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2018 - March **Billing Medical vs. Routine Eye Exams**

This age-old problem continues to be the plight of doctors. What we once thought was just an issue for optometry and vision plans has worked its way into the primary care general practitioner's office, too. We both have patients who have "routine" or "wellness" visit coverage carrying different co-pays and deductibles. And the battle we both fight is when a patient presents with medical conditions, yet the patient expects the visit to be billed as "routine." How do we handle it? Is there a right answer?

The handling of the situation is as much a PR issue as it is a regulatory one. The fact is, there are no straightforward rules guiding us either way. But there are factors that influence our decision making. From a provider's perspective, we will typically be reimbursed better (usually significantly better) if the visit is billed to the medical payer. Our rationale then becomes, "If I'm monitoring for diabetic retinopathy, my reimbursement should be better." The patient's perspective is very different, "My routine visit has no co-pay while my medical care has a $5000 deductible. I want this exam for new glasses to be billed as routine, and it doesn't matter what else is going on."

I think these are both very rational arguments. And we can all very strongly argue from the doctor's side. But I want to take this from the patient's position. Let's consider a couple comes into the office for their "yearly eye exams." Neither are having any significant issue; they simply want to update their glasses. They also both have the same medical insurance and vision plan coverage. Pt 1 has no systemic issues while Pt 2 is a well-controlled type 2 diabetic with no retinopathy. You perform a comprehensive ophthalmological service (92014) and a refraction (92015) on both patients. From their perspective, everything was the same. But this is where it starts to differ. The doctor codes Pt 1's exam as routine and the patient has no co-pay. But the doctor codes Pt 2's exam as a medical visit. Pt 2 now faces a $50 co-pay plus the refraction is now no longer covered (assuming there is no coordination of benefits). Plus, if the patient has not hit their deductible, they will get hit with the rest of the bill once the EOB comes back. So Pt 1 walks out with no costs while their spouse has over $100 in charges for what appears to have been the same service. You can see why these patients would feel upset.

This ultimately comes down to duplicity of coverage. Both patients' medical and vision plans have coverage for 920x4. The definition and requirements for that code do not change based on the payer or the final diagnosis. If the doctor is a provider for both plans, the patient can choose which benefit they wish to use for that service. Therefore, if the doctor can perform a 920x4, the visit is covered by either plan and can be submitted to either. The diagnosis linked to it is ultimately there to simply provide the payer with an explanation for the Reason for Visit. If the patient's RFV was, "SRx update," a refractive dx can be used. Even though the patient may have a medical condition, too, the RFV qualifies as a routine exam.

Keep in mind, this all hinges on whether a "routine exam" can be performed that day. If the patient has a keratitis raging from CL over wear, you can't do a routine exam. You simply inform the patient they have a medical condition that prevents you from doing their routine exam on that day. And their visit will need to be submitted to their medical payer. Once the condition resolves, you will then be able to utilize their vision benefit. This same conversation can happen for any condition that prevents a routine visit from occurring.

In the end, "routine" exams never ignore the evaluation of the health of the eye. Whether the patient is diabetic or not, you are assessing the eye for signs of vascular damage. You also evaluate the cornea and tear film on patients whether they have dry eye or not. The exam elements do not change. As we said in the beginning, there is no solid rule dictating how this is done. If you feel patients no longer qualify for "routine eye care" once they have been diagnosed with a medical condition, the patient needs to be

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informed upfront. They may be perfectly fine with it if they know beforehand. But if the bill is a surprise, they will feel like it was a bait-and-switch. Managing expectations is key.

Having a clear office policy that patients, staff, and doctors are aware of is crucial. If everyone understands what to expect, these situations will cause less problems. There will always be questions, but if the office policy is consistent, fewer issues will pop up.