Optometry Coding & Billing Alert

Prove Medical Necessity for Fitting Contacts and Earn $65 Each Time

92310 won't cut it for keratoconic patients -- but this strategy will

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. You diagnose keratoconus (371.60-371.62) and fit 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 prescribing 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.

"There is confusion about this because different payers have different policies," says **David Gibson, OD, FAAO,** a practicing optometrist in Lubbock, Texas. Code "92310 is used more often for -routine- contact lens wearers, and 92070 is used more for medical conditions needing contact lenses." File your claim with 92070, Gibson says, and if the payer rejects the claim, then "call in, and see what codes they want to use."

Based on the 2008 Medicare physician fee schedule, unadjusted for geographic location, you can expect about $65.13 for 92070 (1.71 total transitional relative value units [RVUs] x 38.0870 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, Gibson says. 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).

Exception: "If you have to use a soft lens, or a combination of a soft lens with an RGP over it, called a piggyback fit, then 92070 may not even cover your costs," Gibson says.

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 with 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 your provider 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.

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Caution: You may get into some sticky split-billing situations when you insert 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.

Stay Away From 92310 for Aphakia

Situation: A patient doesn't have her own natural lens (aphakia, 379.31 or 743.35). The optometrist fits a contact lens for refractive error correction. You can't use 92310 in this case -- it says so right in the code description. So which code should you report?

Solution: The codes for aphakic patients differ based on whether the doctor fit one or both eyes, says **Becky Zellmer, CPC, MBS, CBCS,** provider educator for Prevea Clinic in Green Bay, Wis. Choose from the following codes that represent the prescription of contact lenses for aphakia:

- Prescription for one eye: 92311, Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye

- Prescription for both eyes: 92312, ... corneal lens for aphakia, both eyes

- Prescription for corneoscleral lens: 92313, ... corneoscleral lens.

Medicare will pay for contact lens fitting and supply for patients with aphakia. If an optometrist writes the prescription for an aphakia patient, but a technician who is an independent contractor in your office does the actual fitting, code one of the following:

- Prescription for one eye: 92315, Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens for aphakia, one eye

- Prescription for both eyes: 92316, ... corneal lens for aphakia, both eyes

- Prescription for corneoscleral lens: 92317, ... corneoscleral lens.

Beware: Most Medicare carriers have established guidelines for how often they will replace a contact lens for an aphakic patient. One claim every one or two years per aphakic eye is what many carriers expect to receive. Medicare may deny or suspend the claim and request additional information before processing.

For supplies: Bill your DMERC for the lenses themselves using the HCPCS V25xx codes (for example, V2510, Contact lens, gas permeable, spherical, per lens; or V2522, Contact lens, hydrophilic, bifocal, per lens), adding the RT (Right side) and LT (Left side) modifiers for each eye and modifier KX (Specific required documentation on file) to indicate medical necessity. Include the date of the original surgery and the diagnosis code.

Note: For more information on billing and coding contact lens prescriptions and fittings, see "6 Tips Guide You to More Accurate Contact Lens Claims" in Optometry Coding & Billing Alert, Vol. 6, No. 3.

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