Orthoptic/Vision Therapy

(90303)

Medical Benefit

Effective Date: 04/01/12

Next Review Date: 01/17

Preauthorization

Yes

Review Dates: 11/07, 11/08, 09/09, 09/10, 01/11, 01/12, 01/13, 01/14, 01/15, 01/16

Preauthorization is required.

The following Protocol contains medical necessity criteria that apply for this service. The criteria are also applicable to services provided in the local Medicare Advantage operating area for those members, unless separate Medicare Advantage criteria are indicated. If the criteria are not met, reimbursement will be denied and the patient cannot be billed. Please note that payment for covered services is subject to eligibility and the limitations noted in the patient’s contract at the time the services are rendered.

Description

Orthoptic training refers to techniques designed to correct accommodative and convergence dysfunction/convergence insufficiency. Regimens may include push-up exercises using an accommodative target of letters, numbers, or pictures; push-up exercises with additional base-out prisms; jump-to-near convergence exercises; stereogram convergence exercises; and/or recession from a target. Orthoptic training is used in the treatment of convergence insufficiency and has been investigated for the treatment of attention deficient disorders, dyslexia, and dysphasias.

Summary of Evidence

A 2008 randomized controlled trial (RCT) demonstrated 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. Subanalyses of this RCT have demonstrated improvements in accommodative vision, parental perception of academic behavior, and specific convergence insufficiency-related symptoms. 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; pushup 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, the use of visual therapies is not supported by current specialty society guidelines. 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 these conditions is investigational.

Policy
Office-based vergence/accommodative therapy may be considered medically necessary for patients with symptomatic convergence insufficiency if, following a minimum of 12-weeks of home-based therapy (e.g., push-up exercises using an accommodative target; push-up exercises with additional baseout 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.

Orthoptic therapy is also medically necessary for:
- treatment of amblyopia in children up to and including age seven;
- diplopia in adult strabismus; or
- post strabismus surgery with residual symptoms.

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 or as discussed above.

Policy Guidelines
This Protocol addresses office-based orthoptic training.

Up to 12 sessions of office-based vergence/accommodative therapy, typically performed once per week, has been shown to improve symptomatic convergence insufficiency (CI) in children aged nine to 17 years. If patients remain symptomatic after 12 weeks of orthoptic training, alternative interventions should be considered.

A diagnosis of convergence insufficiency is based on asthenopic symptoms (sensations of visual or ocular discomfort) at near point combined with difficulty sustaining convergence.

Convergence insufficiency and stereoacuity is documented by:
- Exodeviation at near at least four prism diopters greater than at far; AND
- Insufficient positive fusional vergence at near (positive fusional vergence (PFV) less than 15 prism diopters blur or break) on PFV testing using a prism bar; AND
- Near point of convergence (NPC) break of more than 6 cm; AND
- Appreciation by the patient of at least 500 seconds of arc on stereoacuity testing.

Background
Convergence insufficiency (CI) is a binocular vision disorder associated with defects in the eyes’ ability to turn inward toward each other (e.g., when looking at near objects). The diagnosis of convergence insufficiency is made when patients have a remote near point of convergence or difficulty in sustaining convergence in conjunction with sensations of visual or ocular discomfort at near vision. 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 refers to techniques designed to correct accommodative and convergence dysfunction/convergence insufficiency, which may include push-up exercises using an accommodative target of letters, numbers, or pictures; push-up exercises with additional base-out prisms; jump-to-near convergence exercises; stereogram convergence exercises; and recession from a target.¹ A related but distinct training technique is behavioral or perceptual vision therapy, in which eye movement and eye-hand coordination training techniques are used to improve learning efficiency by improving visual processing skills.

In addition to its use in the treatment of accommodative and convergence dysfunction, orthoptic training is being investigated for the treatment of attention deficient disorders, dyslexia, dysphasia, and reading disorders.

References

We are not responsible for the continuing viability of web site addresses that may be listed in any references below.


29. James D. Reynolds, MD, Chairman, Department of Ophthalmology, University at Buffalo, Consultant, 01/11/05.