AMERICAN OPTOMETRIC ASSOCIATION

Vision Therapy and Neuro-Rehabilitation: Optometric Considerations in Third Party Reimbursement

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Vision therapy and neurorehabilitation are used to treat specific diagnosed ocular, visual and visual perceptual conditions. In some cases, vision therapy is the only available and effective treatment option for those conditions. Treatment may be covered under major medical or vision insurance plans. An important consideration of managing a vision therapy practice is to appropriately code for all patients, whether using insurance or not.

Reimbursement of vision therapy

This information packet has been developed to assist individuals involved with medical insurance claims processing and review to better understand the application and utilization of optometric vision therapy. Although vision therapy is not a new area of medical care, information gained from scientific research and clinical application of vision therapy has been expanding in recent years.

Vision therapy has been shown to be an effective treatment modality for many types of problems affecting the vision system. Vision therapy services include the diagnosis, treatment and management of disorders and dysfunctions of the vision system including, but not limited to, conditions involving binocularity, accommodation, oculomotor disorders and visual perceptual-motor dysfunctions. However, the exact length and nature of the therapy program can vary with the specific complexity of the diagnosed condition.

This packet contains fact sheets regarding the treatment and management of various conditions utilizing optometric vision therapy. Because of the differences in complexity of conditions and management approaches, this information should be used only as a framework. Ultimate responsibility for the correct submission of claims and responses to any remittance advice lies with the provider of services.

Coding background

Understanding which codes doctors of optometry should use and their respective definitions is most important in all coding. The entire coding and medical industries are dependent upon accurate code use and interpretation to allow information to be accurately transferred between the provider and the payer. Codes used by optometrists are also used by general medicine and/or other specialty providers. Coding and billing in an optometric office is performed using code sets established and maintained by different entities. The code sets used in this process include: the ICD-10 Clinical Modification code set, the Current Procedural Terminology code set–which is usually called CPT©, and the Health Care Common Procedural Coding System or HCPCS code set. Each code set has a specific purpose in the billing process.

The standard code sets used in optometric practices have specific purposes. They consist of the ICD-10 CM codes for diagnoses, the CPT codes for most procedures and the HCPCS Level II codes for procedures and products not covered under the CPT umbrella. Most carriers have published policies that follow the CPT closely, although it's not uncommon to find that they may have specific policies or guidelines that build on the CPT definition for a particular code. At the current time, ICD-10 CM is developed to allow for greater classification of morbidity and mortality within diagnoses for physicians.

All of these code sets are standardized nationally. The Health Insurance Portability and Accountability Act (HIPAA) prohibits the use of proprietary codes that were previously developed and used by local carriers, insurers and provider groups. It also stipulates that all codes are to be used as they are defined and not to report additional services that are not currently included in the definition.

Medicare contractors and third-party insurance companies have policies regarding coverage decisions about which items or services are reasonable and necessary. Often they elaborate on procedural codes rather than simply relying on the CPT definition. These policies are generally available on the carrier's website or in the provider manual and are referred to in current nomenclature as Local Coverage Determinations (LCDs) by Centers for Medicare and Medicaid Services (CMS) or clinical policy bulletins, medical coverage policy and medical coverage determinations by the major national third-party payers. Regardless of which acronym or name used, they serve the same function by defining the appropriate guidelines in using a particular code.

Delivering quality health care depends on capturing accurate and timely medical data. Medical coding professionals fulfill this need as key players in the health care workplace.

Health information coding is the transformation of verbal descriptions of diseases, injuries and procedures into numeric or alphanumeric designations. Originally, medical coding was performed to classify mortality (cause of death) data on death certificates. However, coding is also used to classify morbidity and procedural data. The coding of health-related data permits access to medical records by diagnoses and procedures for use in clinical care, research and education.

There are many demands for accurately coded data from the medical record. In addition to their use on claims for reimbursement, codes are included on data sets used to evaluate the processes and outcomes of health care. Coded data are also used internally by institutions for quality management activities, case-mix management, planning, marketing and other administrative and research activities.

Which codes could I use?

There are a finite number of codes you will use in the vision therapy portion of your practice. These codes can be subdivided into: examination procedure codes, diagnostic codes, and therapeutic procedure codes. In all of the code choices, the most important factor is documentation. If you have the documentation needed to support the history, examination, treatment plan and medical decision-making requirements, you may have several codes to choose between.

The primary rule of documentation is, "if it wasn't documented, it never happened." In the instance where the work has been performed and properly documented, you can choose procedure codes based on what is covered, what is permitted, and/or what reimburses appropriately for your time. One should not search for the highest reimbursing code, because often the higher reimbursement requires additional non-patient care work including multiple written reports and requires a significant amount of additional staff time. Often, the end result after factoring in all these costs may be a lowered net reimbursement.

Coding is a complex topic for all health care providers, including doctors of optometry. It is strongly suggested that you utilize all resources available when you code for insurance filing. This document is intended only as an introduction to the topic. The key to coding is to have your chart completely support the codes that you used according to the definitions listed by CPT. If you choose to accept insurance in your vision therapy practice, knowledge of your local carriers and their particular requirements is critical to success. Once you have that knowledge, use it to create a consistent, solid pattern of documentation in your records and assume that every time you document, an auditor will see what you have written.

Which examination procedure codes could I use?

The American Medical Association owns the CPT codes. There are several evaluation and management procedural codes that could be used for an office visit to determine if the patient has an ocular, visual or visual perceptual problem. They include 92002, 92004, 92012, 92014, 99202-99205, or 99211-99215. These codes are defined as comprehensive general ophthalmologic examination codes (92004 and 92014), intermediate general ophthalmologic examination codes (92002 and 92012) and the evaluation and management codes (99202-99205 and 99211-99215). You can use these codes in multiple combinations on different days if it best describes the procedures you are performing. For example, a new patient seen in the office today for a 92004 (comprehensive general ophthalmologic examination-new patient), tomorrow for a 92012 (intermediate general ophthalmologic examination-established patient) and next week for a 99213 (evaluation and management exam of an established patient) visit. According to Correct Coding Guidelines, it would be incorrect coding to use these procedure codes simultaneously on the same day.

Who can provide services?

In 2013 the American Medical Association (AMA) established a definition for a Qualified Health Care Professional (QHP) in terms of which providers may report services: A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) **who performs a professional service within his/her scope of practice and independently reports that professional service."** These professionals are distinct from "clinical staff".

A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation and facility policy **to perform or assist in the performance of a specified professional service but who does not individually report that professional service.**

2021 Updated Key elements of the E/M office-visit overhaul:

- Eliminating history and physical exam as elements for code selection. While significant to both visit time and medical decision-making, these elements alone should not determine a visit's code level.
- Allowing physicians to choose whether their documentation is based on medical decision-making or total time. This builds on the movement to better recognize the work involved in non-face-to-face services like care coordination.
- Changing medical decision-making criteria to move away from simply adding up tasks to instead focus on tasks that affect the management of a patient's condition.

The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of the CPT codebook. The inclusion of time as an explicit factor beginning in CPT 1992 is done to assist in selecting the most appropriate level of E/M services. Beginning with CPT 2021 and except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category. Time is not a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult to provide accurate estimates of the time spent face-to-face with the patient. Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. When time is used to select the appropriate level for E/M services codes, time is defined by the service descriptors. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211. A shared or split visit is defined as a visit in which a physician and other qualified healthcare professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of a service for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and or other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted). When prolonged time occurs, the appropriate add-on code may be reported. The appropriate time should be documented in the medical record when it is used as the basis for code selection. Total time on the date of the encounter (office or other outpatient services [99202-99205, 99212- 99215]): For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff). Physician/other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- care coordination (not separately reported)

Other procedure codes to consider are consultation codes. A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. These are the 99241-99245 codes. Usually, these codes are only to be used on the patient's first visit to the office after a physician or other appropriate professional made the referral. Occasionally, the consultation codes can be used for established patients when there was a request for new information from the referring doctor. Consultation codes must have documentation that includes correspondence from the doctor requesting the consultation. While Medicare discontinued reimbursement for consultations in 2009, there are still medical plans that do reimburse for consultations.

If the patient is coming to you for a consultation initiated by a patient and/or family member, and not requested by a physician, you should use the evaluation and management codes 99202-99205.

Which special testing codes could I use?
There are several coding options for patients who require additional testing: 92060 (sensorimotor exam) for motor alignment and function and 96110 (developmental testing; limited), 96112/96113 (developmental testing), and 96116/96121 (neurobehavioral status exam) for visual processing assessment. These codes can be used in combination with evaluation and management codes, by themselves or with each other to best describe the procedures you are doing.

What is a sensorimotor exam?
A basic sensorimotor exam evaluates ocular range of motion to determine if the eyes move together in the various cardinal positions of gaze (12:00, 3:00, 9:00, etc.). This exam element is commonly noted as ocular motility, or extraocular muscles (EOM), in the chart note. A normal range of motion is often noted as "full" or "within normal limits."

CPT lists basic sensorimotor exam as a required exam element of a comprehensive eye exam (920×4); it is an incidental component and not separately reimbursed. A quantitative sensorimotor examination, utilizing prisms to measure ocular deviation, is a more extensive exam and may be separately billable.

Unlike a basic sensorimotor exam, CPT describes the diagnostic test 92060, as sensorimotor examination with multiple measurements of ocular deviation (e.g., restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure). Fundamentally, this test requires the clinician to assess both eyes (and is therefore bilateral); it should not be billed per eye. Pertinent diagnoses include but are not limited to: diplopia, exotropia, esotropia, hypertropia and paralytic strabismus.

The American Association for Pediatric Ophthalmology and Strabismus (AAPOS) issued a position statement in 1999. They state, "Sensorimotor eye exam includes measurement of ocular alignment in more than one field of gaze at distance and/or near, and inclusion of at least one appropriate sensory test in patients who are able to respond." Measuring only primary gaze at distance would not satisfy the requirements. You should include ocular alignment measurements in more than one field of gaze. Primary gaze at distance and near for accommodative esotropia would satisfy the criteria.

Examples of sensory function testing include Worth 4 dot, Maddox rod, and Bagolini lenses. The assessment of sensory function is complementary to the evaluation of the motor function as the term "sensorimotor" implies. It is no less important and is an essential part of the service.

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How is the sensorimotor exam documented in the patient's medical record?
An order for the test should be noted in the chart. Test results for motor function are typically documented in a "tic-tac-toe" format to represent different fields of gaze. Results of the sensory function test are noted, too. Examiners should note which stereopsis test is used and the scored findings (not just pass or fail). Results of a Worth 4 dot often note which lights were seen. An interpretation of the test results and the effect on the patient's condition and course of treatment satisfy the interpretation requirements. Take care that the notations for the test are clearly identifiable and distinct from the office visit notes (e.g., stamp, boxed entry, separate page, etc.).

Repeated testing is indicated when medically necessary for new symptoms, disease progression, new findings, unreliable prior results or a change in the treatment plan. In general, additional testing is warranted when the information garnered from the eye examination is insufficient to adequately assess the patient's disease. For example, if a patient has a history of accommodative esotropia and the basic sensorimotor exam reveals an unstable or worsening condition, the more extensive test is justified. Insurance carriers would not expect a claim for a stable patient who presents with no complaints or one with a controlled condition.

What are cognitive/developmental function tests?
The specific 96000 CPT codes used by physicians are used to report the services provided during testing of the cognitive function of the central nervous system. The testing of cognitive processes, visual motor responses, and abstract abilities is accomplished by the combination of several types of testing procedures. It is expected that the administration of these tests will generate material that will be formulated into a report.

A physician of any specialty can report these services. The use of developmental screening instruments of a limited nature (e.g., Developmental Screening Test II, Early Language Milestone Screen, Parents' Evaluation of Developmental Status, Ages and Stages, and Vanderbilt attention-deficit/ hyperactivity disorder rating scales) is reported using CPT code 96110, developmental testing; limited. Code 96110 is often reported when performed in the context of preventive medicine services, but may also be reported when screening is performed with other E/M services such as acute illness or follow-up office visits. An office nurse or other trained non-physician personnel performs this service; this code does not include any physician work. The review of the screening results is included in the preventive or E/M service. Questions asked by a physician about a child's development, as part of the general history is not a formal measure as such *and is not separately reportable.*

Each administered developmental screening instrument is accompanied by an interpretation and report (e.g., a score or designation as *normal* or *abnormal*). Normal results might be recorded as, "Mother has no significant concerns about her child's fine motor, gross motor, expressive/receptive language, social interactions, or self-help skills." Abnormal results might be recorded as, "Mother has concerns about her child's expressive language and articulation, but no significant concerns about his fine motor, gross motor, receptive language, social interactions, or self-help skills." These interpretive remarks may be included on the screening form or in the progress note of the visit itself. Physicians are encouraged to document any interventions or referrals based on abnormal findings generated by the formal screening. If several tests are administered, results may be combined into a single report. Recommendations for interventions and other supportive measures should be included in the report summarizing the test results.

When developmental surveillance or screening suggests an abnormality in a particular area, more extensive formal objective testing is needed to evaluate the concern. Subsequent periodic formal testing may be needed to monitor the progress of a child whose skills initially may have not been significantly low, but who was clearly at risk for not maintaining appropriate acquisition of new skills.

These longer, more comprehensive developmental assessments using standardized instruments are typically reported using CPT codes. 96112, Developmental test administration and 96113, additional 30 minutes (List separately in addition to code for primary procedure).

These are tests of development, typically performed by physicians or other specially trained professionals, for which the physician work is included as part of the service. Codes 96112/96113 includes the testing and an accompanying formal report.

CPT defines 96112 as "developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour" and 96113,"Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)." They are considered an intra-service that includes administration of assessment procedures and clinical observations of the patient's behavior during the actual testing process.

The following are clinical examples of the procedure from the AMA CPT book.

"A 45-year-old male is 3 months status post cerebrovascular accident (CVA) in the distribution of the left middle cerebral artery. A careful language evaluation is required to determine the nature and extent of aphasia deficits and to make recommendations for rehabilitation. This code includes work in addition to and separate from the neurological evaluation.

Illustration: This code may be reported for the following case. A physician performs an assessment of the developmental status of a 3-year-old girl with spastic diplegia and no language in order to determine early intervention plan (placement in preschool for children with developmental delays). A neurological evaluation of the child has already been performed and a clinical interview with the child's mother preceded the decision for developmental testing.

The frequency of reporting codes 96112/96113 are dependent on the needs of the patient and the judgment of the physician. CPT code 96112 describes no more than 1 hour of face-to-face work and may not be reported more than once a day for the patient. A minimum of 31 minutes must be provided to report any per hour code but the use of the 96113 cannot be applied until after a full 60 minutes has been utilized. Services 96112 and 96116 report time as face-to-face time with the patient and the time spent interpreting and preparing the report. If much less than a full hour is spent performing the service, the use of an E&M service would be appropriate..

When developmental testing is reported in conjunction with an E/M service, the time and effort to perform the developmental testing itself should not count toward the key components (history, physical examination, medical decision making) or time for selecting the accompanying E/M code. The E/M service should be reported with modifier 25 appended to reflect that the service was separate and medically necessary.

CPT code 96116 was redefined in 2019 as Neurobehavioral status examination (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour. These tests are performed for the purpose of making a medical diagnosis. An additional add on code was developed for 2019 of 96121, defined as Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure).

An example of a neurobehavioral status examination would be: an 8-year-old girl is showing significant changes in her behavior at home and school, including attention difficulties, memory problems, and difficulties with making decisions about common daily activities. Mother is concerned that the problems may be a result of the girl falling out of her crib when she was a toddler. The physician performs a neurobehavioral status examination that includes screening for impairments in attention and short-term memory, language, long-term memory, problem solving, and visual and spatial abilities. The physician observes the girl's behavior and records her responses.

Make sure you meet the definition for the code you are using. If you have questions, ask your state association or AOA Third Party committee or the medical director of the third party to whom you are submitting to for clarification in writing.

Which follow-up examination procedure codes should I use?
After therapy has been initiated, you may choose to re-examine the patient at regular intervals. As long as you have the required documentation for history, examination and medical decision-making, you have several coding choices. These would include the same as the initial assessment and may include the special testing codes covered previously.

As this patient has already been seen in your office, only the established patient codes would be applicable.

Which therapy codes could I use?

According to the Current Procedural Terminology Instructions for use of the CPT Codebook, doctors must select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided. When performing orthoptics, the appropriate codes to use are either 92065 or 92066. These codes are generally defined by CPT as orthoptic training. Orthoptics are therapeutic procedures designed to improve the function of the eye muscles. These activities are particularly useful in the treatment of strabismus and other abnormalities of binocular vision. Orthoptics is commonly considered training and strengthening the muscles of the eye, so that they will work together properly.

CPT updated the definition of 92065 in 2022 from Orthoptic and/or pleoptic training, with continuing medical direction and evaluation to simply “Orthoptic training.” This change occurred due the code listing two procedures, orthoptics and pleoptics, and also included continuing care after the service. Pleoptics are exercises designed to improve impaired vision when there is no evidence of organic eye diseases and therefore not necessarily related to orthoptics. The original description of the service 92065 in the CPT manual included “with continuing medical direction.” This refers to the fact that each diagnosed problem is treated differently; therefore a specific treatment plan is established for the patient for each treatment visit. The specific treatment procedures are prescribed by the physician, based upon an evaluation of the overall diagnosis and progress made during previous visits. This treatment may be enhanced when the patient reinforces the in-office treatment at home with appropriate procedures. The home procedures are also prescribed by the physician as appropriate based upon progress made during in-office sessions as well as those previously prescribed out-of-office procedures. This sequence may require additional professional assessment, input and time to demonstrate and explain to the patient in order to assure quality, successful and cost-efficient treatment. This additional evaluation and management may be considered for reimbursement utilizing appropriate E&M or general ophthalmologic codes as long as the appropriate justification and documentation is provided.

For 2023, code 92065 was revised and new code 92066 was added to delineate when the training/therapy is provided directly by the provider and when it is provided by the technician under the supervision of the provider. Previously, code 92065 identified orthoptic training only and did not differentiate who was performing the service.

Code 92065 has been revised as a primary code to code 92066 to specify who is providing this service, “performed by a physician or other qualified health care professional”. The sub-code 92066 has been added to report that the service is performed “under supervision of a physician or other qualified health care professional”.

This is a major change in the model that had been accepted for decades. The primary impetus to the change was the variation of types of provision of service, the variation in duration of service, and the difference in valuation between physician based service versus clinical staff provided service.

<u>As provider type was defined previously in this document, orthoptic services provided by clinical staff such as paraoptometrics, vision therapists, certified optometric vision therapists and other non-licensed employees in the office will be only be able to be submitted with the new 92066.</u>

Two exclusionary parenthetical notes following codes 92065 and 92066 have been added. The first parenthetical note following 92065 has been added to restrict reporting of code 92065 in conjunction with 92066, 0687T, 0688T, when performed on the same day. The second parenthetical note following code 92066 has been added to restrict reporting of code 92066 in conjunction with 92065, 0687T, 0688T, when performed on the same day.

It is uncommon for a doctor of optometry providing any form of vision therapy to provide only orthoptics. Some third-party networks expect professionals of each specialty group to bill the majority of their services within their specialty code set. They often are surprised when doctors of optometry bill outside the 92000 series, and they erroneously try to recode the procedure into the 92000 series. When performing other procedures, you may want to consider the Physical Medicine and Rehabilitation codes (97000 series).

What are Physical Medicine Codes?

The 97000 series of CPT codes are considered "Physical Medicine and Rehabilitation." Many payers are not aware of neuro-optometric rehabilitation and thus may assume that the codes will only be used by licensed occupational or physical therapists providing rehabilitation.

A key component to understanding the concept of rehabilitation coding is to understand the concept of habilitation. Habilitation is defined as assisting a child with achieving developmental skills when impairments have caused delaying or blocking of initial acquisition of the skills. Habilitation can include cognitive, social, fine motor, gross motor, or other skills that contribute to mobility, communication, and performance of activities of daily living and enhance quality of life.

The CPT code 97110 is for therapeutic exercises to develop strength and endurance, range of motion and flexibility. This could be considered for reimbursement when managing patients with convergence insufficiency or accommodative dysfunctions.

The CPT code 97112 is for neuromuscular reeducation of movement, balance coordination, kinesthetic sense, posture and proprioception. This could be considered for reimbursement when managing patients with eccentric fixation training.

The CPT code 97129 is for therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing and sequencing tasks) with direct (one on one) patient contact. As a new code in 2018, CPT offers the following clinical example: A 30 year old male presents with traumatic brain injury sustained in a vehicular accident resulting in memory problems, distractibility, depression, inappropriate social interaction, inability to self-monitor, and impaired organizational skills for executive function.

The HCPCS code G0515 is similarly defined as development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes. CMS had created this code to temporarily replace the CPT code 97532 while 97127 and then 97129 were being developed. It is most appropriate for 2021 and beyond to use the CPT I code when billing.

The CPT code 97530 is for therapeutic activities utilized to restore a patient's functional performance with dynamic activities, such as training in specific functional movements or activities performed during daily living routines. This could be considered for reimbursement when managing patients with oculomotor/saccadic dysfunctions that are impacting performance.

The CPT code 97533 focuses on sensory integrative techniques to enhance sensory processing and to promote adaptive responses to environmental demands, with direct (one-on-one) patient contact by the clinician.

Multiple state boards of optometry have specifically approved these codes to be used by doctors of optometry. These codes may be used with patients who are in need of rehabilitative services to restore the function of the visual system and its connection to the vestibular and motor control function or the habilitation services described previously. The lack of understanding by insurance companies of the function of the doctor of optometry as a member of the rehabilitation team is part of this problem. The introduction to the CPT includes instructions that address this challenge. It states:

It is important to recognize that the listing of a service or procedure and its code number in a specific section of this book does not restrict its use to a specific specialty group. Any procedure or service in any section of this book may be used to designate the services rendered by any qualified physician or other health care professional.

Therefore, when choosing codes, the doctor of optometry must consider the following:

- Which services does my patient require?
- Which interventions are appropriate for my patient?
- Are there existing CPT code(s) that describes the service?
- Are the codes approved by the State Board of Optometry?

97110, 97112 and 97530 are examples of rehabilitation codes that insurance companies may want to change to orthoptics when provided by a doctor of optometry. The 92065 code is defined as "Orthoptic training". In the classical definition, Orthoptics is used to treat strabismus and amblyopia. In 2002, the Department of Health & Human Services Centers for Medicare & Medicaid Services alerted the physician and provider community that Medicare beneficiaries who are blind or visually impaired are eligible for physician-prescribed rehabilitation service. They have directed the providers to consider the physical medicine codes 97000 series for these services.

It should be clear that there is a significant difference between the rehabilitation codes (97000 codes) and the orthoptic training codes. It is a misunderstanding of neuro-optometric rehabilitation that can lead insurance companies to question the use of rehabilitation codes by doctors of optometry. The key is effective communication and education of all involved.

You may want to consider the definitions of neuro-rehabilitation codes (97000 series codes). These codes, in the past, have been mistakenly called occupational or physical therapy codes. These are properly referred to as rehabilitation codes. Many state optometry boards specifically allow doctors of optometry to use these neuro-rehabilitation codes and some do not specify whether or not a doctor of optometry can use these codes in that state. Please check with your state board to see if you are allowed to use these codes. The 97000 series are timed codes as opposed to procedure codes. This means that they can be billed in multiple units per day.

How do I document to meet the coding requirements?

When using the physical medicine codes, the physician or therapist is required to have direct (one-on-one) patient contact. This does not usually allow for "incident-to" billing. Furthermore, documentation guidelines are very specific and fairly complex. Documentation for the provision of vision therapy using

97000 codes should be identified in the indications section of the chart. Once they are established, an individual rehabilitation plan (IRP) must be entered into the patient's record. Minimum documentation requirements in the IRP and sessions executing the plan are as follows:

1. Patient's perceptions of visual function and measures of health-related quality of life (HRQOL).
2. During execution of the treatment plan, progress should be documented.
3. Specific goals based upon answers the patient has provided to questions about concerns; for example, “to increase reading speed to 100 words per minute”.
4. A description of the method that will be employed to achieve each goal should be in the treatment plan.
5. Quantitative measurements of current performance measurements at each session should be compared to baseline performance measurements. A treatment plan may call for achieving goals in a sequential manner. Therefore, quantitative performance measurements of only the goals currently being addressed would be appropriate.
6. Sufficient time between visits is necessary for the patient to apply vision training to his or her activities of daily living. The vision specialist can assess the patient’s improvement following practice by the patient with techniques to maximize performance. This may require periods of at least two (2) to five (5) days between visits.
7. When there is no progress in a quantitative measurement of performance on two occasions following the maximal measure of performance, subsequent treatment for that goal will be considered maintenance and will be considered by most insurers to be a noncovered benefit, payable by the patient.
8. A written progress report of each session is a required element of E&M service, and should identify changes in goals, therapy schedules, or treatment plan.
9. Each session utilizing therapeutic procedures or prolonged services, whose definition includes specific time requirements, must have the face-to-face time between the patient and physician or licensed therapist documented to the minute. Units are calculated as described in prolonged services. In the case of therapeutic services G0515, 97530, and 97533, a minimum of 15 minutes of face-to-face time for each unit of service must be billed. If less than 15 minutes of therapeutic procedure time is involved, no therapeutic service may be billed. If less than 30 minutes of a therapeutic service code face-to-face time is recorded, only one unit may be billed. Three units of therapeutic service require 45 to 60 minutes of face-to-face time.
10. Each session utilizing therapeutic procedures or services, whose definition does not include specific time requirements, must still have the face-to-face time between the patient and physician or licensed therapist documented. In the case of therapeutic services 92065 it is valued by the CMS Relative Value Committee based on physician time per session and limited to one session per day. Some carriers do allow for multiple units to be submitted on the same day, but documentation and medical necessity must warrant.

Further documentation guidelines to successfully pass an audit

The leading cause of payment errors for therapy services is "insufficient" documentation in the medical records. Documentation is often missing the required elements as outlined in the Centers for Medicare

& Medicaid Services (CMS) Internet Only Manual (IOM) Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Sections 220 and 230 found at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf.

For example, a provider indicates in the medical record: "Plan of Care: We would like to see the patient three times per week to initiate exercises and modalities to decrease asthenopia and increase range of motion, strengthening vergences and improving function." This plan is missing key elements to support the medical necessity of the service, such as measurable long-term goals, the patient's diagnosis, the proposed type, duration and frequency of services required to achieve each goal, or anticipated plan of discharge.

Additional widespread issues that result in "insufficient" documentation errors include:

- Missing or illegible signature on the plan of care;
- Missing or illegible signature for physician's certification; and
- Missing legible signature and required treatment minutes in narrative or on flow sheet.

The plan of care shall contain, at minimum, the following information as required by most payers:

- Diagnoses.
- Long-term treatment goals—should be developed for the entire episode of care and not only for the services provided under a plan for one interval of care.
- Type—may be physical therapy, occupational therapy, or speech language pathology, or when appropriate, the type may be a description of a specific treatment of intervention. When a physician or QHP establishes a plan, the plan must specify the type of therapy planned.
- Amount—refers to the number of times in a day the type of treatment will be provided. When amount is not specified, one treatment session a day is assumed.
- Duration—number of weeks or the number of treatment sessions for the plan of care.
- Frequency of therapy services—refers to the number of times in a week the type of treatment is provided. When frequency is not specified, one treatment is assumed.

The plan of care shall be consistent with the related evaluation. The plan should strive to provide treatment in the most efficient and effective manner, balancing the best achievable outcome with the appropriate resources.

Signature and certification of the plan of care

The legible signature and professional identity (e.g., OD, MD, OTR/L) of the individual who established the plan, as well as the date it was established, must be recorded with the plan. A physician or Qualified Health Provider (QHP) must certify (and date) the plan of care (*note: for Comprehensive Outpatient Rehabilitation Facility-services, QHPs may not order or certify therapy services). Certification may be established in the patient's medical record through:

- Physician's or QHP's progress note
- Physician or QHP's order*
- Plan of care that is signed and dated by a physician/QHP*
- Documentation must indicate that the physician/QHP* is aware that the therapy service is or was in progress; and

- Agrees with the plan, when there is evidence the plan was sent to the physician/QHP, or is available in the patient's medical record for the physician/QHP to review.

Treatment notes
The purpose of treatment notes is to create a record of all treatments and skilled interventions that are provided and to record the time of the services to justify the use of billing codes and units on the claim. Documentation is required for every treatment day and every therapy service.

Documentation of each treatment note must include the following required elements:

- Date of treatment.
- Identification of each specific intervention/modality provided and billed (both timed and untimed codes).
- Total timed code treatment minutes and total treatment time in minutes.
- Signature and professional identification of the qualified professional who furnished the services; or, for incident to services, supervised the services, including a list of each person who contributed to the treatment.

Who can submit 97000 codes?
Medicare billable therapy services may be provided by any of the following providers within their scope of practice and consistent with state and local law: physician; non-physician practitioner (QHP) (physician assistants, nurse practitioners, clinical nurse specialists); qualified physical and occupational therapists, speech language pathologists (for CPT codes 97129 and 97533), and assistants working under the supervision of a qualified therapist; qualified personnel, with or without a license to practice therapy, who have been educated and trained as therapists and qualify to furnish therapy services only under direct supervision incident to a physician's service or QHP.

Services may be provided by a physician as defined in §1861 (r)(1) and (4) of the Social Security Act, a qualified occupational therapist, or a qualified physical therapist. Orientation and mobility specialists, low-vision therapists and rehabilitation teachers may also provide this type of therapy "incident to" a physician's service. Services furnished by an employee of the physician may only be done under the physician's direct personal supervision and must meet other "incident to" requirements provided in §2050 of the Medicare Carriers Manual. Direct supervision means that a physician must be in the immediate vicinity of the rehabilitation program, and immediately available or accessible for consultation or emergency. It does not require that the physician be physically present in the room itself. Certified occupational therapy and physical therapy assistants must perform under the appropriate level of supervision as with other therapy services.

"Incident to" services are integral but incidental to the physician's services. Measurement of a visual acuity or blood pressure, or recording a visual field or an electrocardiogram are skills easily taught to a technician and are considered an integral but incidental part of the physician's service. On the other hand, knowledge of optics and the teaching ability necessary to design, execute and adjust a vision rehabilitation plan require extended formal education and clinical experience. Therapeutic services and treatment-planning services are not incidental to vision rehabilitation; they are the determinants of success. Furthermore, these services are not well known or understood by most health care providers, and should not be performed without proper training.

A technician, for example, a paraoptometric, may collect data "incident to" physician's service as part of the vision evaluation or progress assessment, which are evaluation and management services. However, only a physician, occupational or physical therapist, or a professional possessing a certification whose state practice license specifically identifies vision rehabilitation as a service they may provide, may serve "incident to" a physician in the provision of visual rehabilitation.

All other delegation of vision therapy, vision rehabilitation, or other rehabilitative services to vision therapists (certified or not), teachers, paraoptometrics, or other non-licensed staff is not covered by Medicare and many other payers, and should not be billed with these codes.

Therapy modifiers

Providers must report a modifier for any applicable therapy code. The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered:

- GN Services delivered under an outpatient speech-language pathology plan of care;
- GO Services delivered under an outpatient occupational therapy plan of care; or,
- GP Services delivered under an outpatient physical therapy plan of care.

When physicians bill rehabilitation codes, they must follow the policies of the type of therapy they are providing, e.g., utilize a plan of care, bill with the appropriate therapy modifier (GP, GO, GN), and bill the allowed units depending on the plan. These modifiers do not allow a provider to deliver services that they are not qualified and recognized by Medicare to perform. This is applicable to all claims from physicians. A physician shall not bill a rehabilitation code unless the service is provided under a therapy plan of care. All therapy services that a doctor of optometry would provide, aside from the 92065 orthoptic code, are consistent with the occupational therapy model of Physical Medicine and Rehabilitation. The GO modifier is, therefore, most appropriate for all 97000 codes that apply to vision therapy and neuro-optometric rehabilitation.

- Modifier KX-Requirements specified in the medical policy have been met

The beneficiary may qualify for use of the cap exceptions process at any time during the episode when documented medically necessary services exceed caps. All covered and medically necessary services qualify for exceptions to caps. All requests for exception are in the form of a KX modifier added to claim lines. Use of the exception process does not exempt services from manual or other medical review processes. Rather, atypical use of the exception process may invite contractor scrutiny, for example, when the KX modifier is applied to all services on claims that are below the therapy caps or when the KX modifier is used for all beneficiaries of a therapy provider. To substantiate the medical necessity of the therapy services, document in the medical record. The KX modifier is added to claim lines to indicate that the clinician attests that services at and above the therapy caps are medically necessary and justification is documented in the medical record.

Medicare Outpatient Therapy Caps

The Medicare Part B outpatient therapy caps limited the amount of rehabilitation services Medicare would cover per year. These caps were first implemented in 1999 and were enforced for limited periods through 2005. Since 2006, an exceptions process was enacted allowing for medically necessary therapy services above the cap amounts. However, the exceptions process provisions expired at the end of 2017.

In February 2018, the therapy caps were repealed by the federal budget - This means there are no longer any artificial annual limits. This should also apply to Medicare Advantage denials as these plans must offer comparable coverage but we are awaiting specific CMS guidance for such situations.

For 2024, CMS is maintaining the existing regulations as a threshold amount. Once therapy services billed reach the threshold amount (as determined annually by the Medicare Economic Index and released in November), the KX modifier must be appended to any services billed indicating that the services are medically necessary and are justified as such in therapy documentation. Additionally, CMS previously proposed adding a paragraph to the regulation clarifying that the annual threshold amount for targeted medical review continues to be $3,000 for occupational therapy services and will remain at that amount until 2028 without change.

You will still need to submit a KX modifier on claims for any beneficiary services furnished over the cap annually for PT and SLP services combined. This modifier is being used as an attestation of medical necessity. Claims over $2,330 annual thresholds will be denied for noncompliance if not submitted with this coding requirement.

Should I code every patient?
Coding is very similar to learning a foreign language. You must use it to master it. With this in mind, the best approach is to code every patient coming through the office for every visit. By coding everyone, you will master the system faster. Once you begin to code everyone for everything, you will find that thinking in codes becomes second nature.

What should I know about diagnosis coding rules?

1. Code to the highest level of specificity. Don't code strabismus as H50.00 Unspecified Esotropia, instead code for the specific esotropia the patient has (e.g. H50.031 = Monocular Esotropia right eye with V Pattern).

2. Avoid "unspecified" codes.

3. The procedure code must be relevant to the diagnosis code.

4. A single diagnosis may require more than one code. These are identified in the codebooks as codes in brackets. The code in brackets is mandatory. (e.g., Hypertensive Retinopathy H35.033 requires HTN I.10 to be mutually coded.)

5. It may require more than one diagnosis or procedure code to completely describe the patient because the patient has multiple problems.

6. For more information and resources on ICD-10, visit aoa.codingtoday.com/ or aoa.org/optometrists/tools-and-resources/medical-records-and-coding/icd-10.

7. You can purchase the complete *Codes for Optometry* at store.aoa.org/Product/viewproduct/?ProductId=3632850.

Which clinical standards are used to evaluate my claim?

The most widely circulated optometric documents that deal with therapy duration currently include: AOA optometric clinical practice guidelines on (1) *Care of the Patient with Amblyopia*, (2) *Care of the Patient with Strabismus* and (3) *Care of the Patient with Accommodative and Vergence Dysfunction*. Complete versions of the guidelines can be accessed on the AOA website at aoa.org/patients-and-public/caring-for-your-vision/clinical-practice-guidelines.

COVD fact sheets on Conditions of the Visual System Treated with Vision Therapy may also be used and can be obtained from the COVD office (1-330-995-0718). Various position papers and white papers may also be obtained from the COVD office or from the website covd.org/?page=VisionConditions.

Additional resources are included at the end of this document that can be included with all letters to third-party insurance carriers.

What are some good insurance tips?

1. If you are going to bill orthoptics (92065/90266), there is no need to write insurance pre-determination to insurance companies you have already determined do or do not cover orthoptic therapy. Pre-determination letters are beneficial if you are not certain whether a particular insurance company covers orthoptic therapy or if you need to determine the number of sessions a particular patient's policy will cover.

2. If you are going to bill vision rehabilitation (97xxx), there is no need to write insurance pre-determination to insurance companies you have already determined do or do not cover rehabilitation therapy. Pre-determination letters are beneficial if you are not certain whether a particular insurance company covers rehabilitation therapy or if you need to determine the number of sessions a particular patient's policy will cover.

3. Appeal letters are successful if you can "convince" an insurance company that a procedure was medically necessary. Pre-determination and appeal letters are very time-consuming and many offices charge the patient an appropriate fee to write these letters, which includes sending all the appropriate documentation. (See the "Forms/Letters" section of this manual for a sample pre-determination and appeal letter.)

4. Verbal verification or authorization of insurance benefits is not binding. Don't "guarantee" that a patient’s insurance company will pay for testing or therapy procedures, even if a written insurance verification is obtained. Always inform the patient that they are responsible for all fees not covered by his or her insurance, no matter the reason stated in the denial.

5. Be aware that an insurance company can deny reimbursement at any time during or for a limited time after the therapy process. An insurance company may pay for 10 visits and then request a medical review. As a result of this review, they may deny further coverage and in

some cases, can even demand reimbursement for therapies previously covered. Thus, again, it is important to inform the patient *in advance* that he or she is responsible for all services denied or not covered by their insurance company.

6. When dealing with out-of-network insurance companies, collect 100 percent of all fees from the patient at the time of service. However, it is beneficial for the vision therapy doctor's office to file these claims for the patient, as a professional courtesy.
7. When dealing with in-network insurance companies, most providers have found it "safe" to collect only the patient's co-pay for the testing procedures. However, unless you have obtained a written prior authorization notification stating orthoptic therapy or rehabilitation is a covered service by a patient's particular insurance company, there is no guarantee that the patient won't be responsible for additional fees.
8. Most successful practices do file for insurance when applicable; however successful practices often have someone on staff that can market the vision therapy program without relying upon insurance coverage.
9. Documentation is extremely important. Make sure the doctor maintains detailed, up-to-date office notes on all patient visits, as well as the therapist/doctor keeping a log of daily therapy procedures used with the patient. In case of a medical review, these notes will be requested by the insurance company. Successful appeals are usually won based upon these office notes, along with the written testing reports.
10. Keep an updated list of all insurance companies that cover the testing and/or therapy sessions. Include the amount of reimbursement collected for each procedure code. Document the diagnosis codes used successfully for each procedure with each company. This list is an invaluable source for the successful vision therapy practice.
11. Be aware that just because one particular insurance company's policy covers vision therapy does not mean that all policies associated with this company will cover vision therapy. Also be aware that an insurance company may cover vision therapy one year, and the next year may elect not to do so.
12. Keep in mind insurance companies are much more likely to cover vision therapy for visual efficiency areas than they are for visual perceptual areas.

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APPENDICES

The following appendices are intended as general guides and samples. These resources must be tailored and revised to fit the specific needs of your practice, patients, and circumstances.

A) Overview of Coding Procedures
B) Definition of Optometric Vision Therapy
C) Predetermination of Coverage 92065/92066
D) Preauthorization Request
E) Letter of Request for Additional Information 92065/92066
F) Letter of Request for Additional Information 97XXX
G) Letter for Denied Claim
H) Letter for Additional Sessions
I) Letter Explaining Difference Between Sensorimotor vs. Eye Examination
J) Explanation of Patient's Responsibility with Insurance Coverage – Non-participating Physicians
K) Explanation of Patient's Responsibility with Insurance Coverage – Denial Review
L) Alternative Sample Insurance Coverage Form

A) **Overview of Coding Procedures**

General ophthalmologic services

92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits
92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
92014	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits
92015	Determination of refractive state

Special ophthalmological services

92060 Sensorimotor examination with multiple measurements of ocular deviation (e.g., restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)

92270 Electro-oculography with interpretation and report

Special otorhinolaryngologic services vestibular function tests, with observation and evaluation by physician, w/o electrical recording

92531 Spontaneous nystagmus, including gaze

92532 Positional nystagmus test

92534 Optokinetic nystagmus test

Neurology and neuromuscular procedures

95930 Visual evoked potential (VEP) testing central nervous system, checkerboard or flash

0333T Visual evoked potential screening for visual acuity

0464T Visual evoked potential testing for glaucoma

Central nervous system assessments/tests (e.g., neuro-cognitive, mental status)

The following codes are used to report the services provided during testing of the cognitive function of the central nervous system. The testing of cognitive processes, visual motor responses, and abstractive abilities is accomplished by the combination of several types of testing procedures. It is expected that the administration of these tests will generate material that will be formulated into a report.

96110 Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report

96112 Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour

96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)
96116	Neurobehavioral status examination (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)
96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96131	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)

Health Behavior Assessment and Intervention

Health behavior assessment and intervention services are used to identify and address the psychological, behavioral, emotional, cognitive, and interpersonal factors important to the assessment, treatment, or management of physical health problems.

The patient's primary diagnosis is physical in nature and the focus of the assessment and intervention is on factors complicating medical conditions and treatments. These codes describe assessments and interventions to improve the patient's health and well-being utilizing psychological and/or psychosocial interventions designed to ameliorate specific disease-related problems.

Health behavior assessment: includes evaluation of the patient's responses to disease, illness or injury, outlook, coping strategies, motivation, and adherence to medical treatment. Assessment is conducted through health- focused clinical interviews, observation, and clinical decision making.

Health behavior intervention: includes promotion of functional improvement, minimizing psychological and/ or psychosocial barriers to recovery, and management of and improved coping with medical conditions. These services emphasize active patient/family engagement and involvement. These

interventions may be provided individually, to a group (two or more patients), and/or to the family, with or without the patient present.
Codes 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171 describe services offered to patients who present with primary physical illnesses, diagnoses, or symptoms and may benefit from assessments and interventions that focus on the psychological and/or psychosocial factors related to the patient’s health status. These services do not represent preventive medicine counseling and risk factor reduction interventions.
Evaluation and management services codes (including counseling risk factor reduction and behavior change intervention [99401-99412]) should not be reported on the same day as health behavior assessment and intervention codes 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171 by the same provider.
Health behavior assessment and intervention services (96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171) can occur and be reported on the same date of service as evaluation and management services (including counseling risk factor reduction and behavior change intervention [99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412]), as long as the health behavior assessment and intervention service is reported by a physician or other qualified health care professional and the evaluation and management service is performed by a physician or other qualified health care professional who may report evaluation and management services.

Do not report 96158, 96164, 96167, 96170 for less than 16 minutes of service.

96156 Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)

96158 Health behavior intervention, individual, face-to-face; initial 30 minutes

96159 each additional 15 minutes (List separately in addition to code for primary service)
>(Use 96159 in conjunction with 96158)<

96167 Health and behavior intervention, initial 30 minutes, face-to-face; family (with the patient present)

96168 each additional 15 minutes (List separately in addition to code for primary service)
>(Use 96168 in conjunction with 96167)<

96170 Health and behavior intervention, initial 30 minutes, face-to-face; family (without the patient present)

96171 each additional 15 minutes (List separately in addition to code for primary service)
>(Use 96171 in conjunction with 96170)<

Evaluation and management codes for diagnosis

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter. (For services 75 minutes or longer, see Prolonged Services 99417)

99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. No time quantified

99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter. (For services 55 minutes or longer, see Prolonged Services 99XXX)

Prolonged services

Code 99417 is used to report prolonged total time (ie, combined time with and without direct patient contact) provided by the physician or other qualified health care professional on the date of office or other outpatient services (ie, 99205, 99215). Code 99417 is only used when the office or other outpatient service has been selected using time alone as the basis and only after the minimum time required to report the highest-level service (ie, 99205 or 99215) has been exceeded by 15 minutes. To report a unit of 99417, 15 minutes of additional time must have been attained. Do not report 99417 for any additional time increment of less than 15 minutes.

The listed time ranges for 99205 (ie, 60-74 minutes) and 99215 (ie, 40-54 minutes) represent the complete range of time for which each code may be reported. Therefore, when reporting 99417, the initial time unit of 15 minutes should be added once the minimum time in the primary E/M code has been surpassed by 15 minutes. For example, to report the initial unit of 99417 for a new patient encounter (99205), do not report 99417 until at least 15 minutes of time has been accumulated beyond 60 minutes (ie, 75 minutes) on the date of the encounter. For an established patient encounter (99215), do not report 99417 until at least 15 minutes of time has been accumulated beyond 40 minutes (ie, 55 minutes) on the date of the encounter.

Time spent performing separately reported services other than the E/M service is not counted toward the time to report 99205, 99215 and prolonged services time.

For prolonged services on a date other than the date of a face-to-face encounter, including office or other outpatient services (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215), see 99358, 99359. For E/M services that require prolonged clinical staff time and may include face-to-face services by the physician or other QHP, see 99415, 99416. Do not report 99417 in conjunction with 99354, 99355, 99358, 99359, 99415, 99416.

Prolonged services of less than 15 minutes total time is not reported on the date of office or other outpatient service when the highest level is reached (ie, 99205, 99215).

CMS also developed HCPCS code G2212 to append to all Medicare claims. When the practitioner selects a visit level using time, the practitioner may report prolonged office/outpatient E/M visit time using HCPCS add-on code G2212 (Prolonged office/outpatient E/M services). Practitioners should not report prolonged office/outpatient E/M visit time using CPT codes 99354 and 99355 (Prolonged service with direct patient contact), 99358 and 99359 (Prolonged service without direct patient contact), 99415 and 99416 (Prolonged clinical staff services), or 99417 (Prolonged office/outpatient E/M services with or without direct patient contact) (Do not report G2212 for any time unit less than 15 minutes)).

99417 Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient **Evaluation and Management** services)

G2212 Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services).

Case management services

Physician case management is a process in which a physician is responsible for direct care of a patient, and for coordinating and controlling access to or initiating and/or supervising other health care services needed by the patient.

99368 Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional

99441 Telephone evaluation and management service provided by a physician to an established patient, parent or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

99442 Telephone evaluation and management service provided by a physician to an established patient, parent or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

99443 Telephone evaluation and management service provided by a physician to an established patient, parent or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion

Therapeutic procedures

Special ophthalmological services

92065 Orthoptic training; performed by a physician or other qualified health care professional

92066 Orthoptic training; under supervision of a physician or other qualified health care professional

92499 Unlisted ophthalmological service or procedure

0687T Treatment of amblyopia using an online digital program; device supply, educational set-up, and initial session

0688T Treatment of amblyopia using an online digital program; assessment of patient performance and program data by physician or other qualified health care professional, with report, per calendar month

0704T Remote treatment of amblyopia using an eye tracking device; device supply with initial set-up and patient education on use of equipment

0705T Remote treatment of amblyopia using an eye tracking device; surveillance center technical support including data transmission with analysis, with a minimum of 18 training hours, each 30 days

0706T Remote treatment of amblyopia using an eye tracking device; interpretation and report by physician or other qualified health care professional, per calendar month

Physical medicine and rehabilitation

A manner of effecting change through the application of clinical skills and/or services that attempt to improve function. Physician or therapist required to have direct (one-on-one) patient contact.

97110 Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

97112 Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities

97116 Gait training (includes stair climbing)

97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes (Report 97129 only once per day)
97139	Unlisted therapeutic procedure (specify)
97150	Therapeutic procedure(s), group (2 or more individuals) (Report 97150 for each member of group) (Group therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one patient contact by the physician or therapist)
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes
97755	Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes
97799	Unlisted physical medicine/rehabilitation service or procedure

This document is:

1. Current at the time it was published;

2. Based on Medicare and third-party policy that changes frequently and are available for your reference;
3. Prepared as a tool to assist providers and is not intended to grant rights or impose obligations;
4. Developed with reasonable effort to assure the accuracy of the information; and
5. A general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations and rulings.

Ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at cms.hhs.gov/MLNGenInfo on the CMS website.

The AOA, its agents and staff make no representation, warranty or guarantee that this compilation of coding information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.

B) **Definition of Optometric Vision Therapy**

Optometric vision therapy is a sequence of neurosensory and neuromuscular activities individually prescribed and monitored by the doctor of optometry to develop, rehabilitate and enhance visual skills and processing. The optometric vision therapy program is based on the results of a comprehensive eye examination or consultation, and takes into consideration the results of standardized tests, the needs of the patient, and the patient's signs and symptoms. The use of lenses, prisms, filters, occluders, specialized instruments, and computer programs is an integral part of optometric vision therapy. The length of the therapy program varies depending on the severity of the diagnosed conditions, typically ranging from several months to longer periods of time. Activities paralleling in-office techniques are typically taught to the patient to be practiced at home, thereby reinforcing the developing visual skills.

Research has demonstrated optometric vision therapy can be an effective treatment option for:

- Ocular motility dysfunctions (eye movement disorders)
- Nonstrabismic binocular disorders (inefficient eye teaming)
- Strabismus (misalignment of the eyes)
- Amblyopia (poorly developed vision)
- Accommodative disorders (focusing problems)
- Visual information processing disorders, including visual-motor integration and integration with other sensory modalities
- Visual sequela of acquired brain injury

Approved by the American Optometric Association Board of Trustees, April 2009

Optometry: The Profession
Optometry is an independent primary health care profession.

Doctors of optometry (ODs) are the primary health care professionals for the eye. Doctors of optometry examine, diagnose, treat and manage diseases, injuries and disorders of the visual system, the eye and associated structures, as well as identify related systemic conditions affecting the eye.

Doctors of optometry prescribe medications, low-vision rehabilitation, vision therapy, spectacle lenses, contact lenses, and perform certain surgical procedures. They counsel their patients regarding surgical and nonsurgical options that meet their visual needs related to their occupations, avocations and lifestyle.

Doctors of optometry are eye health care professionals state licensed to diagnose and treat diseases and disorders of the eye and visual system.

A doctor of optometry has completed pre-professional undergraduate education in a college or university and four years of professional education at a college of optometry, leading to the doctor of optometry (O.D.) degree. Some doctors of optometry complete an optional residency in a specific area of practice.

C) **Predetermination of Coverage 92065/92066**

<Date>

<Insurance company name>
<Address>

Re: <Patient Name>
<DOB>
<ID#>
<Group#>
<Subscriber Name>

Attention: Predetermination of Benefits Department:

I am writing regarding a pre-determination of benefits for in-network *medical* coverage for CPT Procedure Code (92065/92066) for <*patient name*>. *<Patient name>'s* comprehensive testing was performed on *<date>* and revealed the following diagnosis codes: *<fill in codes>.* These diagnoses relate to the nerves and muscles of the vision system, *not* to routine vision services. Surgery is usually not indicated for these conditions and specifically not indicated for this particular patient.

I am one of thousands of optometrists trained in treating individuals who suffer from visual skills deficiencies related to the *nerves and muscles* of the vision system. My specialty involves providing functional vision evaluation and treatment for qualifying patients as a viable medical alternative to possible costly surgical procedures.

NOTE: THE TREATMENT FOR THE ABOVE PROBLEMS IS MEDICALLY NECESSARY AND IS REFERRED TO AS ORTHOPTIC THERAPY (92065/92066). THE TREATMENT IS SPECIFIC FOR THESE VISUAL NEUROMUSCULAR ANOMALIES AND IS BEING DONE TO CORRECT THE ABOVE CONDITIONS.

Vision therapy is a fully organized therapeutic process utilized to treat visual efficiency and/or visual perceptual problems that cannot be treated with glasses alone. The treatment is complex, involving sophisticated instrumentation, visual therapy exercises, and computers that developmental optometrists have been trained extensively and are certified to perform. The specific activities and instrumentation are determined by the nature and severity of the condition. The frequency and duration of treatments are dictated by the individual's situation. In *<Patient name>'s* case, I feel that *approximately* <#> in-office weekly therapy treatment sessions will be required; he plans to begin this therapy process in *<date>.*

The patient has requested a pre-determination of benefits. If I can be of further service, please do not hesitate to call me.

Sincerely,
<Doctor Name>

D) **Pre-Authorization Request Any CPT Code**

<Date>

<Insurance company name>
<Address>

Re: <Patient Name>
<DOB>
<ID#>
<Group#>
<Subscriber Name>

Diagnosis: ICD-10 <fill>

CPT <fill>> is medically necessary to correct this diagnosed condition or as an alternative to surgery. All information needed to process this claim appears on this form. If additional information is required, please request such in writing.

This is a pre-authorization request for ______ sessions of CPT _______ to manage ICD-10_______.

Please furnish the following information:

1. Is this a covered benefit?
2. What percentage do you pay?
3. Has the deductible been met?
4. Will payment be made directly to the provider or the subscriber?

Sincerely,

Dr. <name>

E) **Letter for Request of Additional Information CPT 92065/92066**

<*Date*>

<*Insurance company name*>
<*Address*>

Re: <Patient Name>
<DOB>
<ID#>
<Group#>
<Subscriber Name>

Medical Coverage for CPT Procedure Code 92065/92066

I am sending you the additional information you requested regarding medical coverage for <*Patient Name*> for procedure code 92065/92066 (orthoptic therapy). The patient's comprehensive examination, performed on <*Date*>, revealed the following Dx codes: ***<fill in codes>*****.**

The treatment for the above problems began on <*date*>**.** The patient's prognosis is good, with approximately ***<fill in number>*** therapy sessions recommended. The patient has completed ***<fill in number>*** of these therapies and has shown great progress. These are therapeutic services and are not connected, in any way, with routine eye care or refractive conditions.

<*Patient's name*>'s diagnoses codes, along with the progress he has already achieved through therapy, certainly indicate orthoptic therapy is an appropriate medical procedure to follow. I am one of thousands of optometrists trained in working with children, youth, and adults like <*Patient's name*> who suffer from visual skills deficiencies**.**

If you need additional information, please do not hesitate to call me.

Sincerely,

Dr. <name>

F) **Letter for Request of Additional Information CPT 97XXX**

<Date>

<Insurance company name>
<Address>

Re: <Patient Name>
<DOB>
<ID#>
<Group#>
<Subscriber Name>

Medical Coverage for **Procedure Code <fill>**

I am sending you the additional information you requested regarding medical coverage for *<Patient Name>* for procedure code <fill in code>. The patient's comprehensive examination, performed on *<Date>*, revealed the following Dx codes: *<fill in codes>*.

Neurobehavioral testing CPT <fill in E&M or 961XX> performed on <Date>, revealed additional deficiencies in the visual cognitive skills areas of <fill in deficient areas>.

The treatment for the above problems began on *<date>*. The patient's prognosis is good, with approximately *<fill in number>* recommended therapy sessions. The patient has completed *<fill in number>* of these therapies and has shown great progress. These are therapeutic services and are not connected, in any way, with routine eye care or refractive conditions.

<Patient's name>'s diagnoses codes, along with the progress they have already achieved through therapy, certainly indicate orthoptic therapy is an appropriate medical procedure to follow. I am one of thousands of optometrists trained in working with children, youth, and adults like *<Patient's name>* who suffer from visual efficiency/perceptual skills deficiencies.

If you need additional information, please do not hesitate to call me.

Sincerely,

Dr. <name>

G) **Letter for Denied Claim**

<Date>

<Insurance company name>
<Address>

Re: <Patient Name>
<DOB>
<ID#>
<Group#>
<Subscriber Name>

Dear Medical Review:

I am writing in response to your claim denial for ***<Patient name and ID #>*** for **Procedure Code 92065/92066 (orthoptic therapy). The diagnoses codes,** established by the sensorimotor exam conducted on *<Date>,* are: ***<fill in codes>.***

NOTE: THE TREATMENT FOR THE ABOVE PROBLEMS IS MEDICALLY NECESSARY AND IS REFERRED TO AS *ORTHOPTIC THERAPY.* THE TREATMENT IS SPECIFIC FOR THE *VISUAL* NEUROMUSCULAR ANOMALIES AND IS BEING DONE TO CORRECT THE ABOVE CONDITIONS *AND IS NOT CONNECTED IN ANY WAY* WITH ROUTINE EYE CARE, REFRACTIVE ERROR, OR GLASSES.

Orthoptic therapy is a fully organized therapeutic regiment utilized to treat a visual efficiency problem that cannot be treated with glasses alone. The treatment is complex, involving sophisticated instrumentation and computers that ***behavioral*** **optometrists** have been trained extensively and are **board certified to perform.** The specific activities and instrumentation are determined by the nature and severity of the condition. The frequency and duration of treatments are dictated by the individual's situation. In *<Patient Name>*'s case, *<fill in number>* therapeutic sessions were needed to correct the problems.

If I can be of further service, please do not hesitate to contact me.

Sincerely,

<Doctor Name>

H) **Letter for Additional Sessions**

<Date>

<Insurance company name>
<Address>

Re: <Patient Name>
<DOB>
<ID#>
<Group#>
<Subscriber Name>

Thank you for your approval of <number> orthoptic therapy visits for ***<patient name, ID number and claim #>.*** The patient has completed this program and showed excellent progress. However, because of the number and severity of visual efficiency problems *<patient name>* had, in order for the patient to receive the maximum benefit from this vision therapy procedure, a minimum of <number> sessions has been a necessity. Thus, we are requesting coverage for additional <number> sessions for *<patient name>*.

I feel the positive testing results more than justify payment for these additional therapy sessions *<patient name>*completed. Thank you for providing coverage for a therapy program that can make such a positive difference in a child's life.

Sincerely,

<Doctor Name>

I) **Letter Explaining Difference between Sensorimotor Exam vs. Eye Examination**

<Date>

<Insurance company name>
<Address>

Re:<Patient Name>:
<DOB>:
<ID#>:
<Group #>:
<Subscriber Name>:

Dear Medical Review:

A sensorimotor examination (Procedure Code 92060) was performed on *<Patient Name>* in my office on *<date>*. A sensorimotor exam is not a vision exam; it is a medical diagnostic exam. A sensorimotor exam has been covered under medical insurance. This exam involves a group of tests that determines what problems, if any, exist with the nerves and muscles of the visual system. It is this exam that enables the doctor to render diagnosis codes, a prognosis, and to recommend a treatment modality, if such a plan is warranted. It is not to determine if the patient needs a refractive prescription. A sensorimotor exam involves numerous tests *not* performed in a comprehensive general ophthalmologic eye exam. *<Patient Name>*'s exam revealed the following diagnosis codes: <list>.

Thus, this sensorimotor exam should be covered under their *medical* insurance. Thank you for making this correction in your insurance records. If I can be of further service, please do not hesitate to contact me.

Sincerely,

<Doctor Name>

J) **Explanation of Patient's Responsibility with Insurance Coverage (Non Participating Physicians)**

Attention to All Patients

Due to the constant change in insurance company policies, we are asking for your help. Please read the following information carefully:

Patients are responsible for knowing the following:

- What percentage your insurance company pays and any deductible due.
- If your insurance plan requires a referral from your primary care physician, you are responsible for obtaining this prior to your visit.
- If your claim is to be billed to your medical insurance or your vision insurance.
- Whether or not your insurance requires that you receive care from a specific provider.

Time does not allow our staff to obtain the above information for you. We will approximate the amount you owe the day of your visit with the understanding that the patient is responsible for the entire balance. We will not be responsible for problems or discrepancies, this must be handled by the insured, but we will be happy to assist you in any way that we can. We will provide you with any information needed to assist with the resolution of any problem that may occur with your carrier. If you have any questions pertaining to our policy, feel free to consult with our staff regarding your concerns or questions.

I, the undersigned, have read and understand the above information regarding the insurance policy of this office.

____ Signature of Patient (Parent if minor)

Date___________________________

K) **Explanation of Patient's Responsibility with Insurance Coverage (Denial Review)**

Insurance Coverage for Vision Therapy

Vision therapy is used to treat diagnosed vision conditions. In some cases, vision therapy is the only available and effective treatment option for these conditions. This treatment may be covered under major medical insurance plans. However, some insurance companies and managed care plans may deny or place severe limits on coverage for Vision Therapy services.

Under all forms of medical insurance plans, you, the consumer and/or patient, have a right to request a review of any service that is denied coverage, or for which coverage is severely limited. If you believe your plan has incorrectly evaluated the claim for coverage, acted arbitrarily, or discriminated unfairly in determining coverage, you could consider requesting a review.

Steps to consider in requesting a review of denial of coverage for vision therapy

1. First, review your medical plan's explanation of benefits booklet to see if there is any statement about the inclusion or exclusion of coverage for vision therapy. Some plans explicitly exclude overage for these services.
   Some plans may exclude coverage for vision therapy to treat educational problems such as learning disabilities, dyslexia, etc. The treatment of learning problems and dyslexia are educational problems that are not within the purview of major medical insurance coverage. However, this should not preclude receiving coverage for vision therapy which is treatment of a diagnosed vision problem.
2. Ask for a written statement on the exact reason that coverage was denied or limited. If an arbitrary statement is given that the company or plan concluded that vision therapy is not considered medically necessary, or is not effective in treating the diagnosed problem, ask for documentation to support that claim.
   Many research studies and clinical reports have been published that support the effectiveness of vision therapy. Unfortunately, your insurance company or plan may not have reviewed this information.
3. Some insurance plans may indicate that the services were reviewed by their "medical consultant" who recommended the services not be covered. You may wish to inquire as to the qualifications of the consultant, especially in regard to the area of determination (i.e., was it a Doctor of Optometry or O.D.?).
   It is common medical practice for questions regarding the medical necessity or appropriateness of treatment to be reviewed by a "medical peer," another doctor with similar training and knowledge in the particular area of care. If the claim for vision therapy services was not reviewed by an optometrist who also provides these services, then true "peer review" did not occur.
4. When claims are denied on the basis that the insurance company or their consultant believes there is a lack of sufficient research to support the effectiveness of vision therapy, supplying documentation of available research may result in approval of coverage.
5. If after going through the above process, coverage of your claim for vision therapy is still denied, you may want to consider the following actions:

- If your medical insurance coverage is provided by your employer, bring the problem to the attention of your company's employment benefits manager and ask for his or her assistance.
- If you purchase insurance coverage yourself, contact your insurance agent and ask for help in getting your claim paid.
- If you are unable to obtain satisfactory resolution of your claim, you could consider filing a complaint with the office of your state commissioner of insurance.

It is important to remember that the unwillingness of your insurance company to pay for these services does not reduce the need for obtaining treatment. Talk with your doctor about payment options that may be available to assist you or your family in obtaining needed care.

L) **Alternative Sample Insurance Coverage Form**

<Date>

<Insurance company name>
<Address>

Re: <Patient Name>
<DOB>
<ID#>
<Group#>
<Subscriber Name>

To Whom It May Concern:

<Patient Name> was recently examined in my office on <exam date>. The diagnostic examination revealed the following medical diagnosis: <ICD-10>.

NOTE: The treatment for the above condition is **medically necessary** and is referred to as visual therapy. The treatment is specific for **neuromuscular anomaly** and is being done to correct the above condition or as an alternative to surgery and is not connected in any way with routine eye care, refractive error or glasses.

Specific treatment program
The treatment program for <ICD-10> requires a minimum of <#> visits and is divided into several phases.

Phase I: Designed to restore normal positive fusional skills and ocular pursuits and saccades, and to integrate pursuits and saccades with other ocular motor skills, as well as to restore normal positive and fusional vergence amplitudes, near point of convergence and accommodative amplitude.

Phase II: Designed to integrate ocular motor skills with accurate motor responses and with sensory skills, as well as to normalize fusional facility in both the positive and negative fusional vergence systems with no suppression.

Phase III: Designed to integrate ocular motor skills with vergence and accommodative systems and with information processing, as well as to create excessive in both the accommodative and fusional systems, and to restore normal vergence facility and amplitude during sustained versions.

Each of these three phases generally requires a minimum of <number> visits. Sessions are weekly or bi-weekly and last <#> minutes. All therapy is under the direct supervision of (Doctor name).

Thank you for your consideration. If you have any questions, please contact me.

Sincerely,
<Doctor Name>