A Guide to Optometry Billing & Coding

Definite Path to Profits!

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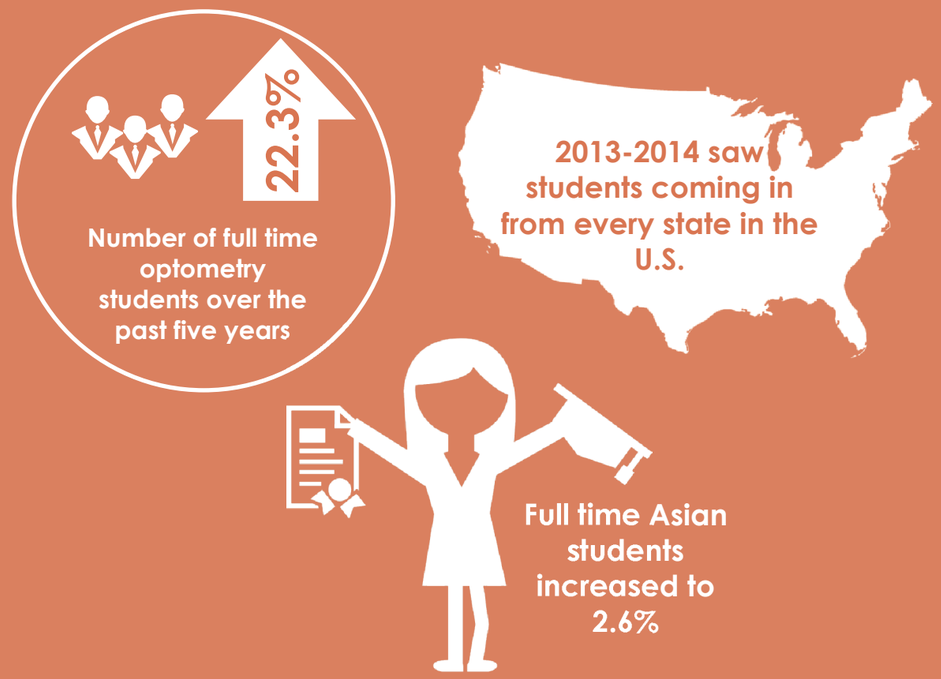
Future of Optometry in US:

The field of optometry is growing & changing at a rapid pace. As per 2013-2014 Association of Schools & Colleges of Optometry (ASCO) Annual Student Data Report, following are some of the major changes that are happening in the optometry student population:



With the changing scope of optometry and its integration into the mainstream health care, the need of the hour is to evaluate the existing optometric workforce. A study was conducted which projected the supply of total eye care providers (both optometrists and ophthalmologists) through 2025. This baseline data indicated a shortage of approximately 4,300 FTE (full-time equivalent) eye care providers over the next decade.

The study further projected increase in patients with Type 2 diabetes by 2025 is around 12 percent of the U.S. population, coverage expansion due to ACA (which includes 25 million adult Americans by 2017-18), and the pediatric essential benefit (which is additional 8.4 million newly covered children). So by 2025, these factors create an undersupply of eye care practitioners to 9,400 FTE.

A significant reason of that increase in demand is also expected to be from the inclusion of optometry as part of the delivery of full-scope medical care. This demand tied to health reform and optometry's growing role in multidisciplinary care of medical conditions (such as diabetes or glaucoma) clearly shows that optometry has a chance to expand into a growing market.

- The aging population with vision problems like cataract, macular degeneration and glaucoma and increased incidences of hypertension and diabetes will generate greater demand for optometric services as these diseases often affect eyesight.
- The popularity of laser surgeries to correct the existing vision problems will require ongoing preoperative and postoperative care for laser surgery patients.
- As per American Optometric Association, around one-quarter of currently practicing optometrists are approaching their retirement age. And as they retire, many individual as well as group practices opportunities will arise.
- Also, optometric assistants and other support personnel employment will increase so that the time an optometrist needs with each patient reduce.

Basics of Coding:

In an Optometric practice, there are around 16 ways in which the eye examinations can be coded. This does not include the consultation visits. So understanding the codes and their definitions is the core of coding and billing. In ophthalmic practice, the standard code sets consist of ICD-9 codes for diagnoses, CPT codes for procedures and HCPCS (Health Care Procedural Coding System) codes for procedures not covered under the CPT umbrella.

Although, most carriers have policies that follow CPT but they may have some specific guidelines and policies build on the CPT definition for a particular code. So, it's important to be sure of a carrier's specific policies related to billing a code rather than relying on the CPT definitions. These policies are referred to as LCDs (Local Coverage Determinations) and are readily available on the carrier's website. These LCDs or LMRPs (Local Medical Review Policies) as referred in older language, define the appropriate guidelines for using a particular code.

The essential 16 codes for coding eye examinations in an optometric practice are:

- 4 Ophthalmic visit codes (920XX),
- 10 evaluation and management (E/M) codes (992XX) and
- 2 HCPCS "S" codes (S062X).

Very often while coding eye examinations, practitioners use the 920XX codes, since the documentation requirements for the same are much easier to meet. Though these codes are best to use for general examination, one still needs to use E/M codes for services that are out of the box & do not fit under the umbrella of the eye codes. The CPT has recognized that while detailing all the components of an examination, Ophthalmic codes work on a different principle from E/M codes:

> ***"Intermediate & comprehensive ophthalmological services constitute integrated services in which medical decision-making cannot be separated from the examining techniques used. Itemization of service components, such as slit lamp examination, keratometry, routine ophthalmoscopy, retinoscopy, tonometry or motor evaluation is not applicable."***

For both New (a patient who has not received any professional service from a physician of the same specialty for last three years) and established patients, eye code visits are either comprehensive or intermediate.

Most common 920XX codes used for 'Medical examination & evaluation with initiation of **diagnostic treatment program'** for:

- 92002 (Ophthalmological Services): New Patient, Intermediate.
- 92004 (Ophthalmological Services): New Patient, one or more visits, Comprehensive.
- 92012 (Ophthalmological Services): Established Patient, Intermediate.
- 92014 (Ophthalmological Services): Established patient, one or more visits, Comprehensive

The exception CPT 92015 -
Refraction is not a part of before mentioned codes.

VISIT CODES

Codes (92004, 92014) as general evaluation of the complete visual system

> ***". . . includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated: biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs."***

Comprehensive Eye Examination,

- The CPT code states "one or more visits" required for an examination i.e. a single service that could not be performed in one session. For example, when a patient declines dilation in the first visit and comes at another time to complete the dilated portion of the exam.
- In such cases, the claim & the respective medical record should reflect that the examination took more than one visit.

Intermediate Eye Exam

Codes (92002, 92012) as defined by CPT:

- Some practitioners down code a service provided, by using intermediate codes to reduce the cost of an eye examination to a non-insured patient & fill over payment claims for insured patients which is unethical.
- Many carriers have become aware of such billing patterns and they take effective measures to curb such practices.

E/M CODES

- These codes are typically used for patients who come with a medical complaint or a continuation of medical case management (i.e., glaucoma, allergy, dry eye).
- The complexity of their application is high and require more than one page of documentation for a comprehensive examination with more specific requirements related to case history, medical decision made and elements of examination used are documented.

S CODES

These "S" codes are a subset of the HCPCS codes.

- The CPT codes are usually known as the 'Level One' codes. Codes which are used by providers for coding procedures that are either inadequately defined by CPT or there is no formal CPT code existent are known as 'Level Two' codes.
- These are basically used for describing internal coding but third-party insurance carriers do not accept or recognize all of these 'Level Two' HCPCS codes.
- For coding an eye exam, Optometry's training is generally limited to the information that the vision insurance/refractive insurance plans provide. But two things are known for sure:
  - The 920XX codes are not for routine patients
  - Refraction is not a part of 920XX examination codes.

What are Modifiers?

Modifiers are abbreviations that help describe the service and get paid properly. There are around 17 modifiers:

-E1	Left Upper Lid
-E2	Left Lower Lid
-E3	Right Upper Lid
-E4	Right Lower Lid
-LT	Left Eye
-RT	Right Eye
-GY	Non-covered service under Medicare
-TC	Technical Component (eg. performing visual field or OCT for another doctor to interpret)
-24	Unrelated service performed by the same physician during a post operative period
-25	Significant, separately identifiable exam service performed by the same physician on the day of a procedure or other service
-26	Professional component only (for example: you do the interpretation and reporting of a visual field performed by someone else)
-50	Bilateral Procedure
-51	Multiple procedures during same session
-52	Reduced Service
-54	Surgical Component only (the surgeon can append this code, if you are performing in the post operative period)
-55	Post Operative Management only (used for post operative care with surgeries)
-79	procedure by the same physician during the post-operative period

How does Optometry Coding & Billing work?

Optometry Coding is the standardized numeric and alpha numeric systems used to identify specific procedures and services performed. *eg: An optometrist no longer does refraction, he performs a 92015 (determination of refractive state) and he no longer takes photos, he performs 92250 (photography with interpretation and report).* Billing refers to the submission of these codes on a claim for reimbursement billed by the payer to the subsequent provider.

Claims are prepared by listing codes that report the patient's condition and the diagnosis and procedure performed.

As per the Medicare Claim processing Manual, there are a set of rules for reporting diagnosis codes on your patient's claims.

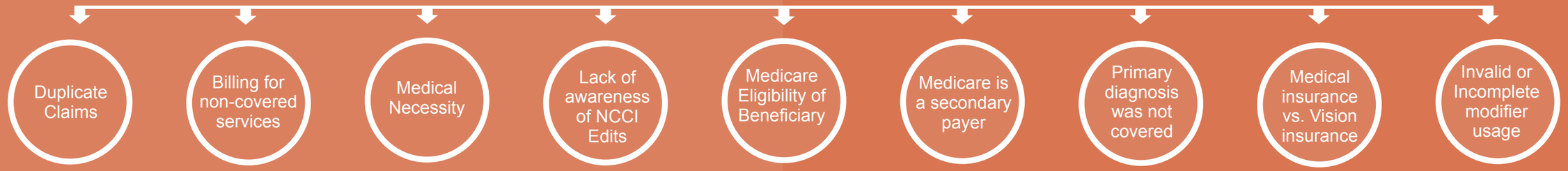
- Use code that accurately describes symptoms & diagnosis,
- Use the code that is responsible for the services provided
- Code a chronic condition as often as possible
- Assign codes with the highest level of specificity
- Code all documented conditions at the time of visit

In some plans, the reason for visit determines the coding.

Beware of discrimination:

There should be one fee schedule for each CPT code. Multiple fee schedules are biased and may lead to reduced reimbursements, if they analyze a pattern of discount in your claims. A worst case scenario could be that you have been discriminate and abusive in your billing patterns and may demand monetary damages.

9 Challenges of Coding & Billing in Optometry



Coding & billing practices have changed a lot either because of unawareness of new regulations or because of complexity of codes & claim procedure. But a clear understanding of these common coding & billing errors is important to overcome such challenges.

Duplicate:	
Claims get denied on account of being duplicate. Either claim is re-filed it as the payment was not made in 30 days or the initial claim was processed with no payment.	In such cases, the second claim is considered duplicate and it's better to call Provider Services to verify the claim processing status before re-filing the claim.
Billing for non-covered services:	
A long list of Medicare exclusions exist like eye exams for prescribing, fitting or changing eyeglasses or contact lenses in the absence of disease or injury to the eye.	It is important to stay up-to date on the current exclusion policies either by checking with your Medicare carrier or by directly visiting Medicare's website.
Medical Necessity:	
A lot of claims are denied on the basis that the payer does not think the procedure done for the diagnosis was a 'medical necessity'.	Here, the medical records should show the preciseness of the tests conducted in form of photos anterior & posterior segment) that help in providing higher level of care.
Lack of awareness of National Correct Coding Initiative Edits:	
A review of which codes can/cannot be billed together on the same date of service will help in fewer denials.	You may access the NCCI Edits on the Medicare Web site & familiarize yourself with the appropriate code status of a specific CPT code. These may change on quarterly basis.

Medicare Eligibility of Beneficiary:	
Claims are denied due to an invalid Medicare number dueto- Non eligibility of beneficiary to receive medical benefits or claim filing to be done to another insurance plan.	Screen the Medicare number of the patient & check for effective date & status.

Medicare is a secondary payer:	
Applicant is 60+ years & covered under Employer's Group health Plan (EGHP) Cases of work related injuries included under workers compensation plan. Where primary filing should be under medical, Personal Injury Protection (PIP), workers compensation, auto, no-fault or policy including self insurance plans.	Obtain detailed information related to status of the Medicare patient on each visit and contact your Service Provider about potential conflicts that may arise and the appropriate coordination of benefits.

Invalid or Incomplete modifier usage:	
Claims are denied because the modifier that is needed to process the claim is either missing, incomplete or invalid.	Know the proper use of CPT modifiers to be used for specific conditions Misuse of modifiers is under the scrutiny of the Office of Inspector General & may result in significant penalties.

Primary diagnosis was not covered:	
Claims could be denied because the primary diagnosis mentioned was not performed.	Familiarize with the policies for medical necessity & related documentation Take caution in using any automated software that provides covered diagnosis.

Medical insurance vs. Vision insurance:	
Medical insurance rather than vision insurance is common. Reimbursement in former are higher than latter.	Before billing read through vision plan contracts. Some may clearly state that the contracting doctor can only collect vision plan co-pay even though the medical services are rendered. Understand medical billing rules which are different from vision plan billing rules

Account Receivables (AR) follow-ups and Denial Management:

Insurance Billing will always entail an outstanding AR, the skill is to keep it within 30 to maximum 90 days bracket. Here, is when the AR follow-up team comes into picture. The AR team:

- Is responsible for follow-up with the insurance company
- Manages the denial from insurance companies and works on their resolution.
- Analyzes the denied claims, partial payments and non-payments.
- Communicates with the patient, insurance company and the hospital/nursing home

Will outsourcing AR and Denial Management functions to medical billing companies beneficial?

Earlier, AR management used to be a departmental activity. The effectiveness of the AR team no doubt will directly impact the financial health of hospitals, doctors and nursing homes.

Outsourcing your AR and Denial Management functions to a medical billing company will not only increase your medical reimbursements, but will also maximize the effectiveness of collecting unpaid claims.

Medical billing companies have an expertise that handles the RCM for hospitals, nursing homes & doctors. They:

- Access the AR data through client's EMR/billing system for analysis and review
- Take care of the critical functions involved in AR management like filing of appeals, updating insurance contracts, assessing insurance low pays, managing unapplied balances and refunds, processing patient statements & delinquency letters.
- Sort the AR into buckets like current, 30-45 days, 45-60 days and above 60 days (working on critical claims first)
- Call the third party payers and insurance companies to check claim status, re-file or for gathering additional information
- Document and analyze the call outcomes to study AR trends like consistently low payments & reason for frequent denials
- Make reports on parameters such as:
  - Status of each claim
  - Payment received
  - Adjustments/ Write-offs
  - AR aging report
  - Outstanding and Trend Analysis

The experts are well trained and experienced in denial management.

Last thoughts on Optometry Billing

Coding for the optometric services has become seemingly complex, but keeping up with the latest policies and guidelines will ensure fewer coding and billing errors with a much higher probability of reimbursements resulting in greater profitability.

- While generating the claims ensure that the primary diagnosis supports the CPT code.
- A claims management system should be an important and integral part of your practice management system.
- If your practice management system has built in ICD codes, ensure that there are some error-checking features to check the accuracy of the claims.
- As an O.D., your practice should ensure that insurance billing is performed daily or at least weekly and not later than that.
- Your front desk staff should check a patient's insurance eligibility and authorization from your practice management system before booking an appointment or proceeding to the examination room.]
- If there are any glitches, you should explain the detailed charges to the patient. If their plan has a co-pay element, ensure that the payment is collected in full at the time of the service and not delayed.

About MBC (Medicalbillersandcoders.com)

MBC is the largest consortium in the US offering physicians customized solutions to all their billing related problems. Our technology and expertise caters to the exact needs of the physicians' billing requirement.

As the scope of Optometry has gone on to be extensive, its billing cycle management too has become an intense exercise. Providers who could easily manage in-house billing, now find it prudent to get it done by an outside agency that ensures cost minimization and revenue optimization, and enable them to focus on quality care.

Having evolved with billing challenges, our billing experts can extend their result-oriented services to the entire gamut of Optometry medical billing including prescription and fitting lenses to improve vision, diagnosis and treatment of eye disease and a multitude of laser surgical procedures.

Our medical billing management cycle results in:

- Simplified revenue cycle with enahnced collection rates
- More patient inflow and referrals, and
- Increased avenue for medical research and development

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