

MedStar Health, Inc.

POLICY AND PROCEDURE MANUAL

Policy Number: MP.104.MH
Last Review Date: 11/14/2019
Effective Date: 01/01/2020

MP.104.MH – Vision Therapy

This policy applies to the following lines of business:

- ✓ MedStar Employee (Select)
- ✓ MedStar CareFirst PPO

MedStar Health considers **Orthoptic Vision Therapy** medically necessary for any one of the following conditions:

- Amblyopia;
- Strabismus (inability of both eyes to focus together) including esotropia, exotropia and hypertropia;
- Convergence insufficiency (eye misalignment occurs when focusing at near);
- Reduced accommodation (focusing problems).

Documented requirements for orthoptic vision therapy include all of the following:

1. Initial evaluation completed by an ophthalmologist/optometrist including comprehensive plan of treatment with quantifiable measurements/percentages to support diagnosis
2. Follow-up examinations with quantifiable measurements or percentage of improvement compared with initial evaluation/visit
3. Use of modalities
4. Coverage is limited to a maximum of 14 sessions per benefit period

Limitations

Vision Therapy is not covered for any of the following:

- An absence of documented improvement demonstrated between initial evaluation and follow-up visits;
- Dyslexia or other learning/educational disabilities including developmental delay;
- Behavioral/perceptual vision therapy;
- Treatment for traumatic brain injury;
- Home computer orthoptic programs.

Background

Vision therapy is an individually prescribed treatment program for the correction and development of vision skills and efficiency. After a comprehensive eye examination,

MP.104.MH – Vision Therapy

Policy Number: MP.104.MH
Last Review Date: 11/14/2019
Effective Date: 01/01/2020

vision therapy is prescribed for the treatment of vision problems such as amblyopia and certain binocular vision disorders. Vision therapy typically incorporates the specialized combined use of lenses, prisms, filters, occlusion, computer programs and other visual mechanisms.

Orthoptic Vision Therapy is a type of vision therapy catered to the improvement of binocular vision and accommodative dysfunction. The therapy consists of supervised in-office and at home reinforcement exercises directed at improvement of the dysfunction. Symptoms of defective binocular vision include eyestrain, difficulty focusing, double vision and headaches.

Codes:

CPT Codes / HCPCS Codes / ICD-10 Codes	
Code	Description
CPT Codes	
92065	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation
ICD-10 codes covered if selection criteria are met:	
H49.00-H49.9	Paralytic strabismus
H50.00-H50.08	Esotropia
H50.10-H50.18	Exotropia
H50.21-H50.22	Vertical strabismus Hypertropia
H51.0	Palsy (spasm) of conjugate gaze
H51.11	Convergence insufficiency
H52.00-H52.7	Disorders of refraction and accommodation
H53.001-H53.09	Amblyopia ex anopsia
H53.30-H53.34	Other and unspecified disorders of binocular vision

References

1. American Academy of Optometry and American Optometric Association: Joint Organizational Policy Statement-Vision Therapy- Information for Health Care and Other Allied Professionals, May 1999. http://www.visiontherapy.org/vision-therapy/pdfs/02_vt_info_AOA_AAO.pdf
2. American Association of Pediatric Ophthalmology and Strabismus: Vision Therapy, Website. Updated 08/2016. <https://aapos.org/glossary/vision-therapy>American Optometric Association: AOA Optometric Clinical Practice Guidelines, Website © 2013 American Optometric Association.

MP.104.MH – Vision Therapy

Policy Number: MP.104.MH

Last Review Date: 11/14/2019

Effective Date: 01/01/2020

<http://www.aoa.org/optometrists/tools-and-resources/clinical-care-publications/clinical-practice-guidelines>

3. [American Optometric Association: Definition of Optometric Vision Therapy. Approved April 2009. https://www.aoa.org/Documents/CRG/definition-of-optometric-vision-therapy.pdf](https://www.aoa.org/Documents/CRG/definition-of-optometric-vision-therapy.pdf)
4. Hayes Medical Technology Directory. Vision Therapy for Accommodative and Vergence Dysfunction. Publication Date: 11/29/2011. Annual Review Date: 5/5/2015. Archived 12/29/2016.

Disclaimer:

MedStar Health medical payment and prior authorization policies do not constitute medical advice and are not intended to govern or otherwise influence the practice of medicine. The policies constitute only the reimbursement and coverage guidelines of MedStar Health and its affiliated managed care entities. Coverage for services varies for individual members in accordance with the terms and conditions of applicable Certificates of Coverage, Summary Plan Descriptions, or contracts with governing regulatory agencies.

MedStar Health reserves the right to review and update the medical payment and prior authorization guidelines in its sole discretion. Notice of such changes, if necessary, shall be provided in accordance with the terms and conditions of provider agreements and any applicable laws or regulations.

These policies are the proprietary information of Evolent Health. Any sale, copying, or dissemination of said policies is prohibited.