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Optometry Coding & Billing Alert

Lens Services: 92072, Not 92310, Is Best Bet for Keratoconus Lenses

Be sure documentation proves medical necessity.

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 our expert advice will help you on the way.

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 92072 (Fitting of contact lens for management of keratoconus, initial fitting). 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 2013 Medicare physician fee schedule, unadjusted for geographic location, you can expect about $127.93 for 92072 (3.76 total transitional relative value units [RVUs] x 34.023 conversion factor).

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 92072 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.

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 92072 because carriers include it in the postoperative package of corneal and cataract surgery.