Optometry Coding & Billing Alert

You Be the Expert: Monitoring Drug Effects

Question: A primary-care physician instructed one of our patients to see an eye doctor annually because a drug therapy she takes can affect vision. Her vision insurance doesn't cover exams annually, so her primary physician told her that her medical insurance would cover due to the medication. What diagnosis should I report? We did not see her for the disease, so would that diagnosis be inappropriate?

Illinois Subscriber

Answer: To report a toxicity observation for a 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).

If 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.

Or, if the patient has completed her course of treatment of the drug, use V67.51 (Follow-up examination; following completed treatment with high-risk medications, not elsewhere classified). List the condition for which the patient is (or was) taking the drug (e.g., 714.0) as a secondary diagnosis.

But if the patient presents with a specific complaint, and the optometrist finds ocular changes related to that complaint, list that diagnosis (e.g., 371.2X, Corneal edema) as the primary ICD-9 code.

You may also list V58.69 or V67.51 as the secondary diagnosis and the underlying condition as a third diagnosis. If the patient has no complaint, stick with the V codes as a primary diagnosis, even if the optometrist finds changes. Remember that for proper coding, the diagnosis should match with the chief complaint.