Optometry Coding & Billing Alert

Exam Coding: Expand Your Coding Options For Patients Refusing Dilation

Tip: You can schedule a second office visit -- but beware this coding stipulation.

You know the routine: A patient shows up for an exam, but he won't let the optometrist dilate his pupils that day. Whatever the reason -- time, the drive home, etc. -- you're stuck trying to find the best way to report a dilation at a separate visit.

Most Medicare carriers assume that a dilated fundus exam will be a part of any comprehensive eye exam you perform and bill with 92004 (Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits) or 92014 (Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits), says **Raequell Duran, CPC,** president of Practice Solutions, a coding, compliance, and reimbursement consulting firm in Santa Barbara, Calif. Without dilation, you cannot perform the fundus exam -- and without the fundus exam, you don't have a comprehensive service.

Count 2 Visits as 1 Service

CPT states that a comprehensive ophthalmological service "often includes" examination with dilation, therefore dilation is not necessarily required to bill 92004 or 92014. However, some payers and state specific guidelines may have their own dilation requirements. For example, Trailblazer says the 92004/92014 exams should be done under dilation unless "medically contraindicated." Check with your carrier if you receive a denial you think is unfounded.

Important: Note the phrase "one or more visits" in the code descriptions. The dilated part of the exam does not have to be performed on the same day as the rest of the exam. If the patient comes back to complete the exam another day, you can report 92004 or 92014 once, with either date as the date of service. You cannot bill each day's work separately because the two visits could have been done in one visit if the patient had been prepared or willing to complete the exam.

Example: An optometrist is following up with a patient every 12 months for cataracts. During the first visit, the patient has no time for the dilated exam. He returns to the clinic two weeks later for dilation. He has no other medical conditions. Bill one unit of 92014, and list the date of the first visit as the date of service.

You can bill for the second visit only if the patient has a new chief complaint or worsening symptoms requiring a new workup and assessment. The time between visits may not matter to an auditor, experts say.

If the visits are far enough apart, you may be able to start the examination over with the second visit and bill for two visits if both are medically necessary -- but you would not be able to bill 92004 or 92014 for the first visit, since it did not include dilation.

Watch for: If you are repeatedly billing two visits close together with no new chief complaint or worsening symptoms requiring new workup (assuming you are not evaluating treatment prescribed at the first visit), you would be on shaky ground in case of an audit.

Don't Submit Bill Until Second Appointment

The real challenge comes into play when you're expecting the patient to come back for the dilated exam and he never shows up. This is a difficult situation, as you don't want to bill for services not rendered, nor do you want to undercode a

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visit.

If you actually bill the insurance company for the initial visit before the time of the second visit, and the patient doesn't show up, document carefully that the patient refused dilation on the first visit, scheduled a return visit and then refused to keep the appointment. However, it is not recommended to bill for services that have not been rendered or refused by patients under any circumstances.

Better idea: Don't file the claim until the second appointment.

Another option: Dilate at the initial visit with phenylephrine hydrochloride. The mild dilation it creates will allow you get a view of the posterior pole with a handheld 78D (or something similar) lens, leaves the pupil somewhat reactive to bright lights, and satisfies the dilation requirement if the patient fails to return for the full dilation visit.

You could downcode to a 92002/92012 (intermediate service) if the patient failed to show up and you would not have to pursue the patient to return. You could not bill the comprehensive codes in this case because the first visit did not include a dilated fundus examination.

Another alternative: Bill each service separately with consideration to medical necessity and the level of service rendered with E/M codes 99201-99215 (Office or other outpatient visit ...), suggests **Maggie M. Mac, CPC, CEMC, CHC, CMM, ICCE,** Director, Best Practices-Network Operations at Mount Sinai Hospital in New York City. "The second visit for a dilated exam only may only allow a CPT code assignment of 99212 and the patient will be required to pay two (2) copays for the two office visits, but since it is the patient's choice to return at their own convenience for the dilated exam, they should be expected to pay for the second visit," she says. "A verbal explanation to patients discussing second visit copays in this scenario is essential and may convince the patient to undergo the dilated exam during the first encounter."

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