

Coding and Billing an Eye Exam

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Many doctors feel that they're either billing too high or not high enough. This is complicated by many doctors feeling intimidated by the process of medical billing and coding and, therefore, they tend to under-bill for their work. Recent third-party audits found that there is also a large percentage of doctors not meeting the level of service billed for. It is important also to remember that doctors and their paraoptometric are interested in learning proper medical billing and coding. The following sections of this article will address these issues in greater depth.

Background

The entire coding and medical industries are dependent upon accurate code use and interpretation to allow information to be accurately transferred between the provider and the payer. All of the codes used by optometry are also used by general medicine and/or other specialty providers. Coding and billing in an optometric office is performed using code sets established and maintained by different entities. The code sets used in this process include the ICD-10 Clinical Modification code set and the Current Procedural Terminology code set—which is usually called “CPT,” and the health care common procedural coding system or HCPCS code set.

Each code set has a specific purpose in the billing process.

Understanding what codes doctors of optometry should use and their respective definitions is most important in all coding. The standard code sets used in optometric practices consist of the ICD-10 codes for diagnoses, the CPT codes for most procedures and the HCPCS Level II codes for procedures and products not covered under the CPT umbrella. Most carriers have published policies that follow the CPT closely, though it's not uncommon to find that they may have specific policies or guidelines that build on the CPT definition for a code.

These code sets are standardized nationally. The Healthcare Insurance Portability and Accountability Act (HIPAA) prohibits the use of proprietary codes that were previously developed and used by local carriers and insurers. It also stipulates that all codes are to be used as they are defined and not to report additional services that are not currently included in the definition.

Always be sure of a carrier's specific policy regarding billing a code rather than simply relying on the CPT definition. These policies are generally available on the carrier's website or provider manual and are referred to in current nomenclature as Local Coverage Determinations (LCDs) or previously known as Local Medical Review Policies (LMRPs). Whatever acronym used, they serve the same function in defining the appropriate guidelines in using a code.

Eye examination options

There are several primary codes available to be used for most eye health evaluations. They include four ophthalmological services codes (920XX), 10 evaluation and management (E/M) codes (992XX) and two HCPCS "S" codes (S062X). All are appropriate for coding eye examinations that occur within an optometric practice.

Optometry is fortunate to have these three codes sets from which to choose as it is one of the few subspecialties to have its own office visit codes. Most often in coding eye examinations, we use the 920XX codes because it's easier for most practitioners to meet the documentation requirements, particularly the history components.

Although these codes won't cover every possible situation, they're probably the best to use for most general examinations. The office will still need to use E/M codes for services that don't fit within the guidelines for eye codes. The CPT recognizes that ophthalmic codes work on a principle different from E/M codes, particularly with regard to detailing all of the components of an examination:

"Intermediate and comprehensive ophthalmological services constitute integrated services in which medical decision-making cannot be separated from the examining techniques used. Itemization of service components, such as slit lamp examination, keratometry, routine ophthalmoscopy, retinoscopy, tonometry or motor evaluation, is not applicable."

Ophthalmologic services are either comprehensive or intermediate for both new and established patients. Remember the definition of a new patient is one who hasn't received any professional services from the physician or another physician of the same specialty in the same group practice within the past three years. Below are the (most common) 920XX codes:

- * 92002 (Ophthalmological services): Medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient.
- * 92004 (Ophthalmological services): Medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits.
- * 92012 (Ophthalmological services): Medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient.
- * 92014 (Ophthalmological services): Medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits.

It's also important to understand that refraction (CPT 92015) **is not** a part of any of the above-mentioned codes. According to HIPAA, it's a distinct and separate service that we should always

bill as a separate line item on our claim form with a distinct and separate fee.

The comprehensive exam

Comprehensive eye examination codes (92004, 92014) describe a general evaluation of the complete visual system. The CPT defines it as:

"... includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated: biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs."

Remember that a comprehensive eye examination requires gross visual fields and a basic sensorimotor examination, while other elements of an examination that most of us would expect to include aren't required. Notably, the CPT definition lists dilation as optional, though many carriers have policies stating that it's required unless medically contraindicated.

The CPT definition also states that these codes define an examination that occurs on "one or more visits." These codes describe a single service that need not be performed in one session. This means the physician can complete an examination over more than one visit in a day (morning and afternoon) or more than one day (start today, complete the examination tomorrow). Although multiple visits are performed, only one visit is submitted.

The most common application of this principle is when a patient declines dilation during the initial examination and returns at another time to complete the dilated portion of the exam. In this case, the office would submit one claim and the medical record would reflect the fact that the examination took more than one visit. The "one or more visit" concept doesn't apply to E/M services.

The intermediate exam

CPT defines intermediate codes (92002, 92012) as:

"... an evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis, including history, general medical observation, external ocular and adnexal examination and other diagnostic procedures as indicated; may include the use of mydriasis for ophthalmoscopy."

As with comprehensive visits, dilation may be optional. Some clinicians use the intermediate codes to reduce the cost of an examination to an uninsured patient. This is inappropriate, as it's considered down coding a service that was provided. Many carriers have become aware of this billing pattern and have recaptured overpayments for their insured patients for similar services.

The E/M codes

Typically, eye care practitioners don't use the E/M codes for what most doctors of optometry consider a general

eye examination. They are more typically used for patient encounters when the patient presents with a medical complaint or a continuation of medical case management (i.e., glaucoma, allergy, dry eye). The five levels of E/M codes are universally applicable for all manner of disease, yet they are more complicated to apply and require more than one page of chart documentation for a comprehensive examination.

These codes have much more specific requirements of fulfillment in the areas of case history, elements of examination and medical decision making. While appropriate in the medical management of a patient, using them to code a general examination would again tend to put the office in harm's way under the scrutiny of an audit, where we have a better CPT code in the 920XXs that most appropriately describes the services provided.

S Codes

The "S" codes are a subset of the HCPCS codes. Whereas the CPT codes are more specifically known as the Level One codes, the Level Two codes are codes health care providers use on a national basis for coding procedures where a formal CPT code is not in existence or inadequately describes a procedure.

Most vision plans and some medical carriers have instructed the doctors (by contract) to use the 920XX codes for describing each and every eye examination-often including refraction in the code. Yet, as described earlier, we know two definite things:

1. The 920XX codes weren't originally designed for routine patients.
2. Refraction has never been included within the definition of a 920XX examination service.

Two codes specifically offer eye care practitioners an option for coding of well vision services: S0620 and S0621. HCPCS defines them as "routine ophthalmological examination including refraction" for new and established patients respectively. Certain insurance companies bundling other diagnostic tests in to the reimbursement have muddled the appropriateness of these codes.

Insurance concerns

Insurance guidelines specify that the office have one fee schedule for each CPT code. The dilemma that most eye care practitioners face is choosing the appropriate code for eye examinations while maintaining their fees at appropriate levels for the services they provide. Thus, when the office establishes a price for providing a 92004, the office must charge all patients the same fee for the same service, regardless of who's paying the bill. Multiple fee schedules are discriminatory and, at a minimum, could lead to reduced reimbursements from the carriers if they establish a pattern of discount. In a worst-case scenario, a carrier could determine that the office had been abusive in its billing patterns and demand monetary damages. S codes provide a viable method to avoid the discount fee patterns that often exist.

When performing a well vision examination on a healthy patient, these codes are a good alternative to the usual CPT codes that were developed with a "sick" patient in mind. Careful patient differentiation of well vision eye exams versus patients presenting with either a complaint or a pre-existing condition allows the office to appropriately bill the patient privately or through insurance.

This ability to use these multiple coding options allows the office to maintain good compliance with insurance guidelines for single-fee schedules by enabling the office to set its fees for well

vision examinations competitively while still capturing appropriate reimbursements for commensurate services provided by CPT guidelines. Moreover, they reduce the temptation to apply inappropriate time of service, prompt pay discounts or the misuse of modifiers. They keep our practices safely within coding guidelines, our prices appropriately set for the services performed and the patients happy.