# Third-Party Payment for Vision Therapy:

# An Overview of the Michigan Situation and Recommendations

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Believe it or not, Michigan optometrists are billing insurance companies, and other third-party providers, for vision therapy services rendered to patients--and getting paid! The purpose of this paper is to stimulate your interest in this growing trend and to relate some practical information which will help you and your patients take advantage of this payment alternative.

While the concept of third-party payment for vision therapy is not new, Michigan optometrists have lagged behind their counterparts in some other areas of the country in utilizing this method of compensation. Most reported payments have been by private insurance companies, via major medical coverage. Many of these policies recognize surgical techniques as treatment for strabismus. Payment for vision therapy should be sought on behalf of insured patients when vision therapy is decided on as a treatment method, if the prognosis is equal to or greater than that expected from a surgical procedure. The relative costs of these two alternatives will also be a deciding factor for a third party provider.

## Definitions

The following definitions are offered here to prevent misunderstandings, and disruptions in the text.

Third Party: Any entity or group other than the patient who pays for diagnostic and/or therapeutic procedures. Included in this definition are private insurance companies, Medicaid, CHAMPUS (Civilian Health and Medical Program of the Uniformed Services), private philanthropic organizations such as local Lion's Clubs, and nonprofit providers like Blue Cross and Blue Shield. The collective terms 'insurance companies' and

'providers' will be used interchangably to signify any of the above.

Vision Therapy: is used here as a composite term including diagnostic and therapeutic procedures which result in an effective alternative to surgical management of strabismus. Diagnosis and therapy of non-strabismic visual dysfunctions will be mentioned separately.

## Vision Therapy vs. Surgery

Optometric and ophthalmological literature present a continuous flow of material debating the efficiency of vision therapy and surgical procedures in treating strabismus. My purpose is not to become enmeshed in that debate. I simply point out that orthoptics has been an optometric tool used to aid patients with binocular dysfunctions for over fifty years. Vision therapy is a non-invasive means of altering binocular performance and comfort, that can be used effectively, alone in some cases and in combination with surgery in others. Unless Michigan optometrists become more involved in promoting these techniques we will effectively be encouraging surgery, which in many cases offers a poorer eventual prognosis. Insurance companies understand the medical/surgical means of patient treatment.

Advisors to major medical providers are physicians. They help set the standards of care and decide which ailments will be covered. This is a logical arrangement for the most part. It has unfortunately eliminated optometric input into the structuring of eyecare benefits. Third party providers are slowly coming to understand the cost effectiveness and patient safety considerations, present in optometric treatment of strabismus.

Aetna alone, has reportedly funded nearly three hundred vision therapy cases nation wide. They have been the most active company to support

optometric procedures by all available reports. Michigan payments have accounted for a mere 0.5% of the nearly 3,000 cases known to have been paid for across the country.

Insurance providers do not normally list vision training or orthoptics as a covered service. Some companies specifically exclude the procedures. The method by which these generally unmentioned techniques, become reimbursable, involves the wording in the particular policy, with regard to eye care benefits, and state insurance laws governing patient freedom of choice of therapy provider. For instance, if a particular strabismic patient's policy states that coverage is available for <u>treatment of</u> strabismus, then that patient is entitled to receive treatment from the practitioner of his choice who is licensed to treat the condition. In many instances this can be an optometrist, even though the presumed source would be a surgeon.

<u>Professional Review for Quality Control</u>

To keep practitioners of any persuasion from abusing claims for reimbursable treatment, the providers utilize treatment review committees composed largely of physicians. These groups review case details submitted by the treating doctor. They may then authorize payment for the planned treatment, or as in the case of many of the submitted vision therapy cases, reject payment. Valid claims on behalf of optometric patients should be pursued by the patient and optometrist, in spite of an initial rejection. Many companies have had little or no contact with this type of therapy and may misunderstand their legal obligations to the patient. An increase in the number of vision therapy cases submitted for coverage will raise the consciousness of both third-party providers, and the public, concerning orthoptic treatment. Fees for diagnostic services should also be included

in the total case fee when submitted.

Case Eligibility - When to File a Claim

The nature of optometry as a primary care health profession indicates the source of most strabismic patients. They simply present for general eye examinations, often without any particular goals for strabismic treatment. Thus diagnostic services will have been provided in many instances without prior approval from a third-party provider.

The appropriate course of action for the practitioner who has diagnosed a patient with a good prognosis for strabismic cure would be similar, in most respects, to the routine presentation and management of the case. That is, first, the patient (or guardian) would be presented with the doctor's findings and treatment options. Then, billing for the examination would be handled in the normal manner. If the patient elects to pursue vision therapy for the condition, the doctor should inquire about major medical coverage. For insured patients explain that there is a possibility that the insurer will pay for treatment. Claim forms will be supplied by the patient in most cases. It should be stressed to the patient that they will be responsible for the fees charged for therapy, and that no guarantees can be made by you that the insurer will reimburse.

You may elect to further explain that third-party provision for the services you will provide is a rather new concept, and that each case tends to be handled on an individual basis by the insurers at this point. Advise the patient that you will be supportive of re-application if the claim is initially rejected.

For Medicaid, CHAMPUS, Blue Cross, Lion's Clubs and other noncommercial providers you will need prior approval if you expect reimbursement for services rendered.

## Case Presentation - COIT, COPT, ICD-9-CM

Regardless of who the third-party provider is you will at some point need to present a summary of your diagnostic findings and treatment plan for billing purposes. Standardization of these reports is valuable from the insurer's viewpoint for several reasons. These include computer recording of claims by the companies, facilitation of communication with company professional review committees, and reduction of claim processing time within the company. The necessary standardization can be achieved by utilizing numerical diagnostic and treatment coding systems already available to optometrists.

Two pamphlets, obtainable from the American Optometric Association for a small fee, contain all the needed information. These are 'Current Optometric Information and Terminology' (COIT) and 'Current Optometric Procedural Terminology' (COPT). They present a list of ocular and visual anomalies, and treatment methods numerically coded for standardized reference. COIT is derived from the International Classification of Diseases - Clinical Modification (ICD-9-CM), a numerical classification scheme for referencing known diseases.

Standardized reporting of case results is not unique to this situation. It represents a combination of events including greater input into all health care by government and other third-parties, a part of the maturation of the profession of optometry, and is the classic attribute of computerization impinging on any human activity.

## Rejected Claims

Claim rejection by providers is inevitable if you become involved in this area. There is a natural resistance to change, present in any situation.

It will take time for insurers to become familiar with our terms and methods, just as it will for us to learn to interact with their bureaucracies.

Rejected claims should be (and have successfully been) pursued. The patient must be involved with the doctor in following up rejected claims. Around the country, courts have decided in favor of reimbursement to optometrists in carefully prepared cases. Other litigation is currently underway in which precedents may be set that would streamline approval of future claims.

## Report Successes, Failures

Statistics on precisely how many optometrists are involved with third-party payment for vision therapy are practically non-existent. The most extensive information available is prepared by the College of Optometrists in Vision Development (COVD). Member optometrists are encouraged to submit reports on the number of paid and rejected claims they file. This provides only a humble beginning to the information needed to develop a national program, to educate insurers to the advantages of vision therapy as a treatment alternative. Any voluntary reporting system will result in under-reporting of actual activity. Continual reminders to doctors, to report the number and status of claims filed are needed so that meaningful data can be accumulated. This will allow organized optometry to target their approach to particuarly resistant insurers. For now, reports should be sent to the COVD by member and non-member doctors alike (see address below).

## Non-Strabismic Cases

Because non-strabismic cases have no surgical counterpart in treatment, you can expect greater resistance from providers when filing claims for payment. It should be stressed when communicating with third-party providers

that a whole range of physiological vision dysfunctions exist which can have serious economic and safety consequences for the individual if not attended to. For example, a non-strabismic amblyope is diagnosed at a young age, but never undergoes amblyopia therapy. This could be because of poor advice from the vision specialist, economic problems in the family, misunderstanding by the parents, or a variety of other reasons. As an adult this patient sustains damage to the good eye with resultant loss of vision. In most cases this will have a devastating effect on the person's livelihood and future safety. As optometrists we realize that this tragic situation could perhaps have been avoided if appropriate therapy was instituted as early as possible.

The point to be stressed when dealing with insurance providers is that optometrists diagnose and treat physiological dysfunctions of the visual system, as do ophthalmologists. Do not overlook the use of therapeutic lenses as part of the treatment plan in strabismic and non-strabismic patients when indicated. And recall again, the cost effective nature of many of our procedures, relative to their surgical or medical alternatives.

## Summary

Michigan optometrists need to become more involved in billing third-party providers for vision therapy services received by eligible patients. There is a growing trend toward increased utilization of third-party funds for orthoptic services across the nation.

Optometric involvement with third-party providers has several advantages beyond the obvious, immediate economic return. First, it helps communicate information about vision therapy to a greater public audience. Orthoptics is one of optometry's unique specialty areas. In these times of growing commercialism, vision therapy remains a part of professional optometry almost

exclusively. Secondly, vision training impacts directly on ophthalmology. If a strabismic patient undergoes a successful vision therapy program rather than a surgical procedure, both the patient and professional optometry benefit.

Another benefit to optometry from increased activity with insurance companies is the strengthening of orthoptics as a recognized optometric specialty. Development of a good track record with private companies will undoubtedly carry over to the public sector, when the cost effectiveness of various treatment alternatives is analyzed with respect to national health insurance.

Next time you see a patient in need of orthoptic services take a little extra time to find out if a third-party involvement is possible. Chances are if you don't, a surgeon will. That would be unfortunate for you, professional optometry and perhaps the patient as well. If you're not sure in a particular case, refer to an optometric specialist for further evaluation. Give your patients a chance to exercise their freedom of choice. Don't just write yourself out of the picture.

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## References

Information in this paper was gleaned primarily from the following sources:

1. College of Optometrists in Vision Development (COVD), P.O. Box 285, Chula Vista, California 92012.

   This is an optometric educational and accrediting group involved in developmental vision. They coordinate statistics on third-party payment for orthoptic treatment from voluntary reports submitted by optometrists.

2. American Optometric Association, 243 N. Lindbergh Blvd., St. Louis, Missouri 63141

   The COIT and COPT booklets are available from this address.

3. William W. Reinerston, Director, Vision Care Benefit Plans, American Optometric Association, 1730 M Street, N.W., Washington, D.C. 20036

   Mr. Reinerston coordinates A.O.A. involvement in third-party payment plans. Most of his work involves the growing area of eye-glass benefits. He does have an information packet available on third-party coverage of vision therapy which contains some valuable reference material.

4. Robert M. Greenburg, O.D., Reston, VA 22091

   Dr. Greenburg provided conceptual assistance and acted as a reference source. He is a fellow and member of the Board of Directors of COVD.

5. Jack Richman, O.D., The College of Optometry, Ferris State College, Big Rapids, Michigan 49307.

   Dr. Richman helped initiate this project. He continued to serve as a reference source, sounding board, and catalyst in the development of this draft.

6. Lawrence M. Glazer, 736 Michigan National Tower, Lansing, Michigan 48933

   Mr. Glazer is legal counsel to the Michigan Optometric Association.