Optometry Coding & Billing Alert

FAQ: Tackle These Exam-Without-Dilation Coding Scenarios

It's a thorny coding dilemma, but savvy coders know the solution.

A dilation is a necessary part of any eye exam, right? The optometrist may think so, and most of your payers may agree, but every practice sooner or later will have to deal with a patient who, for one reason or another, does not want his pupils dilated.

Because Medicare and most other payers 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), that leaves you in a dilemma.

Read on for our experts' answers to coders' frequently asked questions about coding for eye exams without pupil dilation.

Question: How do I code when a patient's exam takes two visits?

Answer: 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. 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.

Question: Can I bill each day's work separately?

Answer: No, 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.

Question: When do I submit the bill if the exam takes two visits?

Answer: Your best bet is to wait until the second appointment.

Rationale: 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.

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.

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 ...). 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 copays for the two office visits, but since it is the patient's choice to return at his own convenience for the dilated exam, they should be expected to pay for the second visit, experts say.

When reporting an E/M code, "remember that the elements of an E/M service are much more defined as to things like case history and difficulty of medical decision making," says **David Gibson, OD, FAAO**, a practicing optometrist in Lubbock, Texas. "Be sure to document the date of onset, frequency and duration of symptoms, level of discomfort, whether the condition is improving, and other details defined in the E/M codes that are not specified in the eye codes."

A verbal explanation to patients discussing second visit copays in this scenario is essential, experts recommend, and may convince the patient to undergo the dilated exam during the first encounter.