Prior Authorization Review Panel  
MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review. Policies submitted without this form will not be considered for review.

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<tr>
<th>Plan: Aetna Better Health</th>
<th>Submission Date: 10/01/2018</th>
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<tr>
<td>Policy Number: 0078</td>
<td>Effective Date:</td>
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<td>Policy Name: Learning Disabilities, Dyslexia, and Vision</td>
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Type of Submission – Check all that apply:
- ☑ New Policy*
- □ Revised Policy
- □ Annual Review – No Revisions

*All revisions to the policy must be highlighted using track changes throughout the document. Please provide any clarifying information for the policy below:

CPB 0078 Learning Disabilities, Dyslexia, and Vision

Policy is new to Aetna Better Health of Pennsylvania.

Name of Authorized Individual (Please type or print): Dr. Bernard Lewin, M.D.

Signature of Authorized Individual: [Signature]

[www.aetnabetterhealth.com/pennsylvania]
Learning Disabilities, Dyslexia, and Vision

Number: 0078

*Please see amendment for Pennsylvania Medicaid at the end of this CPB.

Policy

Aetna considers visual training and behavioral vision therapy for members with dyslexia and/or learning disabilities experimental and investigational. As indicated in a policy statement developed jointly by the American Academy of Pediatrics (AAP), American Academy of Ophthalmology (AAO), the American Association for Pediatric Ophthalmology and Strabismus (AAPOS), and the American Association of Certified Orthoptists (2009), there is no known eye or visual cause for dyslexia and learning disabilities and no effective visual treatment. Multi-disciplinary evaluation and management must be based on proven procedures demonstrated by valid research.

Aetna considers the use of colored filtered/tinted lenses experimental and investigational for treatment of dyslexia or learning disabilities because their effectiveness for these indications has not been established.

Policy History

Last Review
05/03/2018
Effective: 11/29/1995
Next Review: 01/24/2019

Definitions

Additional Information

Clinical Policy Bulletin Notes
See also

CPB 0321- Visual Perception Training and Vision Restoration Therapy (../300_399/0321.html)
and CPB 0489 - Vision Therapy (../400_499/0489.html).

Background

The issue of learning disorders, including dyslexia, has become a matter of increasing personal and public concern. Inability to read and comprehend is a major obstacle to learning and may have far-reaching social and economic implications. Concern for the welfare of children with dyslexia and learning disabilities has lead to a proliferation of diagnostic and remedial treatment procedures, many of which are controversial. This policy statement addresses these issues, which are of importance to affected individuals, their families, teachers, doctors, allied health personnel, and society.

A broad-based consensus of educators, psychologists, and medical specialists has recommended that individuals with dyslexia or related learning disabilities should receive (i) early comprehensive educational, psychological, and medical assessment; and (ii) educational remediation combined with appropriate psychological and medical treatment. Although it is obvious some children do not read well because they have trouble seeing, research has shown that the majority of children and adults with reading difficulties experience a variety of language defects that stem from complex, altered brain morphology and function, and that the reading difficulty is not due to altered visual function per se.

However, in spite of these facts, a certain number of children who experience reading difficulty may also experience a treatable visual difficulty in addition to their learning dysfunction. Doctors can identify the majority of those who have reduced visual acuity. However, in a small percentage of
children, a visual abnormality such as farsightedness may not be detected during pediatric office screening procedures. Therefore, doctors who evaluate children for reading difficulties should consider referral to an ophthalmologist familiar with children's eye problems.

In their position statement on learning disabilities, dyslexia, and vision, the American Academy of Pediatrics (AAP), American Academy of Ophthalmology (AAO), and American Association for Pediatric Ophthalmology and Strabismus (AAPOS) concluded the following:

1. Those considered to be at risk for learning disabilities, dyslexia or attention defects, should be thoroughly assessed by both educational and psychological specialists.

2. Learning disabilities, including dyslexia and other forms of reading or academic under-achievement, require a multidisciplinary approach to diagnosis and treatment, involving educators, psychologists, and physicians. Research has established that the basis of dyslexia and other specific learning disabilities is within the central nervous system and is multi-factorial and complex.

3. Unfortunately, however, it has become common practice among some to attribute reading difficulties to one or more subtle ocular or visual abnormalities. Although the eyes are obviously necessary for vision, the brain interprets visual symbols. Therefore, correcting subtle visual defects can not alter the brain's processing of visual stimuli. Children with dyslexia or related learning disabilities have the same ocular health statistically, as children without such conditions. There is no peripheral eye defect that produces dyslexia or other learning disabilities and there is no eye treatment that can cure dyslexia or associated learning disabilities.

4. Ocular defects should be identified as early as possible and when correctable, managed by the ophthalmologist. If
no ocular defect is found, the child should be referred to a primary care physician to coordinate required multi-disciplinary care.

5. Eye defects, subtle or severe, do not cause reversal of letters, words, or numbers. No scientific evidence supports claims that the academic abilities of dyslexic or learning disabled children can be improved with treatment based on a) visual training, including muscle exercises, ocular pursuit, tracking exercises, or “training” glasses (with or without bifocals or prisms); b) neurological organizational training (laterality training, crawling, balance board, perceptual training), or c) tinted or colored lenses. Some controversial methods of treatment result in a false sense of security that may delay or even prevent proper instruction of remediation. The expense of these methods is unwarranted, and they can not be substituted for appropriate remedial educational measures. Claims of improved reading and learning after visual training, neurological organization training, or use of tinted or colored lenses, are typically based upon poorly controlled studies that rely on anecdotal information or testimony. These studies are frequently carried out in combination with traditional educational remedial techniques.

6. Since remediation may be more effective during the early years, early diagnosis is paramount. The educator ultimately plays the key role in providing help for the learning disabled or dyslexic child or adult.

In a review on the applicability and effectiveness of eye exercises, Rawstron et al (2005) noted that eye exercises have been purported to improve a wide range of conditions such as vergence problems, ocular motility disorders, accommodative dysfunction, amblyopia, learning disabilities, dyslexia, asthenopia, myopia, motion sickness, sports performance, stereopsis, visual field defects, visual acuity, and general well-being. Small controlled studies as well as a large number of case reports support the treatment of convergence
insufficiency. Less robust evidence indicates visual training may be useful in developing fine stereoscopic skills and improving visual field remnants following traumatic brain injury. The authors concluded that, as yet, there is no clear scientific evidence published in the mainstream literature supporting the use of eye exercises in the remainder of the areas reviewed, and their use therefore remains controversial.

A technology assessment of vision therapy by the Institute for Clinical Systems Improvement (ICSI, 2003) concluded that available studies provide inadequate evidence of the effectiveness of vision therapy for learning disabilities.

Irlen syndrome (also known as scotopic sensitivity syndrome) is a visual-perception dysfunction that is thought to contribute to dyslexia and learning disabilities. The syndrome was identified by California psychologist Helen Irlen, who published a book called Reading by the Colors, and, since 1983, has been marketing red and blue non-prescription eyeglasses to dyslexics. A number of Irlen Clinics have been opened around the country.

Skottun and Skoyles (2008) stated that it has been suggested that dyslexia is the result of a deficit in rapid sensory processing. Several methods have been used to assess this with regards to vision: temporal contrast sensitivity, visual persistence, temporal order judgments, temporal acuity, and coherent motion. These investigators examined these methods and found that several of them -- visual persistence, temporal order judgments, and coherent motion -- are poorly suited to evaluating the dynamic aspects of vision. In the case of temporal contrast sensitivity and temporal acuity the results from these tests either are conflicting or provide little support for an impairment. As far as vision is concerned there is little evidence for a specifically temporal deficit.
Kruk et al (2008) noted that the potential role of visual processing deficits in reading difficulty was brought to public attention by claims that a large proportion of children with dyslexia suffer from a perceptual dysfunction currently referred to as Meares-Irlen syndrome (MISViS). A previous study showing that visual perceptual measures involving visual memory and discrimination predict independent variance in reading achievement provided a basis to examine their relationships with the diagnostic criteria of MISViS. This study examined these visual processing characteristics in 8- to 10-year old children (n = 36), half of whom were experiencing reading difficulty. Children were assessed for MISViS by Irlen screeners; approximately 50% of the participants in each group were positively identified. Concurrent performance on standardized visual processing tests showed that while a positive diagnosis of MISViS is not indicative of reading ability, nor in particular of a visual-processing deficit subtype identified by Watson and Willows, MISViS can indicate visual processing difficulties potentially related to visual attention inefficiency.

Hawelka and Wimmer (2008) stated that in 2 previous studies they assessed the difficulty of dyslexic readers with letter string processing by using variants of the partial report paradigm, which requires report of a letter name in response to a position cue. The poor dyslexic performance was interpreted as evidence for a visual-attentional deficit of dyslexic readers. In the present study, these researchers avoided verbal report by using a task that only required the detection of pre-defined targets (e.g., letters or pseudo-letters) in strings. On this purely visual task, the dyslexic readers did not differ from non-impaired readers. This finding speaks against a basic visual-attentional deficit; rather it suggests that the dyslexic deficit on partial report paradigms stems from a problem in establishing a string representation which includes position and name codes.
Pieh and Lagrèze (2008) stated that Irlen therapy, visual training, training of ocular motor control, and the correction method of HJ Haase represent a diversity of treatment methods that are mainly aimed at dyslexia, fatigue while reading, and general lack of concentration. These investigators summarized the theoretical background of these methods, treatment approaches, and related clinical trials. None of these methods, because of incorrect theoretical concepts and an attempt to simplify the underlying causes, was found to have a specific influence on the patients' complaints. The absence of specific therapeutic effects, the high costs, and time expenditure required should discourage practitioners from recommending these methods.

von Suchodoletz (2010) stated that a wide variety of methods based on very different concepts are available to treat children with dyslexia. Basically, symptomatic and causal principles can be distinguished. Among the symptomatic methods are systematic programs based on learning theory, in which reading and spelling or precursors of these abilities are directly trained. Causal methods promise pronounced and persistent improvement of reading and spelling abilities through elimination of the postulated reason underlying the learning disabilities. Among the causal methods are treatment programs that train low-level functions. Such training is based on the assumption that deficits of auditory, visual or kinesthetic perception, of motor skills or of the coordination of cerebral functional areas are at the bottom of specific learning disabilities. Concepts of other causal methods act on the assumption that learning processes are blocked or that abnormal medical conditions or psychiatric disorders constitute the background of dyslexia. The author reviewed treatment concepts for children with dyslexia in the German-speaking countries and the methods of treatment derived from the different concepts. It is emphasized that effectiveness is proven only for symptomatic training programs but not for causal methods.
Quercia et al (2013) noted that developmental dyslexia affects almost 10% of school-aged children and represents a significant public health problem. Its etiology is unknown. The consistent presence of phonological difficulties combined with an inability to manipulate language sounds and the grapheme-phoneme conversion is widely acknowledged. Numerous scientific studies have also documented the presence of eye movement anomalies and deficits of perception of low contrast, low spatial frequency, and high-frequency temporal visual information in dyslexics. Anomalies of visual attention with short visual attention spans have also been demonstrated in a large number of cases. Spatial orientation is also affected in dyslexics who manifest a preference for spatial attention to the right. This asymmetry may be so pronounced that it leads to a veritable neglect of space on the left side. The authors concluded that the evaluation of treatments proposed to dyslexics whether speech or oriented towards the visual anomalies remains fragmentary.

Ramsay et al (2014) stated that dyslexia affects 5% to 8% of the population of the Western world. While reading, different eye movements are required. Compared to other persons, dyslexics have more and longer fixations, shorter saccade amplitude, a higher percentage of regression, and more fixation disparity when reading. In non-reading situations, dyslexics do not have more binocular problems than others. These researchers examined if computerized orthoptic vergence training could improve reading ability for dyslexic children. The study was conducted at an elementary school exclusively for dyslexic children. A total of 12 subjects, aged 13 to 14 years, were trained with RetCorr, a computerized vergence training program. Reading speed was assessed before and after treatment. The results were compared with an age-matched control group. The dyslexic subjects conducted on average 11.75 sessions (± 2.53 standard deviation [SD]) of orthoptic training over a 5-week period. On average, the number of words read per minute before training were 87.83 (± 16.80 SD) and after training 95.58 words (±
The difference was statistically significant ($p = 0.0066$). In the control group, the change was from 85.00 ($\pm 19.68$ SD) words to 89.37 words ($\pm 19.71$ SD) over the same time period. This difference was not significant ($p = 0.1235$). The authors concluded that most scientists agreed that dyslexia is mainly a phonological impairment. Nevertheless, the results showed that vergence treatment might help dyslexics. They stated that larger studies are needed to provide guidance in this area.

Creavin and co-workers (2015) explored associations between specific learning disorder with impairment in reading (dyslexia) and ophthalmic abnormalities in children aged 7 to 9 years. Cross-sectional analysis was performed on cohort study data from the Avon Longitudinal Study of Parents and Children. Reading impairment was defined according to Diagnostic and Statistical Manual of Mental Disorders, 5th Edition criteria. Children who achieved greater than 2 SD below the mean in the Neale Analysis of Reading Ability Scale II and level less than 4 in non-mathematical national key stage 2 tests were defined as having severe reading impairment (SRI); children with blindness or IQ less than 70 were excluded. Data were available for 5,822 children, of whom 172 (3%) met the criteria for SRI. No association was found between SRI and strabismus, motor fusion, sensory fusion at a distance, refractive error, amblyopia, convergence, accommodation, or contrast sensitivity. Abnormalities in sensory fusion at near were mildly higher in children with SRI compared with their peers (1 in 6 versus 1 in 10, $p = 0.08$), as were children with stereo-acuity worse than 60 seconds/arc (1 in 6 versus 1 in 10, $p = 0.001$). The authors concluded that 4 of every 5 children with SRI had normal ophthalmic function in each test used. A small minority of children displayed minor anomalies in stereo-acuity or fusion of near targets. They stated that the slight excess of these children among those with SRI may be a result of their reading impairment or may be unrelated. These investigators found no evidence that vision-based treatments would be useful to help children with SRI.
Yeari and colleagues (2017) noted that a controversy has recently developed regarding the hypothesis that developmental dyslexia may be caused, in some cases, by a reduced visual attention span (VAS). To examine this hypothesis, independent of phonological abilities, researchers tested the ability of dyslexic participants to recognize arrays of unfamiliar visual characters. Employing this test, findings were rather equivocal: dyslexic participants exhibited poor performance in some studies but normal performance in others. The present study explored 4 methodological differences revealed between the 2 sets of studies that might underlie their conflicting results. Specifically, in 2 experiments these researchers examined whether a VAS deficit is (i) specific to recognition of multi-character arrays as wholes rather than of individual characters within arrays, (ii) specific to characters' position within arrays rather than to characters' identity, or revealed only under a higher attention load due to (a) low-discriminable characters, and/or (b) characters' short exposure. Furthermore, in this study these investigators examined whether pure dyslexic participants who do not have attention disorder exhibit a reduced VAS. Although co-morbidity of dyslexia and attention disorder is common and the ability to sustain attention for a long time plays a major role in the visual recognition task, the presence of attention disorder was neither evaluated nor ruled out in previous studies. The authors concluded that the findings of this study did not reveal any differences between the performance of dyslexic and control participants on 8 versions of the visual recognition task. They stated that these findings suggested that pure dyslexic individuals do not present a reduced visual attention span.

Colored Filtered/Tinted Lenses:

There is considerable controversy over whether the treatment of dyslexia with colored lenses is effective, or whether the Irlen syndrome truly exists; Available evidence is of poor quality, with inconsistent results.
A systematic evidence review (Albon et al, 2008) concluded that there is insufficient evidence of the effectiveness of colored lenses for dyslexia.; "Meta-analysis and qualitative assessment of eight included RCTs did not show that the use of coloured filters led to a clear improvement in reading ability in subjects with reading disability. It was not possible to comment on whether coloured filters can improve symptoms of visual stress that may be associated with reading disability due to a lack of available evidence. Based on the evidence obtained from this systematic review there can be no major implications for current practice in the treatment of reading disability. It remains a possibility that there exists a subgroup of people who may experience an improvement in reading through the use of coloured filters, while others find that there is no beneficial effect. Further well-designed research may generate clearer results”.

A policy statement issued by the AAP's Committee on Children with Disabilities, AAO, and AAPOS (1992) stated that “visual problems are rarely responsible for learning difficulties. No scientific evidence exists for the efficacy of eye exercises, vision therapy, or the use of special tinted lenses in the remediation of these complex pediatric neurological conditions”.

In a joint statement on learning disabilities, dyslexia, and vision, the AAP, AAO, AAPOS, and the American Association of Certified Orthoptists (2009) stated that most experts believe that dyslexia is a language-based disorder. Vision problems can interfere with the process of learning; however, vision problems are not the cause of primary dyslexia or learning disabilities. Scientific evidence does not support the effectiveness of eye exercises, behavioral vision therapy, or special tinted filters or lenses for improving the long-term educational performance in these complex pediatric neurocognitive conditions. Diagnostic and treatment approaches that lack scientific evidence of efficacy, including
eye exercises, behavioral vision therapy, or special tinted filters or lenses, are not endorsed and should not be recommended.

Palomo-Alvarez and Puell (2013) stated that possible beneficial effects of yellow-tinted spectacle lenses on binocular vision, accommodation, oculomotor scanning, reading speed and visual symptoms were assessed in children with reading difficulties. These researchers performed a longitudinal prospective study in 82 non-dyslexic children with reading difficulties in grades 3 to 6 (aged 9 to 11 years) from 11 elementary schools in Madrid (Spain). The children were randomly assigned to 2 groups: (i) a treatment (n = 46) and (ii) a without-treatment group (n = 36). Children in the treatment group wore yellow spectacle lenses with best correction if necessary over 3 months (in school and at home). The tests were first undertaken without the yellow filter. With best spectacle correction in each subject, measurements were made of: distance and near horizontal heterophoria, distance and near horizontal fusional vergence ranges, the accommodative convergence/accommodation (AC/A) ratio, near point of convergence (NPC), stereo-acuity, negative relative accommodation (NRA) and positive relative accommodation (PRA), monocular accommodative amplitude (MAA), binocular accommodative facility (BAF), oculomotor scanning, and reading speed (words per minute). The Convergence Insufficiency Symptom Survey (CISS) questionnaire was completed by all children. After the 3-month period, measurements were repeated with the yellow lenses (treatment group) or without the yellow lenses (without-treatment group) but with refractive correction if needed. Over the 3 months, the 2 groups showed similar mean changes in the variables used to assess binocular vision, accommodation, oculomotor scanning, and reading speed. However, mean relative changes in convergence insufficiency symptoms differed significantly between the groups (p = 0.01). The authors concluded that no effects of wearing yellow spectacles
emerged on binocular vision, accommodation, oculomotor scanning, and reading speed in children with reading difficulties. The yellow filter had no effect even in children with low MAA and BAF. The reduction in visual symptoms observed in children with reading difficulties using the yellow filters was clinically insignificant. Ritchie and colleagues (2011) examined the effectiveness of Irlen colored overlays for alleviating reading difficulties ostensibly caused by Irlen syndrome, a proposed perceptual disorder with controversial diagnostic status. A total of 61 schoolchildren (aged 7 to 12 years) with reading difficulties were assessed by an Irlen diagnostician. These researchers used a within-subject study design to examine differences in reading rate across 3 conditions: (i) using an overlay of a prescribed color; (ii) using an overlay of a non-prescribed color; and (iii) using no overlay. In a subset of 44 children, all of whom had a diagnosis of Irlen syndrome, these researchers also used a between-group design to test the effects of Irlen colored overlays on a global reading measure. The Irlen diagnostician diagnosed Irlen syndrome in 77% of poor readers. These researchers found no evidence for any immediate benefit of Irlen colored overlays as measured by the reading-rate test or the global reading measure. The authors concluded that the findings of this study suggested that Irlen colored overlays did not have any demonstrable immediate effect on reading in children with reading difficulties.

Kusano and associates (2015) stated that Irlen syndrome is a proposed perceptual processing disorder characterized by visual distortions while reading. Patients with this syndrome may experience light sensitivity, visual stress, and other related problems such as dyslexia. Tinted lenses and colored overlays have been designed to help individuals with the symptoms of Irlen syndrome. However, there is still debate over the effectiveness of these interventions and whether this syndrome actually exists. In this report, these investigators described a case involving an 8-year old girl with dyslexia who
experienced severe visual hyper-sensitivity and whose symptoms completely resolved after wearing tinted lenses. While it is possible that she experienced a psychogenic visual disturbance that was relieved because of the placebo effect, the clinical course of her symptoms matched the findings previously described by Irlen. The patient was unable to read without tinted lenses. With tinted lenses, she could read at the appropriate age level, suggesting that her difficulty was due to a problem in optical information processing. The concepts underlying Irlen syndrome are vaguely defined, and several groups insist that the visual stress associated with this syndrome might be responsible for dyslexia as well as other disorders. These ambiguous criteria may be responsible for the criticism over the validity of this condition. Although this was only an anecdotal case, the patient exhibited the core functional deficit described in Irlen syndrome and showed a dramatic improvement with tinted lenses; therefore, this case may facilitate investigations into the mechanism underlying Irlen syndrome, if it actually exists. The authors concluded that although further studies are needed to confirm the validity of this syndrome and the therapeutic approach, Irlen syndrome should be recognized as a disorder since its symptoms can be easily relieved by wearing tinted lenses or color filters.

Vision Therapy for the Treatment of Learning Disabilities:

Rucker and Phillips (2017) stated that traditional orthoptic therapy used by ophthalmologists, orthoptists, and optometrists is directed at improving visual acuity, ocular alignment, or both. For example, convergence exercises are used to treat convergence insufficiency (CI). However, other forms of "vision therapy" are directed at improving "visual processing and efficiency". The therapeutic regimen often entails repetitive ocular motor tasks performed during multiple office visits with a behavioral optometrist. These ocular motor tasks are used to treat diverse conditions such as learning disabilities, poor reading ability, dyslexia, and attention-deficit hyperactivity disorder (ADHD). These investigators reviewed
the evidence regarding the effectiveness of therapy directed at ocular motility for the treatment of multiple conditions. Randomized, controlled, double-masked studies showed that convergence exercises reduced symptoms and improved signs of CI in otherwise healthy patients. However, the most effective convergence tasks, and the optimal duration and frequency of these tasks, remain unknown. Patients with learning disabilities, poor reading ability, dyslexia, or ADHD do not consistently have unique ocular motor deficits. Patients who acquire ocular motor deficits do not develop these conditions. There are no randomized controlled trials (RCTs) that showed treatment consisting of repetitive ocular motor tasks improved learning disabilities, reading, dyslexia, or ADHD. The authors concluded that convergence exercises effectively treated CI in healthy patients; the optimal treatment regimen is unknown. Moreover, they stated that there is insufficient evidence to recommend "vision therapy" for the treatment of learning disabilities, impaired reading, dyslexia, or ADHD.

CPT Codes / HCPCS Codes / ICD-10 Codes

Information in the [brackets] below has been added for clarification purposes. Codes requiring a 7th character are represented by "+":

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Amendment to
Aetna Clinical Policy Bulletin Number:
0078 Learning Disabilities, Dyslexia, and Vision

There are no amendments for Medicaid.

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New 10/01/2018