Based Therapy for Symptomatic Convergence Insufficiency in Children: A Randomized Clinical Trial. Optom Vis Sci. 2016 December; 93(12): 1457–1465.

## **APPROVAL HISTORY**

January 21, 2005: Reviewed by the Clinical Coverage Criteria Committee

Subsequent endorsement date(s) and changes made:

- November 4, 2005: The requirement of a consult with a pediatric ophthalmologist was removed from the criteria.
- January 13, 2006: Reviewed and renewed without changes
- March 15, 2007: Reviewed and renewed without changes
- May 28, 2008: Coding added to covered diagnoses
- July 6, 2009: Reviewed and renewed without changes
- May 2010: Reviewed at MSPAC, no changes
- August 10, 2011: Reviewed at MSPAC, and approved by Integrated Medical Policy Advisory Committee; no changes
- August 8, 2012: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC), renewed without changes. ICD-10 codes will be added prior to the next IMPAC approval.
- June 26, 2013: Reviewed by IMPAC, no changes.
- June 11, 2014: Reviewed by IMPAC, renewed without changes
- May 13, 2015: Reviewed by IMPAC, renewed without changes
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- March 25, 2016: Coding updated; ICD-9-CM codes removed
- May 11, 2016: Reviewed by IMPAC, renewed without changes
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- May 10, 2017: Reviewed by IMPAC, renewed without changes
- February 14, 2018: Reviewed by IMPAC. For effective date July 1, 2018, clarification of coverage for convergence insufficiency disorder only and addition of criteria for home exercise compliance. Allowed number of visits changed from 15 to 12.
- October, 2018: Template and disclaimer updated
- March 20, 2019: Reviewed by IMPAC, renewed without changes
- December 18, 2019: Reviewed by IMPAC. Note added to clarify Vision Therapy Services, may include but are not limited to computer orthoptics.
- March 18, 2020: Reviewed by IMPAC, renewed without changes
- March 24, 2020: Unify fax number updated

## **BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION**

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic

[Provider Services](#)