Codify
BY AAPC

Optometry Coding & Billing Alert

Reader Questions: Make Up Difference for Progressive Lenses

Question: I'm a little confused about coding for optical supplies. One of our patients got bifocals and decided she wanted progressive lenses to get rid of the line between the two lenses. The optical shop, however, coded them as bifocal lenses (V2200) along with V2781 for the progressive lens. I don't think this is right, but the optical shop says they've always coded this way. What's the correct coding?

Oregon Subscriber

Answer: If you're providing bifocals, submit a bifocal code (V2200-V2299) on the first line of your claim. On the second line, report V2781 (Progressive lens, per lens) for the difference between the cost of the standard bifocal and the progressive lens.

The patient is responsible for that difference and should sign an advance beneficiary notice (ABN).

Example: The patient chooses a progressive lens
with a cost of $100 per lens ($200 for the pair of lenses). Your retail charge for a standard bifocal lens is $45 ($90 for the pair).

Code two units of V2200 (Sphere, bifocal, plano to plus or minus 4.00d, per lens) on the first line, with your standard total charge of $90. Code two units of V2781 on the second line with a total charge of $110 ($200 - $90). Your coding would look like this:

Line 1: V2200-RT-LT x 2

Line 2: V2781-EY-GA-RT-LT x 2

Append modifier EY (No physician or other licensed healthcare provider order for this item or service) to V2781 to show that the progressive lenses are the patient's preference, not a medically necessary addition.

Append modifier GA (Waiver of liability statement on file) to show that the patient has signed an ABN and is aware that she is responsible for the additional charge for the progressive lenses.

Watch for: Depending on how the insurance company handles amounts above whatever is allowable, coding just for the progressive option may not be enough-- you may also have to break out tints, coatings, and other options to prevent the insurance company from shifting the fee into an overage or provider discount column.

If the insurance company just wants to see charges for ophthalmic materials, a single line of the progressive lens would be acceptable and certainly simpler.

But if you have to write off anything above the allowable, you need to break out the separate amounts for progressive, tint, and other options so the payer can transfer the extra charges to be the patient's responsibility.

If the company just pays the allowable and makes the patient responsible for any excess, the simple one-line, one-code approach will work.

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