

## Optometry Coding & Billing Alert

### Expand Your Billing 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 you 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 **Carol Courtney, CPC**, coder and biller with Vancouver Eye Care in Vancouver, Wash. Without dilation, she says, "you cannot count 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 (Ophthalmological services ...; comprehensive, new patient) or 92014 (Ophthalmological services ...; comprehensive, established patient). However, some payers 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, says **Linda Wildberger, CPC**, patient accounts specialist with the Black Hills Regional Eye Institute in Rapid City, S.D. 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 or doctor had been prepared or willing to complete the exam," says **David Gibson, OD, FAO**, a practicing optometrist in Lubbock, Texas.

**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, Gibson says. The time between visits may not matter to an auditor, he says. "The regulations do not specify a time frame between the two visits, so if it is one month or one day, there's probably no difference," he says.

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 - 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 (assuming you are not evaluating treatment prescribed at the first visit), "you would be on shaky ground in case of an audit," Gibson says.

#### 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 visit," Gibson says.

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," Gibson says. "Even a copy of a letter to the patient strongly encouraging him to comply would be a good defense in case the claim were to ever be called into question."

**Better idea:** Don't file the claim until the second appointment. "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," Gibson says. You could not bill the comprehensive codes in this case because the first visit did not include a dilated fundus examination. "If this were to become more than an occasional problem, I would hesitate to bill the 92004/92014 [comprehensive service] codes until the entire service was complete."