Clinical Policy Title: Vision therapy for visual system disorders

Clinical Policy Number: 10.02.01

Effective Date: March 1, 2014
Initial Review Date: November 20, 2013
Most Recent Review Date: November 18, 2015
Next Review Date: November, 2016

Related policies:
None

ABOUT THIS POLICY: Arbor Health Plan has developed clinical policies to assist with making coverage determinations. Arbor Health Plan’s clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of “medically necessary,” and the specific facts of the particular situation are considered by Arbor Health Plan when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. Arbor Health Plan’s clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. Arbor Health Plan’s clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, Arbor Health Plan will update its clinical policies as necessary. Arbor Health Plan’s clinical policies are not guarantees of payment.

Coverage policy
Arbor Health Plan considers the use of vision therapy for visual system disorders to be investigational and, therefore, not medically necessary.

Limitations:
This policy is specific to vision therapy and is not intended as policy for medical eye diseases or refractive disorders.

Alternative covered services:
Routine physician office visits and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening.

Background
The American Optometric Association (AOA) broadly defines vision therapy (also called vision or visual training) as a structured program of visual activities prescribed to improve eye coordination and eye focusing abilities (AOA 2009). The goals of vision therapy are to reinforce the eye and brain connection and help correct deficiencies in eye movement, eye focusing and eye teaming. Vision therapy has been used to remediate vision problems associated with:
• Ocular motility dysfunctions (eye movement disorders).
• Non-strabismic binocular disorders (inefficient eye teaming).
• Strabismic binocular disorders (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 sequelae of acquired brain injury (AOA 2009).

Modalities used in vision therapy include “passive” therapies, such as occlusion therapy (i.e., eye patching), prescriptive or prismatic lenses, filters, and other materials and equipment. “Active” therapies include orthoptics, pleoptics, behavioral training and computer-based training. Orthoptics are exercises designed to improve the function of the eye muscles, and pleoptics are exercises designed specifically to improve the amblyopic eye. The length and type of therapy programs vary depending on the severity of the diagnosed conditions, and may last from several months to longer periods of time. Vision therapy may be office- or home-based and is provided most often by an optometrist. Vision therapy is used most commonly in pediatric ophthalmology populations and in adults with disorders specific to neuro-ophthalmology and adult eye muscle disorders (AAO 2013; AOA 2009).

This policy addresses orthoptics, pleoptics, behavioral training and computer-based training for treatment of vision disorders.

Searches

Arbor Health Plan searched PubMed and the databases of:

• UK National Health Services Center for Reviews and Dissemination.
• Agency for Healthcare Research and Quality’s National Guideline Clearinghouse and other evidence-based practice centers.
• The Centers for Medicare & Medicaid Services (CMS).

We conducted searches on October 3, 2015. Search terms were: "orthoptics,pleoptics(MeSH)" and" visual system disorders (MeSH)".

We included:

• Systematic reviews, which pool results from multiple studies to achieve larger sample sizes and greater precision of effect estimation than in smaller primary studies. Systematic reviews use predetermined transparent methods to minimize bias, effectively treating the review as a scientific endeavor, and are thus rated highest in evidence-grading hierarchies.
• Guidelines based on systematic reviews.
• Economic analyses, such as cost-effectiveness, and benefit or utility studies (but not simple cost studies), reporting both costs and outcomes — sometimes referred to as efficiency studies — which also rank near the top of evidence hierarchies.
Findings

Results from systematic reviews show an array of vision therapy modalities has been used to treat amblyopia, accommodative disorders, strabismic and non-strabismic binocular vision disorders, visual information processing disorders, and sequelae of acquired brain injury. Evidence of the effectiveness of vision therapy is limited by small numbers of subjects, largely unsystematic retrospective designs, lack of standard treatment methods and protocols, inadequate reporting of patient selection criteria and treatment administration, and lack of comparison groups. Except for vision therapy for convergence insufficiency (CI), virtually no adequate randomized controlled trials (RCTs) of vision therapy have been published, and evidence on the long-term effectiveness and durability of these treatments is largely absent.

- Moderate-quality evidence from the Convergence Insufficiency Treatment Trial (CITT) Study Group (ClinicalTrials.gov identifiers: NCT00347945, NCT00338611) suggests intensive office-based vision therapy and orthoptic computerized exercises with home exercises improves symptoms and clinical signs of CI in children more than home-based pencil push-ups or home-based computer vergence/accommodative therapy and pencil push-ups, with sustained improvement for at least one year (Scheiman 2005; CITT 2008; CITT 2009). However, critics of the trial pointed out the treatment arms were not applied with equal intensity and may not reflect current practices (Lavrich 2010). It is not known if their program of office-based computerized vision therapy and orthoptic exercises reinforced with home exercises is as effective outside of a controlled, research environment.
- There is insufficient evidence of effectiveness of other types of active vision therapy for all other clinical indications.

Available systematic reviews of vision therapy. No economic analyses were identified.

Policy updates:
No change in policy coverage.

Summary of clinical evidence:

<table>
<thead>
<tr>
<th>Citation</th>
<th>Clinical Indication</th>
<th>Content, Methods, Recommendations</th>
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</thead>
<tbody>
<tr>
<td><strong>Amblyopia</strong></td>
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</table>
| Taylor (2012) Cochrane review | Unilateral and bilateral refractive amblyopia | Key points:  
  - 11 RCTs included.  
  - In some cases of unilateral refractive amblyopia, refractive correction alone is effective.  
  - Where amblyopia persists, adding occlusion is effective.  
  - Insufficient evidence to tailor individual treatment plans for amblyopia.  
  - Insufficient evidence to determine dose/response effect from occlusion.  
  - In unilateral refractive amblyopia, partial occlusion as effective as glasses alone when started simultaneously.  
  - Treatment regimens for bilateral and unilateral refractive amblyopia need to be investigated further. |
| Taylor (2011) Cochrane | Strabismic amblyopia | Key points:  
  - Three RCTs included.  
  - Occlusion with necessary refractive correction more effective than refractive correction alone. |
| Citation                        | Clinical Indication                                                                 | Content, Methods, Recommendations                                                                                                                                                                                                 |
|--------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------
| review                         |                                                                                      | The benefit of combining near activities with occlusion is unproven. No RCTs were found that compared the role of either partial occlusion or optical penalization to refractive correction for strabismic amblyopia. |
| Schmucker (2010)               | Early vs. late treatment for amblyopia or its risk factors (strabismus, refractive errors) | **Key points:**  
Three direct comparisons within one study; one indirect comparison between two studies included.  
Evidence inconclusive regarding the age at which treatment for amblyopia is effective. |
| Accommodative dysfunction      |                                                                                      |                                                                                                                 |
| American Optometric Association (2013) | Refractive disorders                                                                 | **Key points:**  
15 studies including three RCTs were included.  
Evidence from RCTs shows no effect of vision therapy (VT) on myopia.  
Lower-quality evidence suggests subjective but not objective improvement in visual acuity from VT.  
No evidence that VT affects progression of myopia, improves visual function in patients with hyperopia or astigmatism, or improves vision caused by diseases such as glaucoma, diabetic retinopathy and macular degeneration. |
| Hayes (2011)                   | Accommodative and vergence dysfunction                                               | **Key points:**  
Six RCTs of CI, one RCT, one randomized crossover study, two nonrandomized controlled trials of accommodative dysfunction (AD); two studies with combined CI and AD included.  
Overall quality — low to moderate.  
VT is safe, with no reported side effects.  
Sufficient evidence of effectiveness that office-based computerized VT/orthoptic exercises with home exercises can improve symptoms and clinical signs of CI in children. Reduction in symptoms and signs of CI appears to be maintained in the majority of patients for at least one year (moderate evidence from CITT).  
Insufficient evidence of effectiveness for home-based computer vergence/accommodative therapy for CI in children or base-in prism glasses for treatment of CI.  
Insufficient evidence of effectiveness for VT for other vergence disorders.  
Low-quality evidence of effectiveness for different office-based and home-based VT programs for treatment of AD with or without CI (several small trials).  
Insufficient evidence to establish definitive patient selection criteria for the use of vision therapy for treatment of vergence and AD. |
| Binocular vision disorders     |                                                                                      |                                                                                                                 |
| Scheiman (2011)                | Non-surgical treatment for CI                                                        | **Key points:**  
Six RCTs included.  
Base-in prism reading glasses as effective as placebo reading glasses in children (one RCT with low risk of bias).  
Base-in prism glasses using a progressive addition lens design was more effective than progressive addition lens alone in adults (one RCT with high risk of bias).  
Outpatient (or office-based) vision therapy/orthoptics was more effective in terms of clinical measures of near point of convergence and positive fusional vergence than home-based convergence exercises (pencil push-ups) in children or home-based computer vision therapy/orthoptics in children (CITT with low risk of bias).  
Outpatient vision therapy/orthoptics was more effective than home-based convergence exercises in improving positive fusional vergence at near (7.7 diopters, 95% CI 0.82 to 14.58), but not in other outcomes in young adults |
<table>
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<tr>
<th>Citation</th>
<th>Clinical Indication</th>
<th>Content, Methods, Recommendations</th>
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</thead>
</table>
| Gnanaraj (2005)     | Intermittent distance exotropia              | • (one RCT with low risk of bias).  
• Inconclusive evidence of effectiveness of various non-surgical interventions in adults.  

**Key points:**  
• No RCTs identified.  
• Insufficient evidence; consists mainly of retrospective reviews with variations in definition, intervention criteria and outcome measures.  
• Nonsurgical treatment may be appropriate in small-angle deviations or as a supplement to surgery.  
• Robust clinical trials needed.  

| Elliott (2005)      | Infantile esotropia                           | **Key points:**  
• No RCTs identified.  
• Insufficient evidence; consists of retrospective studies or prospective cohort studies.  
• Not possible through this review to resolve the controversies regarding type of surgery, non-surgical intervention and age of intervention.  
• Good-quality trials needed. |
|---------------------|----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Richardson (2003)   | Intermittent distance exotropia              | **Key points:**  
• No RCTs identified.  
• Insufficient evidence; consists mainly of retrospective case reviews with large variation in the definition of intermittent distance exotropia, intervention criteria and outcome measures.  
• Quality clinical trials needed.  

**Other systematic reviews**

| Hayes (2012)        | Dyslexia Learning disabilities (LD)          | **Key points:**  
• 12 studies, including six parallel arm RCTs and five randomized crossover studies.  
  ○ 10 studies of colored filters as VT.  
  ○ One study of monocular occlusion.  
  ○ One study of office-based treatment program designed to correct AD or binocular vision dysfunction.  
• Overall quality — low.  
• Vision therapy is safe with no reported side effects.  
• Insufficient evidence of benefit to establish patient selection criteria for the treatment of dyslexia and other reading or LDs.  
• The majority of studies found no benefit of colored filters relative to placebo or no treatment conditions.  
• Insufficient evidence of effectiveness of other types of VT or other treatments of dyslexia and other reading or LDs. |
| Bouwmeester (2007)  | Visual field defects due to brain damage      | **Key points:**  
• Two RCTs and 12 within-subject repeated-measures designs (RMD).  
• Poor to moderate evidence that scanning compensatory therapy (SCT) is effective for increasing the visual search field (up to 30 degrees), increasing reading speed or decreasing reading errors.  
• It is unclear to what extent patients benefit from restoration therapy in relation to a more efficient scanning strategy that enables them to read faster or to avoid obstacles in a better way. |
| Rawstron (2005)     | Eye exercises for variety of eye disorders    | **Key points:**  
• 43 studies included (14 were clinical trials [10 controlled studies], 18 review articles, two historical articles, one case report, six editorials or letters, and two position statements from professional colleges).  
• Sufficient evidence from small controlled trials and large number of cases support VT for the treatment of CI. |
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<tr>
<th>Citation</th>
<th>Clinical Indication</th>
<th>Content, Methods, Recommendations</th>
</tr>
</thead>
</table>
| ICSI (2003) | Vision therapy | Key points:  
- Evidence consists of predominantly poor-quality case series.  
- Insufficient evidence of effectiveness of VT for patients with LDs, amblyopia, strabismus, CI or ADs. |

- Less robust evidence of effectiveness for VT in developing fine stereoscopic skills and improving visual field remnants after brain damage.  
- No clear scientific evidence supporting the use of eye exercises in other disorders.

**Other clinical policies:**

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<th>Organization</th>
<th>Policy</th>
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"The patient must have a potential for restoration or improvement of lost functions, and must be expected to improve significantly within a reasonable and generally predictable amount of time. Rehabilitation services are not covered if the patient is unable to cooperate in the treatment program or if clear goals are not definable. Most rehabilitation is short-term and intensive, and maintenance therapy — services required to maintain a level of functioning — is not covered… 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. Services furnished by an employee of the physician may only be provided incident to the physician’s professional services, must be furnished under the physician’s direct personal supervision, and must meet other incident to requirements provided in §2050 of the Medicare Carriers Manual. Certified occupational therapy and physical therapy assistants must perform under the appropriate level of supervision as other therapy services."

Low vision services use optical devices and non-optical adaptive equipment, skill training, environmental adaptations and counseling to minimize vision-related disability when no restorative process (e.g., correction of refractive error, corneal transplantation or cataract surgery) is possible.

The level of vision impairment is defined as:

1. Moderate — best corrected visual acuity is less than 20/60.
2. Severe — (legal blindness) best corrected visual acuity is less than 20/160, or visual field is 20 degrees or less.
3. Profound — (moderate blindness) best corrected visual acuity is less than 20/400, or visual field is 10 degrees or less.
4. Near-total — (severe blindness) best corrected visual acuity is less than 20/1000, or visual field is 5 degrees or less.
5. Total — (total blindness) no light perception.

Loss of central area of detail with macular degeneration results in distortion, and:

1. Missing segments of words.
2. The need for magnification of reading material to allow a patient to read.

**Indications for low vision service**

The criteria for a low vision evaluation (L/VE) by a physician is self-reported functional deficit secondary to any level of visual impairment that cannot be resolved by standard glasses, medicine or surgery.
The criteria for rehabilitation therapy for low vision are met when any of the following categories are fulfilled, and functional deficit compromising daily activities has been confirmed and delineated by an L/VE:

1. 369.00-369.25 — Impairment of central visual acuity; remaining vision in the better eye after best correction is documented at less than 20/60.
2. 368.41 — A central scotoma is demonstrated.
3. A visual field reduction is demonstrated, including 368.45 (generalized constriction), 368.46 (homonymous bilateral field constriction) or 368.47 (heteronymous bilateral field constriction).

An individualized plan of care must be entered into the patient's record. A plan of care includes rehabilitation goals, progress assessment at each session and determination of discharge.

Rehabilitation services for vision impairment

A Medicare beneficiary with vision loss may be eligible for rehabilitation services designed to improve functioning by therapy, and to improve the performance of activities of daily living, including self-care and home management skills. Evaluation of the patient's level of functioning in activities of daily living, followed by implementation of a therapeutic plan of care aimed at safe and independent living, is critical and should be performed by an occupational or physical therapist.

Glossary of terms

Accommodative dysfunction — Difficulty maintaining clear focus on an object as its distance varies.

Amblyopia — Vision in one of the eyes is reduced because the eye and the brain are not working together properly, resulting in the brain favoring the other eye. Not fully corrected with eyeglasses or contact lenses, called “lazy eye.” In layman’s terms.

Binocular disorders — The inability to move both eyes together in an effective manner to maintain clear single vision.

Convergence disorders (insufficiency) — The inability of the eyes to turn inward and maintain single vision when reading or doing work up close.

Crossed eyes — See strabismus.

Dyslexia — A learning disability involving difficulties in acquiring and processing language that is typically manifested by a lack of proficiency in reading, spelling and writing.

Divergence disorders — Inability of the eyes to turn outwards and maintain single vision when looking at objects at a distance.

Esotropia — A form of strabismus where the eyes are deviated inward, “crossed eyes.”

Exotropia — A form of strabismus where the eyes are deviated outward, “wall eyes.”
Myopia — See nearsightedness.

Nearsightedness — A vision condition in which you can see close objects clearly, but objects farther away are blurred.

Orthoptics — The treatment of defective visual habits, defects of binocular vision and muscle imbalance by reeducation of visual habits, exercise and visual training.

Pencil push-ups — A home-based exercise for convergence insufficiency whereby the patient follows a small letter on a pencil as the pencil is moved toward the bridge of his or her nose until the letter is no longer single and becomes double. The goal is to get the pencil closer and closer each day, thereby strengthening the medial rectus muscles of the eye.

Pleoptics — A system of treating amblyopia by retraining visual habits using guided exercises.

Refractive disorders — Too much or too little deflection of light on to the retina, resulting in blurred vision.

Strabismus — A condition in which both eyes do not look at the same place at the same time. Typically involves a lack of coordination between the extraocular muscles, caused by either a brain disorder or muscle imbalance, which hampers proper binocular vision and may adversely affect depth perception.

Vergence — Movement of one eye in relation to the other.

References

Professional society guidelines/others:


**Peer-reviewed references:**


Clinical trials:

Searched clinicaltrials.gov on October 17, 2015 using terms strabismus OR amblyopia OR accommodative OR binocular OR convergence OR esotropia OR exotropia OR divergence. | Open Studies. 68 studies found, seven relevant.


**CMS National Coverage Determinations (NCDs):**

No NCDs identified as of the writing of this policy.

**CMS article:**

**Local Coverage Determinations (LCDs):**


**Commonly submitted codes**

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Comment</th>
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</thead>
<tbody>
<tr>
<td>92065</td>
<td>Orthoptic and/or pleoptic training, with continuing medical direction and evaluation.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Description</th>
<th>Comment</th>
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</thead>
<tbody>
<tr>
<td>367.51</td>
<td>Paresis of accommodation.</td>
<td></td>
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<tr>
<td>367.52</td>
<td>Total or complete internal ophthalmoplegia.</td>
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<tr>
<td>367.53</td>
<td>Spasm of accommodation.</td>
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<tr>
<td>368.00</td>
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<tr>
<td>368.9</td>
<td>Unspecified visual disturbance.</td>
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<tr>
<td>378.00</td>
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<td>378.02</td>
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<td>ICD-10 Code</td>
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<td>Internal ophthalmoplegia (complete) (total), left eye</td>
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<td>H52.513</td>
<td>Internal ophthalmoplegia (complete) (total), bilateral</td>
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<td>H52.519</td>
<td>Internal ophthalmoplegia (complete) (total), unspecified eye</td>
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<td>Spasm of accommodation, bilateral</td>
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<tr>
<td>H49.03</td>
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