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Optometry Coding & Billing Alert

Play by Medicare Rules to Ensure Your Fair Share of Routine Exam Reimbursement

Help patients understand: Explain that no complaint equals no coverage.

Often, ODs don't grab their fair share of the Medicare market since many patients only need routine, non-covered services, such as refractions and routine check-ups. But wait: You can serve the Medicare patients in your area and get paid if you follow these three simple rules from our experts.

#1: Don't Overlook Covered Chief Complaints

Of course you can't -- and don't -- manufacture patient complaints. But it does no harm to ask patients follow-up questions to glean relevant information -- and potentially discover that an office visit is benefit-eligible.

Payment rules: Medicare will not cover examinations performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury. For instance, a refraction test (92015, Determination of refractive state) is a type of non-covered service that is typically unrelated to diagnosing a specific complaint. Routine eye exams, sometimes coded as S0620 (Routine ophthalmological examination including refraction; new patient), are also not covered. However, you may bill Medicare if your patient presents a genuine complaint that establishes the medical necessity of diagnosis and treatment.

Just ask: "If I'm not finding a reason for the exam in the case history, what I like to ask new patients is, 'Did your previous doctor tell you that you had cataracts or glaucoma or anything like that?'" says **David Gibson, OD, FAAO,** a practicing optometrist in Lubbock, Texas. If the patient says yes, and that the problem concerns her, "there is your medical reason for the exam," he says. "While the patient may not be complaining of their cataracts, they are almost always concerned about the presence of whatever was diagnosed by the previous doc."

Tip: Probe gently for a complaint, but take care to avoid force-feeding one, suggested **Raequell Duran, CPC,** president of Practice Solutions, a coding, compliance, and reimbursement consulting firm based in Santa Barbara, Calif., at The Coding Institute's December conference in Orlando.

Not covered: If a patient says he needs new glasses, of course Medicare will not cover the visit because it is seemingly unrelated to a specific illness, symptom, etc.

When appropriate, think about training your front desk staff to ask a follow-up question to uncover the true nature of the visit. Consider asking "Why do you feel you need glasses?" or "Are you having problems with your distance vision or trouble reading the computer screen?"

Covered: An example of a covered visit would be if the patient responded by complaining of "decreased visual acuity, distance and near, gradual decrease X 6 months, both eyes," Duran remarked.

"If the patient is complaining of a change in their vision, you should be able to find a reason for the change," notes Gibson. "More than likely, there will be a medical reason for the change, but if it is a refractive-only change, Medicare won't cover it. But in Medicare patients, it is generally early cataracts (366.xx, Cataract) driving the refractive change, and that is covered."

Vital: Remember that you must code according to the initial purpose of the office visit, regardless of the visit's ultimate findings, Duran pointed out. For instance, if a patient complains of eye injury or discomfort, Medicare will cover the resulting services (except for eye refractions) even if the outcome is only an eyeglasses prescription. On the flip side,

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when a beneficiary requests an eye examination with no specific complaint, the exam's cost is not covered even if the outcome is the discovery of a pathologic condition, Duran said.

Don't miss: Case history doesn't end just because the exam started, cautions Gibson. "You may not find the chief complaint until the end of the exam," he says. "Sometimes, patients forget to tell you a critical piece of history until the end of the exam."

#2: Convert Repeat Visits to Covered Follow-Ups

Do you see Medicare beneficiaries who avoid needed check-ups because they fear paying out-of-pocket expenses? If so, it may be worth reviewing whether you are communicating about follow-up visits appropriately.

Case in point: Instead of just sending out form letters to remind all patients that it's time for their regular check-up, single out patients with identified problems by sending a different message.

Example: A patient needs to schedule an appointment for a one-year follow-up to monitor nuclear sclerosis (NS) cataracts (366.16, Nuclear sclerosis, cataracta brunescens, nuclear cataract). Take care to communicate to such a patient that their follow-up visit is covered by Medicare because it is medically necessary.

Bottom line: Be sure to note in the record that the appointment is for cataract follow-up. If you follow this advice, you'll head off potential miscommunications at the front desk when a covered patient unwittingly says she is there for her "regular check-up," said Duran.

#3: Avoid These 2 Documentation Mistakes

You know the golden rule of reimbursement: If it's not written in the medical record, it doesn't count. Take this lesson to heart by reminding yourself to follow these best practices in Medicare documentation:

1. Spell out "standing orders." Medicare does not pay for undocumented "standing orders." A standing order is a policy or understanding that staff should routinely perform a particular test on certain patients even in the absence of a specific written order, explained Duran.

Example: If your office has an understanding that patients with an intraocular pressure (IOP) of over 25 automatically have an optical coherence tomography (OCT) test (92136, Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation), don't forget to write the order down in the chart. If such notes are missing if the claim comes up for audit, you will not receive payment for this test even if you conducted it, Duran reminded the attendees.

2. Record test interpretations. It's not enough to simply have proof that you ordered and conducted some tests. In many cases, you must also take the added step of documenting your interpretation of test results, offered Duran. You can record your interpretation with a dictated report, a notation on the progress note, or a notation on the test itself, she continued.

Example: Many physicians do not document their interpretations for fundus photography because it is "documentative" in nature, not "diagnostic," Duran noted.

However, this point should not preclude you from making some type of interpretative notation in the chart, such as "photo shows increased cupping, which is consistent with elevated IOPs and visual field defect," Gibson offers.

"It is important to record your train of thought while the case is fresh," Gibson continues. "A small detail in the photo may go unnoticed next year when reviewing the previous records unless you record the detail in the context of the exam today." You must remember to initial your interpretative notation, Duran concluded.

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