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Optometry Coding & Billing Alert

Insurance Dilemma: Seeing Patients With Both Medicare and Routine Vision Coverage? Read This First

Use the patient's chief complaint and history of present illness to decide who gets the bill

A patient presents for what he thinks will be a routine vision exam -- but you find cataracts. Should you bill his vision plan or Medicare? Be careful: The wrong answer could get you in hot water with your patient, not to mention CMS.

Along with Medicare or other medical insurance, many of your patients might have supplemental private insurance -- such as AARP Eye Health Services, Clarity Vision, or Vision Service Plan -- to cover routine eye examinations, typically one exam per year. Many state Medicaid programs will also cover routine exams.

When you find a medical problem like cataracts or glaucoma while doing a routine eye exam on these patients, you have a dilemma. Should you bill the patient's medical insurance, since you found a medical condition? Should you bill the patient's vision insurance? Or can you even bill both?

Bill Medical Coverage if There Is a Complaint

The answer depends on the patient's reason for being there, as well as his expectations. Bill based on the patient's chief complaint and history of present illness (HPI), says **Deena Happel, CMA, CPC, CCS-P,** coder and accounts manager at Lifetime Eyecare in Geneseo, Ill. If he has a specific complaint that can be attributed to a non-refractive diagnosis, then it's a medical visit and should be billed to the medical insurance.

Example: A patient arrives complaining of blurred vision. You find that cataracts are causing the blurriness. Bill the patient's medical insurance with the appropriate eye exam code (92002-92014, Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program -) and link it to the appropriate cataract code (366.xx).

As a secondary diagnosis, report 368.8 (Other specified visual disturbances [blurred vision NOS]). If, however, you found no cataracts or any other condition causing the blurred vision, report 368.8 as the primary diagnosis.

Bill Routine Coverage if There's No Complaint

What if the patient doesn't have a complaint? The rule still holds: Code according to why the patient is there. If the patient comes in with no specific complaint, but you diagnose a medical problem, report the routine visit as the primary diagnosis and the medical condition as the secondary diagnosis. Bill that visit to the patient's vision carrier.

Coding the exam: Many vision plans specify that you use HCPCS codes S0620 (Routine ophthalmological examination including refraction; new patient) and S0621 (- established patient) for a routine exam. Other plans may want the general ophthalmological services CPT codes 92002-92014, Happel says. In most cases, vision plans look for ICD-9 code V72.0 (Special investigations and examinations; examination of eyes and vision) as the primary diagnosis, says **Donna Marks, CPC, CCS-P, OCS,** coder at the Lahey Clinic in Peabody, Mass.

What is -routine-? Different insurers may have different definitions of what a routine exam includes. Arkansas Medicaid, for example, says that S0620-S0621 must include case history, general health observation, external exam of the eye and adnexa, ophthalmoscopic examination, determination of refractive state, basic sensorimotor and binocularity examination -- but it may also include the initiation of diagnostic and treatment programs or a referral.

Other plans point to the definition of -comprehensive ophthalmological services- in the introduction to the -Ophthalmology- section of the CPT manual.

Have Patient Return for Further Tests

Experts say: When you do find a medical problem during a routine exam, it may be better to have the patient return on another day for further tests, rather than convert the exam from routine to medical. A patient who discovers that what he thought was going to be a routine screening with a $20 copay may be confused and upset when he sees a bill for a medical eye exam -- even if his out-of-pocket expenses are the same.

-I have converted several exams from routine to medical based on the complaints and sound judgment, and without exception, the patient then complains about being charged the higher fee for a comprehensive exam,- says **David Gibson, OD, FAAO,** a practicing optometrist in Lubbock, Texas. -Some patients don't understand the difference between routine care and medical care. They just know that they want to use that routine exam benefit, so we let them.-

If there is a follow-up exam later, the medical condition will be the primary diagnosis and the bill goes to the patient's medical insurance.

Example: A patient comes in for the routine eye exam that his vision insurance provides and has no complaint. You discover glaucoma. Bill the patient's vision insurance with S0620 or S0621 and link it to ICD-9 code V72.0. As a secondary diagnosis, report the glaucoma code (365.xx).

When the patient returns for further diagnostic tests -- such as 9208x (Visual field examination, unilateral or bilateral, with interpretation and report ...) and 92020 (Gonioscopy) -- link the codes to the glaucoma diagnosis and send the claim to the medical insurer.

Bill Both When Performing Extra Tests That Day

If a patient presents with no complaints, but you find something that makes it necessary to perform tests in addition to the routine screening on that day, you may be able to bill both the medical and the visual insurance, Happel says.

Example: A patient is in for a routine exam and has no complaints. As part of your exam, you find intraocular pressures of 30 mm Hg in both eyes and suspicious cupping. Because of the unusually high IOP, you perform fundus photography and visual fields immediately, but find no glaucoma.

Since the patient had no complaints, you would need to bill the patient or his vision plan for the initial visit. But you could bill the fundus photos and visual fields as medical, even if you perform them on the same day.

Bill the eye exam with the appropriate eye code to the patient's vision insurance. Bill the visual fields (9208x) and the fundus photos (92250) to the patient's medical insurance. Link the CPT codes to ICD-9 code 365.01 (Borderline glaucoma [glaucoma suspect]; open angle with borderline findings) -- or the appropriate 365.xx code if you found glaucoma.

Key: You can only bill one insurer for the initial exam (S0620-S0621 or 92002-92014). Billing both companies for the same exam is considered double-dipping and may lead to fraud charges.