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Optometry Coding & Billing Alert

Lens Services: 92070 With 371.6x Focuses on Medical Necessity for Fitting Keratoconic Lenses

Follow this strategy and earn $67 for each contact lens procedure.

You know you can't bill Medicare for regular refractive contact lenses, but you can expect reimbursement for contact lenses for patients presenting with keratoconus and aphakia -- if you know these expert rules of the road.

Prove Medical Necessity for Keratoconus Patients

Situation: A 16-year-old patient presents with distorted and blurred vision along with glare and light sensitivity. The optometrist diagnoses keratoconus (371.60-371.62) and fits special contact lenses to correct the problem. You know that 92310 (Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia) isn't right because the patient's carrier considers it to be a refractive error correction. Is there a more specific code you can use to describe the procedure?

Solution: To avoid denials when the optometrist prescribes a contact lens to treat keratoconus, use 92070 (Fitting of contact lens for treatment of disease, including supply of lens). Keratoconus is "a non-inflammatory eye condition in which the normally round dome-shaped cornea progressively thins causing a cone-like bulge to develop," according to the National Keratoconus Foundation at www.nkcf.org. For mild cases of keratoconus, glasses may adequately correct the patient's vision. More severe cases of keratoconus may require hard or gas-permeable contact lenses.

Based on the 2011 Medicare physician fee schedule, unadjusted for geographic location, you can expect about $66.933 for 92070 (1.97 total transitional relative value units [RVUs] x 33.9764 conversion factor).

2012: But for claims beginning with date of service January 1, 2012, 92070 will no longer be an option; CPT® 2012 deletes the code. In its place, for a keratoconus patient, you would report new code 92072 (Fitting of contact lens for management of keratoconus, initial fitting).

Supplies: The kind of contact lens used to treat keratoconus is a rigid, gas-permeable (RGP) lens, which may be a standard design, or a special design keratoconus lens, depending on the degree of the keratoconus. Using 92070 for a patient with keratoconus shows that the lens is for treatment of a medical condition, not a refractive condition. And because the code specifies that it includes the supply of the lens, your regular Medicare carrier will reimburse you for supplying the lens as part of the procedure fee -- so you shouldn't separately report the lens to a durable medical equipment regional carrier (DMERC).

Documentation: Years ago, you could bill both the service and the lens to Medicare, but this changed after Medicare conferred with a consultant who stated that the majority of the time optometrists used an inexpensive, soft contact lens to perform the service. If the doctor was unsuccessful using a soft lens to treat a disease and must use the more expensive hard or gas-permeable lens, you can attempt to bill your carrier for the expense. To receive payment, you will need to send a brief explanation detailing why the optometrist used the lens, along with chart documentation of the failed attempts at using a soft contact lens. You will also need to provide an invoice to substantiate the lens' cost.

For the actual billing of the lens, use 92070-22 (Increased procedural services). Reporting a service with modifier 22 along with documentation automatically routes the claim for review and special pricing. Submit these claims by paper so the carrier is sure to keep your documentation with your claim. Tip: You should provide a concise statement about how this service differs from the usual, along with the operative report.

"CPT® does not provide specific direction as to the specific amount of time and/or percentage increase of time or work

required to compliantly report modifier 22," says **Marvel J. Hammer, RN, CPC, CHCO,** president of MJH Consulting in Denver. The typical rule of thumb, however, is your physician must spend at least 50 percent more time and/or put in at least 50 percent more effort than normal for you to append modifier 22.

Caution: You may get into some sticky split-billing situations when the optometrist inserts a bandage contact lens (BCL) during a patient's postoperative period for cataract or corneal surgery. The problem with billing for the service, if the patient has Medicare, is that a global surgical package applies that includes all additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room.

If the optometrist places the lens in the patient lane, which is not an operating-room setting, you cannot report 92070 because carriers include it in the postoperative package of corneal and cataract surgery.