VIEWPOINTS SHOULD OPTOMETRY FIGHT TO INCLUDE VISION THERAPY AS A COVERED SERVICE IN MANAGED CARE

Editor's Comments

Similar to many aspects of health care, the move toward Managed Care has significantly reduced the frequency of vision therapy as a covered service. Behavioral optometrists are generally coping with this situation by either presenting it as a non-covered, self-pay service, or individually expending efforts to seek coverage for their patients. In this Viewpoints, Dr. Norman Haffner, President of the State University of New York (SUNY), State College of Optometry, and a former SUNY Vice Chancellor, presents reasons to fight for coverage from a broad prospective that includes a public health need and the fact that vision therapy has long been an integral part of optometry.

Dr. Mark Wright is an adjunct faculty member of The Ohio State University College of Optometry, and a highly successful private practitioner. He is a frequent lecturer on strategies to present vision therapy as a patient self-pay service, and as Dr. Haffner, presents compelling arguments for his Viewpoint. The "Letter to the Editor" in this issue by Dr. Samuel A. Berne further expounds Dr. Wright's position.

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OPTOMETRY *SHOULD* FIGHT TO INCLUDE VISION THERAPY AS A COVERED SERVICE IN MANAGED CARE

A.N. HAFFNER, O.D., PH.D.

Abstract

The need for optometry to seek inclusion of vision therapy services in private and governmental Managed Care plans is made from the standpoint of a national public health need, particularly for children. While it is an established and valuable component of optometric care, the point is made that outcome and utilization studies must be made for vision therapy.

Key Words

Managed Care, vision therapy, outcome studies, utilization studies, Medicare, Medicaid

A preliminary but essential statement is in order. A frequently held maxim in our profession is that we speak to each other too frequently and not enough to others. How is it possible to enunciate the central nature and clinical importance of vision therapy if we do not more actively reach out to those in related healing professions and those involved in the shaping of health care policy, again and again "making the case" for vision therapy (VT)? It is absolutely ironic that, with optometry's expansion of the scope of professional practice to treat diseases of the eye, the body politic of the profession, from coast to coast, has very vigorously asserted and defended its newly acquired responsibilities and authorities and brought this message to the state and federal governments, third party insurers, Managed Care companies and other health care providers. Yet, it is altogether appropriate to raise the question of why the profession, at virtually all levels, has not similarly rallied to defend that which clearly has been within optometry's scope of practice for a century, namely: vision therapy.

When the editor of this *Journal* asked me to write this Viewpoints commentary, I was somewhat bemused by the suggested title. My first thought was, "Whom would we fight"? Next, I asked myself, "Why should we fight"? Finally, "Who would be the beneficiary of the proposed fight"? There are some very complex issues involved in these three questions and they deserve careful thought and deliberation on the part of the profession, in general, and on the part of the readership of this Journal in particular.

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OPTOMETRY SHOULD *NOT* FIGHT TO INCLUDE VISION THERAPY AS A COVERED SERVICE IN MANAGED CARE

MARK R. WRIGHT, O.D.

Abstract

The management of Managed Care compromises the quality of patient care. These compromises harm patients needing vision therapy. The compromises are: interfering with the doctor-patient relationship, preventing patients from receiving care, delaying care and cost shifting.

Key Words

quality care, compromised care, third party, major medical, Managed Care, ERISA, doctor-patient relationship, cost shifting

We should not fight to include vision therapy in third party coverage because the management of Managed Care compromises quality patient care. Third party Managed Care is not new. Optometrists providing vision therapy services have dealt with Managed Care in its many forms for decades. Handling patients covered by governmental agencies, private pay insurance companies and ERISA companies have been part of everyday practice. With such a long history, the strengths and weaknesses of Managed Care are known. Over time, the management of Managed Care by third parties often results in compromised patient care. These compromises harm patients needing vision therapy. Third party major medical Managed Care companies compromise care by interfering with the doctor-patient relationship, preventing patients from receiving care, delaying care and cost shifting.

Forbidding participating providers from administering certain procedures interferes with the doctor-patient relationship. Some major medical companies dictate that vision therapy will not be provided to its covered members. This is different than just denial of vision therapy as a covered service. In this situation, panel doctors are prohibited from delivering vision therapy services to patients. This occurs because third parties are beyond simple decisions of coverage or non-coverage. In today's arena, third party medical directors decide which care can be delivered and how it can be delivered. In an attempt to control finances and image by creating a force of look-alike providers, medical directors dictate what used to be independent decisions between doctors and patients. The result is an invasion of the traditional doctor-patient relationship by third party medical directors.

This invasion of the doctor-patient relationship forces doctors into the no-win situation of either accepting decisions made by third party medical directors which may be in opposition to the best interest of quality patient care or going against the medical director's decisions, jeopardizing provider status. Go along with the major medical director and the patient is prevented from receiving needed care. Oppose the medical director and lose provider status, thereby preventing even more patients from receiving your care. Neither of these options improves the quality of patient care. Both options decrease quality patient care. Both options exist only because of the attempt by third parties to manage Managed Care.

Managed Care closed panels prevent patients from receiving quality care. In closed panels, care is covered when patients see panel doctors and is not covered (or covered at a reduced rate) when patients seek care outside the panel. The incentive is to see a panel doctor. What happens when the best doctor to treat a condition is not a panel doctor? What happens when the best doctor to treat the condition is not permitted to be a panel doctor because of allowable discrimination? In the real world of Managed Care, patients are limited by the list of panel doctors. If care is rendered at all, patients often suffer by receiving care from less than the best. Why are there closed panels? Because third parties manage Managed Care.

Claim denials can compromise patient care. Patients pay attention to claim denials. For example, if a claims administrator for a Managed Care company tells a patient a procedure is experimental, therefore not a covered procedure, then it must be true. It doesn't matter that vision therapy is not considered experimental at any of the state boards of optometry, state col-

leges or universities, hospital settings, or governmental agencies where it is administered. The third party denied the claim so something must be wrong with vision therapy. Because of claim denials, the doctor's prescribed treatment plan is often jeopardized. This results in patient care delays while the provider attempts to reason with the third party. In many cases, care is simply terminated when patients believe inaccurate information communicated by major medical companies. Since claim denial is unique to Managed Care, it is irrelevant if claim denial is reasonable or unreasonable based on Managed Care coverage. The result of claim denial is compromised patient care.

Claim denials impact beyond the claim. Patients may permanently leave the practice over a claim denial. Doctors understand that just because a third party does not cover a procedure does not mean the procedure would not help the patient. Many decisions by third parties and employers purchasing third party plans are simply economic (e.g., one drug is on a formulary and another is not simply because the third party negotiated a better deal). On the other hand, many patients believe if a third party does not cover a procedure, something is wrong with the procedure; therefore something is wrong with the doctor doing the procedure.

When patients find out vision therapy is not covered, they often believe that if it was a legitimate service it would be covered. This causes a credibility problem between the patient and the doctor. The patient, along with friends and family, may choose another provider because of this credibility issue. This compromises care. Why are there claim denials? Because third parties manage Managed Care.

Third party Managed Care companies compromise quality care by delaying patient care. Patients often do not want to begin treatment until they know that coverage is available. In making decisions, major medical companies request additional information, second opinions, "peer" review, ... the list goes on and on. All of these are legitimate functions of a fiscally responsible company. However, the practical result is delayed patient care. These management issues often delay vision therapy a minimum of 30 days. Patients with major medical coverage begin therapy sooner and, therefore, finish therapy sooner. Delays caused by third party management systems compromise quality patient care. Again, management of Managed Care by third parties is the source of the problem.

Third party Managed Care companies compromise quality care by cost shifting tactics. All third parties require additional work to process claims. All third parties shift as much of this work as possible onto the backs of providers. The popular mantra of Managed Care is true: "More work for less pay." What results from decreased provider reimbursement and increased provider costs? Patients ultimately suffer as a result of this arrangement. With limited funds available, doctors must hire staff to handle the additional work required by third parties. Every person hired to do paper work is one less person able to assist in delivering patient care. Managed Care is driving doctors to see more people with fewer staff in less time. Fewer people available to provide patient care compromises quality care. Fewer dollars available limits equipment upgrades and equipment purchases. The culprit again is Managed Care.

When third parties increase the cost of providing care in order to improve the ability to sell contracts, this form of cost shifting does nothing to improve quality care. As an example, one national third party vision care program audits providers as a matter of routine. Audits occur, not because of suspected problems, simply because it is your turn. With a finite number of hours in each work week, any audit causes office disruption. Files have to be pulled, patients currently in the office have to be protected, staff and doctors have other work they could be doing, yet the demands of the auditor require attention. When questioned about this policy, the executive director of this company took the position that it is a small price for optometrists to pay to see patients covered by the program.

The issue of cost shifting by third parties is significant. Who pays for the cost shifting? Since participating providers cannot raise fees to patients covered by third parties, it is patients without third party coverage who pay higher fees than necessary to subsidize Managed Care programs. This is not fair.

Are compromises caused by Managed Care simply procedural issues which should be endured, or are these problems symptomatic of an irresolvable problem? One way to answer the question is to ask if the problem is getting better or worse. My observation is it is getting worse. Even though third party major medical programs are not intentionally attempting to compromise care, it is simply the nature of the beast. In order for third parties to manage Managed Care, compromises occur. With the increasing number of ERISA programs and the shifting from indemnity to ERISA, the problems of third parties compromising quality care for vision therapy patients continue to increase. In order to provide the highest level of quality care to patients, optometrists should work to have vision therapy eliminated from third party major medical Managed Care coverage.

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Background

The national elections of 1996 witnessed the end of the discussion and debate phase on issues and problems of the nation and the states. The present marks the beginning of major actions on at least two health fronts: Medicare and Medicaid. The compelling arguments to shrink the growth of these two key health programs have been essentially agreed to by both major political parties. For Medicare, the only open questions will be how quickly and how much will growth be curtailed. For Medicaid, changes will come that are both structural and financial, with more decentralization away from the federal government and to the authority of the states. This will follow the pattern of welfare decentralization with increased flexibility to the states. This restructuring of intergovernmental responsibilities in Medicaid is occurring simultaneously with the significant impact of market place forces of Managed Care. Medicare, too, will be influenced by Managed Care, but to a far lesser extent than Medicaid.

Comment is in order about a "displacement" phenomenon that has just begun as a result of major legislative actions enacted in 1996. Congress has mandated a series of insurance coverages that have been widely reported in the media. They are: stated minimum hospital stays for obstetrical deliveries, ability to move health insurance coverage from one place of employment to another (portability), a qualified assurance that coverage for pre-existing conditions will be sustained, and, finally, a major breakthrough in the extension of basic coverage for mental health problems. All four of these mandates will assuredly escalate the costs of health insurance coverage regardless of the delivery mode (HMOs, private practitioners, etc.). It is widely acknowledged that the mental health provision constitutes the principal reason for the expected cost escalation of speculative magnitude. Insurance carriers and medical service organizations are currently seeking to "shrink" existing coverages in order to cushion the expected cost increases occasioned by the four new mandates cited above.

That there is a continued increase in the number of uninsured is not in doubt. Though the magnitude of those without health coverage is reliably estimated to be 41.5 to 43 million persons, the fastest growing component of the uninsured is among children —about half of the total.[1] It is surely significant to observe that the incremental changes in health policy (the four new legislative mandates cited above) do not, in any way, relate to universal entitlement nor specifically to the nation's children. Indeed, there is a serious void in national social policy relating to children's health. Moreover, the recently enacted welfare reform compounds the intensity of the critical problem facing children.[2,3] I believe that the strategy to ensure that vision therapy is an included service in private and government health plans, mandate that several actions be taken.

Classified Outcomes Studies

It is essential that the clinical leadership of the profession embark upon a serious and sustained analysis of clinical outcomes as a result of utilizing vision therapy as a rehabilitative and/or therapeutic intervention for a series of carefully classified and defined binocular vision problems. Absent these outcome studies, any meaningful presentations to insurance carriers, HMOs and medical service organizations will, in my view, be relatively fruitless. Clinical outcome studies, condition to condition, disease to disease, are the emerging mechanisms that drive, and will continue to drive, the reimbursement systems. Anecdotal observations and unclassified studies, no matter how well intentioned, will not suffice and will not be acceptable. It is my personal view that clinical task forces of O.D.s, together with health service specialists, can be (and essentially must be) organized and sustained to conduct appropriately classified outcome studies. The academic institutions should be "partners" in these outcome studies in order to provide the standing that will be needed.

Classified Utilization Studies

Just as important as outcome studies are those that are related to utilization. These, too, must be carefully classified in terms of defined functional vision problems and specified protocols of rehabilitative and therapeutic interventions. Sound and quantified "treatment plans," condition by condition, rather than anecdotal utilization estimates are essential.

These two requisites, outcome studies and utilization studies, are of paramount importance in presenting an organized case for vision therapy as a clinical rehabilitative methodology for the range of carefully classified functionally based visual conditions. Our profession cannot "fight" for VT as a covered service absent these essential studies.

Conclusion

In suggesting the title for this article, the editor of this *Journal* was quite correct. "Whom would we fight?" To me, the answer is clear. The first order of business is to challenge those who are indifferent (and some among us even hostile) to the scientific and professional value of that modality, vision therapy, which can effectively and efficiently abate so many visual disabilities. It is within our intellectual and academic capacity and within our scope of professional responsibility. We can professionally fight no others unless we are resolute among ourselves as doctors of optometry.

"Why should we fight?" Without resolution among ourselves, we cannot fight and, indeed, we shouldn't. But we should fight because vision therapy is an avowed, legitimate and valuable part of optometry. Indeed, it constitutes significant subject matter in the didactic and clinical curricula in every one of optometry's schools and colleges; it is an area in which students must show competence in the National Board's testing; it is represented in the American Academy of Optometry (AAO) and the American Optometric Association (AOA); and two other venerable organizations, the Optometric Extension Program Foundation (OEP) and the College of Optometrists in Vision Development (COVD), are devoted to its continuance and enhancement. Articles regarding vision therapy appear in the Journals of the AAO and AOA, and OEP and COVD publish Journals that are exclusive to VT and related topics. Further, there is an impressive literature in the form of textbooks that has evolved regarding VT[4-7] and related topics.[8,9] Consequently, to not fight would in my respectful view, be anti-intellectual, and would be to turn our backs not only on our heritage, but to deprive these services to numbers of deserving children and adults alike. These will be the ultimate beneficiaries of our fight.

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