# Editorial ▸ An Open Letter to Blue Cross Blue Shield

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In the summer of 2011, Southern College of Optometry was presented with what seemed to be wonderful news: vision therapy would be covered for a diagnosis of convergence insufficiency. To be honest, we were elated. We silently asked ourselves if this would be a first step towards universal coverage for vision therapy?

We immediately started billing a few test cases with the appropriate diagnosis and were left speechless when the claims were denied. As you will see below in an open letter to Blue Cross Blue Shield, the reason was related to a policy, hidden in the small print, that makes little sense and is a slap in the face to the research that demonstrates the efficacy of office-based vision therapy for convergence insufficiency.

The answer I recieved back several months later was not surprising. The company of course refused my request. I made a second request verbally to our representative: show me the research that supports the use of a secondary treatment prior to offering the gold standard. Essentially, I showed them my proof, but where was theirs? This request did not garner a response.

I have since been made aware that Blue Cross Blue Shield has expanded this program to many other states and perhaps nationwide. Why is it acceptable for this insurance company to insist upon a less effective treatment before allowing the proven, more effective treatment? Would this be acceptable in medical specialities? I think not. Each practicioner must act now. Bring the issue to your state association and/or board. Insist that national organizations like COVD and the AOA get involved. These actions by Blue Cross Blue Shield are subversive and dangerous to all of us!

To whom it may concern:

In the policy statement titled "Orthoptic Training for the Treatment of Vision or Learning Disabilities," which was implemented 18 October 2011 in the State of Tennessee, the following is stated:

Office-based orthoptic training for the treatment of symptomatic convergence insufficiency is considered medically necessary if the medical appropriateness criteria are met. (See Medical Appropriateness below.)

*MEDICAL APPROPRIATENESS*

*Office-based orthoptic training for the treatment of symptomatic convergence insufficiency is considered medically appropriate if ALL of the following criteria are met: Documentation submitted shows that the individual's symptoms failed to improve with at least a 12-week home-based orthoptic training session (e.g., pencil push-up exercises using an accommodative target; push-up exercises with additional base-out prisms; jump to near convergence exercises; stereogram convergence exercises; recession from a target; and maintaining convergence for 30-40 seconds).*

In looking closely at the heading of Medical Appropriateness from the policy statement, the requirement that the individual's symptoms failed to improve with at least a 12-week home-based orthoptic training program does not correspond to the literature and standard of care. The home-based program requirements as listed in the policy statement, including pencil push-up exercises using an accommodative target, push-up exercises with additional base-out prisms, jump to near convergence exercises, stereogram convergence exercises, recession from a target, and maintaining convergence for 30-40 seconds, also do not follow accepted guidelines. There is no mention of home-based computer vergence/accommodative therapy in the policy statement, and the activities listed are not traditionally given for home-based therapy as they require specialized equipment and detailed instruction. Again, this is not standard of care in the treatment of convergence insufficiency.

I am hereby requesting that the policy statement be amended by striking out the need to provide the 12-week home treatment program as a prerequisite to doing the proper treatment. Forcing optometrists to follow your recommended guidelines provides care that is less than the recognized standard of care and should not be required.

If you have any questions or need further clarification, please feel free to contact me at 901-722-3353 or mtaub@sco.edu.

Sincerely,
Marc B. Taub, OD, MS, FAAO, FCOVD
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## Appendix

The following results of the randomized controlled studies from the Convergence Insufficiency Treatment Trial Study Group completed in 2005 and 2008 speak directly against the efficacy of the "required" approach and call into question the need for the 12-week home-based orthoptic training.

- **Scheiman M, Mitchell GL, Cotter S, Cooper J, et al. A randomized clinical trial of treatments for convergence insufficiency in children. Arch Ophthalmol 2005 Jan;123(1):14-24.**
- The objective of this study was to compare vision therapy/orthoptics, pencil push-ups, and placebo vision therapy/orthoptics as treatments for symptomatic convergence insufficiency in children 9 to 18 years of age.

- The results showed that vision therapy/orthoptics was more effective than pencil push-ups or placebo vision therapy/orthoptics in reducing symptoms and improving signs of convergence insufficiency in children 9 to 18 years of age. Neither pencil push-ups nor placebo vision therapy/orthoptics was effective in improving either symptoms or signs associated with convergence insufficiency.
- **Convergence Insufficiency Treatment Trial Study Group. Randomized clinical trial of treatments for symptomatic convergence insufficiency in children. Arch Ophthalmol 2008 Oct;126(10):1336-49.**
- The objective of this study (221 children aged 9 to 17 years with symptomatic convergence insufficiency) was to compare home-based pencil push-ups (HBPP), home-based computer vergence/accommodative therapy and pencil push-ups (HBCVAT+), office-based vergence/accommodative therapy with home reinforcement (OBVAT), and office-based placebo therapy with home reinforcement (OBPT) as treatments for symptomatic convergence insufficiency.
- After 12 weeks of treatment, the OBVAT group's mean Convergence Insufficiency Symptom Survey score (15.1) was statistically significantly lower than those of 21.3, 24.7, and 21.9 in the HBCVAT+, HBPP, and OBPT groups, respectively (P < .001). The OBVAT group also demonstrated a significantly improved near point of convergence and positive fusional vergence at near compared with the other groups (P <or= .005 for all comparisons). A successful or improved outcome was found in 73%, 43%, 33%, and 35% of patients in the OBVAT, HBPP, HBCVAT+, and OBPT groups, respectively.
- Twelve weeks of OBVAT results in a significantly greater improvement in symptoms and clinical measures of near point of convergence and positive fusional vergence and a greater percentage of patients reaching the predetermined criteria of success compared with HBPP, HBCVAT+, and OBPT. Application to Clinical Practice: Office-based vergence accommodative therapy is an effective treatment for children with symptomatic convergence insufficiency.
- **Borsting E, Mitchell GL, Kulp MT, Scheiman M, et al. Improvement in Academic Behaviors After Successful Treatment of Convergence Insufficiency. Optom Vis Sci 2011 Nov 10. [Epub ahead of print]**
- A successful or improved outcome after convergence insufficiency treatment was associated with a reduction in the frequency of adverse academic behaviors and parental concern associated with reading and school work as reported by parents.
- **Scheiman M, Cotter S, Kulp MT, Mitchell GL, et al. Treatment of Accommodative Dysfunction in Children: Results from a Randomized Clinical Trial. Optom Vis Sci 2011 Nov;88(11):1343-52.**
- Vision therapy/orthoptics has been shown to be effective in improving accommodative amplitude and accommodative facility in school-aged children with symptomatic CI and accommodative dysfunction.