Optometry Coding & Billing Alert

YOU BE THE EXPERT ~ Link First Plaquenil Exam to Underlying Condition

Question: What is the proper way to code a visit to monitor a patient on a high-risk medication such as Plaquenil? In this particular case, she started taking the medication one week prior to the visit, and her primary-care physician is insisting her insurance will cover the visit.

Maine Subscriber

Answer: To report a toxicity observation for Plaquenil or other high-risk drug, you will use different codes for the baseline visit (before the patient starts the drug) and the follow-up visits to monitor the effects.

For the baseline visit, report an evaluation and management code and use the ICD-9 code for the condition for which the patient will take the drug -- for example, 714.0 (Rheumatoid arthritis).

Because your patient had already started the medication prior to her first visit, code it as you would a follow-up visit, not a baseline visit. Again, use an E/M code for the visit itself. If the optometrist finds no ocular changes, list V58.69 (Long-term [current] use of other medications) as the primary diagnosis code. List the condition for which the patient is taking the drug (e.g., 714.0) as a secondary diagnosis.

However: If the optometrist does find ocular changes, list that diagnosis (e.g., 371.2x, Corneal edema) as the primary ICD-9 code -- but only if you-re submitting a Medicare electronic claim. For these claims, list V58.69 as the secondary diagnosis and the underlying condition as a third diagnosis.

For non-Medicare carriers, list V58.69 as the primary diagnosis, the ocular change (e.g., 371.2x) as secondary, and the underlying condition (e.g., 714.0) as a third diagnosis.