VISION THERAPY (ORTHOPTICS)

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Medical Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

The section identified as “Description” defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as “Criteria” defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Medical Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Medical Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

Description:

Vision therapy includes visual training, eye muscle and eye/hand coordination exercises and perceptual training. It is used to treat eye movement disorders, inefficient eye teaming, misalignment of the eyes (strabismus), poorly developed vision (amblyopia), focusing problems (accommodative disorders), visual information processing disorders, including visual-motor integration and integration with other sensory modalities.

Vision therapy may also be known as orthoptics.
VISION THERAPY (ORTHOPTICS) (cont.)

Criteria:

VISION THERAPY IS NOT A COVERED BENEFIT FOR MOST PLANS. REFER TO THE MEMBER’S SPECIFIC BENEFIT PLAN BOOK.

➢ If benefit coverage for vision therapy (orthoptics) is not available, vision therapy is considered a benefit plan exclusion and not eligible for coverage.

➢ If benefit coverage for vision therapy (orthoptics) is not available, sensorimotor examination with measurements of ocular deviation performed in conjunction with vision therapy is considered a benefit plan exclusion and not eligible for coverage.

➢ If benefit coverage for vision therapy (orthoptics) is available, vision therapy is considered medically necessary for individuals age seven (7) years and older with documentation of ANY of the following:

1. Accommodative dysfunctions
2. Ambylopia
3. Binocular dysfunctions
4. Convergence insufficiency
5. Exophoria
6. Exotropia, intermittent
7. Following surgery to correct intermittent exotropia for distance fixation - greater than 20 feet
8. Strabismus

➢ If benefit coverage for vision therapy (orthoptics) is available, vision therapy for the treatment of learning disorders, including dyslexia, is considered not medically necessary.

➢ If benefit coverage for vision therapy (orthoptics) is available, vision therapy for all other vision disorders not previously listed is considered experimental or investigational based upon insufficient scientific evidence to permit conclusions concerning the effect on health outcomes.
VISION THERAPY (ORTHOPTICS) (cont.)

Resources:


