ACCOMMODATIVE DYSFUNCTION
ICD-9-CM: 367.53

DEFINITION:
A non-presbyopic, non-refractive sensory and neuromuscular anomaly of the visual system characterized by inadequate accommodative accuracy and/or stability, reduced accommodative facility and/or flexibility, reduced amplitude of accommodation, inadequate sustenance of accommodation, inertia of accommodation, or accommodative spasm.

SIGNS AND SYMPTOMS:
The symptoms and signs associated with accommodative dysfunction are related to performance of prolonged visually demanding near-centered tasks. They may include, but are not limited to, the following:

- Transient blurred vision (ICD: 368.12)
- Diminished accuracy with increased time on task
- Abnormal postural adaptation/abnormal working distance (ICD: 781.9)
- Inaccurate/inconsistent work product
- Reduced efficiency and productivity
- Asthenopia (ICD: 368.13)
- Orbital pain (ICD: 379.91)
- Inaccurate/inconsistent visual attention/concentration and/or awareness
- Increased distractibility
- Difficulty sustaining near visual function
- Abnormal general fatigue

DIAGNOSTIC FACTORS:
Accommodative dysfunction is characterized by one or more of the following diagnostic findings:

- Low accommodative amplitude relative to age
- Reduced accommodative facility at near and/or far
- Reduced accommodative flexibility at near and/or far
- Reduced accommodative stability at near and/or far
- Reduced ranges of relative accommodation
- Abnormal lag of accommodation
- Unstable accommodative findings

Additional testing may be appropriate as part of the differential diagnostic workup for accommodative dysfunction in order to rule out or define other concurrent medical conditions and to differentiate associated visual conditions.

THERAPEUTIC MANAGEMENT CONSIDERATIONS:
The doctor of optometry determines appropriate diagnostic and therapeutic modalities, and frequency of evaluation and follow-up, based on the urgency and nature of the patient's conditions and unique needs. The management of the case and duration of treatment would be affected by:

- The severity of symptoms and diagnostic factors including onset and duration of the problem
- The implications of associated visual conditions
- Implications of patient's general health and effects of medications taken
- Etiological factors
- Extent of visual demands placed upon the individual
- Patient compliance and involvement in the prescribed therapy regimen
- Type, scope, and results of prior interventions
ACCOMMODATIVE DYSFUNCTION (CONT'D.)

PRESCRIBED TREATMENT REGIMEN
A percentage of cases are successfully managed solely by the prescription of therapeutic lenses and/or prisms. Most accommodative dysfunctions, however, require orthoptics/vision therapy. Optometric vision therapy for accommodative dysfunction usually incorporates the prescription of specific treatments in order to:

- Normalize accommodative amplitude relative to age
- Normalize ability to sustain accommodation
- Normalize relative ranges of accommodation
- Normalize accommodative facility relative to age
- Normalize accommodation flexibility relative to age
- Normalize accommodative stability relative to age
- Normalize accommodative/convergence relationship
- Integrate accommodative function with information processing

DURATION OF TREATMENT:
The following treatment ranges are provided as a guide for third-party claims processing and review purposes. Treatment duration will depend upon the particular patient’s condition and associated circumstances. When duration of treatment beyond these ranges is required, documentation of the medical necessity for additional treatment services may be warranted.

- The most commonly encountered accommodative dysfunction usually requires 24 to 32 hours of office therapy.
- Uncomplicated accommodative dysfunction characterized only by a transient loss of accommodative function: up to 8 hours of office therapy.
- Accommodative dysfunction complicated by:
  - a reduced amplitude of facility for age: up to an additional 12 hours of office therapy
  - accommodative convergence anomalies: up to an additional 16 hours of office therapy
  - other diagnosed visual anomalies: may require additional office therapy
  - associated conditions such as stroke, head trauma, and/or other systemic conditions: may require substantially more office therapy

FOLLOW-UP CARE:
At the conclusion of the active treatment regimen, periodic follow-up evaluation should be provided at appropriate intervals. Therapeutic lenses may be prescribed during or at the conclusion of active vision therapy for the maintenance of long-term stability.