Medical Policy
Orthoptic Training for the Treatment of Vision or Learning Disabilities

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Policy Number: 611
BCBSA Reference Number: 9.03.03
NCD/LCD: NA

Related Policies
- Endothelial Keratoplasty, #180
- Epiretinal Radiation Therapy for Age-Related Macular Degeneration, #610
- Gas Permeable Scleral Contact Lens, #371
- Implantation of Intrastromal Corneal Ring Segments, #235
- Intravitreal Angiogenesis Inhibitors for Choroidal Vascular Conditions, #343
- Keratoprosthesis, #221
- Photocoagulation of Macular Drusen, #607
- Photodynamic Therapy for Choroidal Neovascularization, #599
- Phototherapeutic Keratectomy, #597
- Transpupillary Thermotherapy for Treatment of Choroidal Neovascularization, #600
- Vision Services, #675

Policy
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity
Medicare HMO BlueSM and Medicare PPO BlueSM Members

Office-based vergence/accommodative therapy may be MEDICALLY NECESSARY for patients with symptomatic convergence insufficiency if, following a minimum of 12 weeks of home-based therapy (eg, push-up exercises using an accommodative target; push-up exercises with additional base-out prisms; jump to near convergence exercises; stereogram convergence exercises; recession from a target; and maintaining convergence for 30-40 seconds), symptoms have failed to improve.

Up to 12 sessions of office-based vergence/accommodative therapy, typically performed once a week, has been shown to improve symptomatic convergence insufficiency in children ages 9 to 17 years. If patients remain symptomatic after 12 weeks of orthoptic training, alternative interventions should be considered.
Orthoptic eye exercises are considered **NOT MEDICALLY NECESSARY** for the treatment of learning disabilities.

Orthoptic eye exercises are **INVESTIGATIONAL** for all other conditions, including but not limited to the following:

- Slow reading
- Visual disorders other than convergence insufficiency such as:
  - Amblyopia
  - Eye movement disorders
  - Focusing disorders
  - Non-strabismic binocular dysfunctions
  - Nystagmus
  - Strabismus.

**Prior Authorization Information**

Pre-service approval is required for all inpatient services for all products. See below for situations where prior authorization may be required or may not be required.

Yes indicates that prior authorization is required.

No indicates that prior authorization is not required.

N/A indicates that this service is primarily performed in an inpatient setting.

<table>
<thead>
<tr>
<th></th>
<th>Outpatient</th>
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</thead>
<tbody>
<tr>
<td>Commercial Managed Care (HMO and POS)</td>
<td>No</td>
</tr>
<tr>
<td>Commercial PPO and Indemnity</td>
<td>No</td>
</tr>
<tr>
<td>Medicare HMO BlueSM</td>
<td>No</td>
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<tr>
<td>Medicare PPO BlueSM</td>
<td>No</td>
</tr>
</tbody>
</table>

**CPT Codes / HCPCS Codes / ICD Codes**

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

**CPT Codes**

<table>
<thead>
<tr>
<th>CPT codes</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>92065</td>
<td>Orthoptic and/or pleoptic training, with continuing medical direction and evaluation</td>
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</table>

The following ICD Diagnosis Codes are considered medically necessary when submitted with the CPT code above if medical necessity criteria are met:

**ICD-9-CM Diagnosis Codes**

<table>
<thead>
<tr>
<th>ICD-9-CM diagnosis codes</th>
<th>Code Description</th>
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</thead>
<tbody>
<tr>
<td>378.83</td>
<td>Other disorders of binocular eye movements; convergence insufficiency or palsy</td>
</tr>
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</table>
ICD-10-CM Diagnosis Codes

<table>
<thead>
<tr>
<th>ICD-10-CM diagnosis codes:</th>
<th>Code Description</th>
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</thead>
<tbody>
<tr>
<td>H51.11</td>
<td>Convergence insufficiency</td>
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</table>

**Description**
Orthoptic training is a technique of eye exercises intended to improve eye movements and/or visual tracking. In addition to its use in the treatment of convergence insufficiency, orthoptic training has been investigated for treatment of attention deficient disorders, dyslexia, dysphasia, and reading disorders.

**Background**
Convergence insufficiency is a binocular vision disorder in the ability for the eyes to turn inward toward each other (e.g., when looking at near objects). Symptoms of this common condition may include eyestrain, headaches, blurred vision, diplopia, sleepiness, difficulty concentrating, movement of print, and loss of comprehension after short periods of reading or performing close activities. Prism reading glasses, home therapy with pencil push-ups, and office-based vision therapy and orthoptics have been evaluated for the treatment of convergence insufficiency.

Some learning disabilities, particularly those in which reading is impaired, have been associated with deficits in eye movements and/or visual tracking. For example, many dyslexic persons may have unstable binocular vision and report that letters may appear to move around, causing visual confusion.

Orthoptic training is a technique of eye exercises intended to improve eye movements and/or visual tracking. Orthoptic training is being investigated for the treatment of attention deficient disorders, dyslexia, dysphasia, and reading disorders. Also known as vision therapy or ocular pursuit, the treatment may include the use of training glasses, prism glasses, or tinted or colored lenses.

**Summary**
A higher quality randomized controlled trial from 2008 indicates that office-based vision/orthoptic training improves symptoms of convergence insufficiency in a greater percentage of patients than a home-based vision exercise program consisting of pencil push-ups or home computer vision exercises. However, in this trial as in others, the home-based regimen may not have included the full range of home-based therapies, and therefore the evidence is insufficient to evaluate whether office-based vision/orthoptic training is more effective than the current standard of home-based therapy. Clinical input from academic medical centers and physician specialty societies supports the use of office-based orthoptic training when home-based therapy has failed. Therefore, orthoptic training may be considered medically necessary in patients with convergence insufficiency whose symptoms have failed to improve with a trial of at least 12 weeks of home-based treatment. Home-based therapy should include push-up exercises using an accommodative target; push-up exercises with additional base-out prisms; jump-to-near-convergence exercises, stereogram convergence exercises; recession from a target; and maintaining convergence for 30 to 40 seconds. Based on the available evidence, clinical input, and lack of alternatives in patients who have failed home-based therapy, orthoptic training may be considered medically necessary for patients with symptomatic convergence insufficiency who have failed a course of home-based therapy.

For learning disabilities, no evidence has been identified in the past decade that would alter the conclusions reached in the 1996 TEC Assessment regarding the use of orthoptic training. In addition, there is consensus that visual therapies are not effective for reading/learning disorders such as dyslexia. Therefore, orthoptic training for the treatment of learning disabilities is considered not medically necessary.

There is insufficient evidence to evaluate the effect of orthoptic training in children or adults who are slow readers without identified learning disabilities or symptoms of convergence insufficiency, or for the treatment of other visual disorders. Therefore, orthoptic training for all other conditions is investigational.
Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>9/2017</td>
<td>Medically necessary criteria clarified. 9/1/2017.</td>
</tr>
<tr>
<td>4/2017</td>
<td>New references added from BCBSA National medical policy.</td>
</tr>
<tr>
<td>3/2015</td>
<td>New references added from BCBSA National medical policy.</td>
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<tr>
<td>5/2014</td>
<td>Medical policy ICD10 remediation: Formatting, editing and coding updates. No changes to policy statements.</td>
</tr>
<tr>
<td>2/2012</td>
<td>MPG Psychiatry and Ophthalmology, no changes in coverage were made.</td>
</tr>
<tr>
<td>9/2011</td>
<td>Added covered indication (378.83: Other disorders of binocular eye movements; convergence insufficiency or palsy) for orthotopic/pleotopic training effective 9/1/2011.</td>
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Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:
- Medical Policy Terms of Use
- Managed Care Guidelines
- Indemnity/PPO Guidelines
- Clinical Exception Process
- Medical Technology Assessment Guidelines

References