

# Optometry Coding & Billing Alert

Your practical adviser for ethically optimizing coding, payment, and efficiency in optometry practices

December 2011, Vol. 9, No. 5 (Pages 25-32)

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## Lens Services

### 92070 With 371.6x Focuses on Medical Necessity for Fitting Keratoconic Lenses

Follow this strategy and earn \$67 for each contact lens procedure.

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. The optometrist diagnoses keratoconus (371.60-371.62) and fits 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 the optometrist prescribes 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](http://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.

Based on the 2011 Medicare physician fee schedule, unadjusted for geographic location, you can expect about \$66.933 for 92070 (1.97 total transitional relative value units [RVUs] x 33.9764 conversion factor).

2012: But for claims beginning with date of service January 1, 2012, 92070 will no longer be an option; CPT® 2012 deletes the code. In its place, for a keratoconus patient, you would report new code 92072 (*Fitting of contact lens for management of keratoconus, initial fitting*).

**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. 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

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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).

**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 to perform 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 the optometrist 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. *Tip:* You should provide a concise statement about how this service differs from the usual, along with the operative report.

“CPT® does not provide specific direction as to the specific amount of time and/or percentage increase of time or work required to compliantly report modifier 22,” says **Marvel J. Hammer, RN, CPC, CHCO**, president of MJH Consulting in Denver. The typical rule of thumb, however, is your physician must spend at least 50 percent more

**ICD-10 Bridge**

Once ICD-10 is implemented in 2013, the diagnosis codes in the above story will be different. Check out this crosswalk for the correct keratoconus diagnoses:

ICD-9	ICD-10
371.60 ( <i>Keratoconus, unspecified</i> )	H18.601 ( <i>Keratoconus, unspecified; right eye</i> ) H18.602 (... <i>left eye</i> ) H18.603 (... <i>bilateral</i> ) H18.609 (... <i>unspecified eye</i> )
371.61 ( <i>Keratoconus, stable condition</i> )	H18.611 ( <i>Keratoconus, stable; right eye</i> ) H18.612 (... <i>left eye</i> ) H18.613 (... <i>bilateral</i> ) H18.619 (... <i>unspecified eye</i> )
371.62 ( <i>Keratoconus, acute hydrops</i> )	H18.621 ( <i>Keratoconus, unstable; right eye</i> ) H18.622 (... <i>left eye</i> ) H18.623 (... <i>bilateral</i> ) H18.629 (... <i>unspecified eye</i> )

*Optometry Coding & Billing Alert* (ISSN 1947-167x for print; ISSN 1947-1688 for online) is published monthly 12 times per year by The Coding Institute LLC, 2272 Airport Road S. Naples, FL 34112. ©2011 The Coding Institute. All rights reserved. Subscription price is \$199. Periodicals postage is paid at Durham, NC 27705 and additional entry offices.  
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time and/or put in at least 50 percent more effort than normal for you to append modifier 22.

**Caution:** You may get into some sticky split-billing situations when the optometrist inserts 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. □

## CPT® 2012

# Establish Whether A Patient is New With CPT®'s Latest E/M Tweaks

## New rules place emphasis on subspecialties.

It's an age-old debate — when an established patient presents to your practice to see a new physician, should you report a new patient office visit code? CPT® 2012 attempts to clarify when that's possible with a revision to the “New and Established Patient” section of the CPT® manual.

**The rules:** Currently, CPT® indicates that a “new patient” refers to a patient who has not received any professional services, such as an E/M or other face-to-face service from the physician or physician group practice — within the same physician specialty — within the past three years.

**Clarification:** CPT® 2012 takes that definition a step further, now stating, “A new patient is one who has not received any professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.” The portions of the description that are new for 2012 are underlined.

**What this means to you:** If your practice employs various subspecialists, CPT® now makes it clear that claims for patients who see different doctors with different subspecialties can be billed using a new patient code (such as 99201-99205). **Peter A. Hollmann, MD**, chair of the CPT® Editorial Panel, offered the following example during the CPT® 2012 Annual Symposium in Chicago on Nov. 16:

**Example:** A cardiology practice employs a general cardiologist and an electrophysiologist (EP), and both physicians are classified as these separate specialties with their payers. The cardiologist refers a patient to the EP for consideration of an implantable cardioverter-defibrillator. In this situation, the visit with the EP should qualify as a new patient visit, assuming the payer accepts these CPT® rules. □

## 5010 Readiness

# Medicare Won't Penalize You for 5010 Non-Compliance Until March 31, 2012

## Plus: Avoid PO boxes on 5010, despite what your MAC tells you.

Sweating over the fact that your 5010 standard won't be in place by the Jan. 1 deadline? CMS has an early holiday gift for your practice, with the Nov. 17 announcement that it will not initiate enforcement action regarding 5010 until March 31, 2012.

**Not a deadline shift:** CMS stresses in its statement that the 5010 compliance date remains Jan. 1, 2012. However, the agency will not penalize practices that aren't using 5010 until

after the new 90-day “discretionary enforcement period” ends in March, as long as practices can demonstrate that they are working toward 5010 use.

“If requested, covered entities that are the subject of complaints must produce evidence of either compliance or a good faith

*(Continued on next page)*

effort to become compliant with the new HIPAA standards during the 90-day period,” CMS says in its statement.

To read the complete CMS announcement, visit [www.cms.gov/ICD10/Downloads/CMSStatement5010EnforcementDiscretion111711.pdf](http://www.cms.gov/ICD10/Downloads/CMSStatement5010EnforcementDiscretion111711.pdf)

## Know the Rules for Address Field

If you’re sticking to your guns and leaving a PO box as your place of service address on the new 5010 form that will be required on Jan. 1, 2012, expect denials. That’s the word from CMS’s **Chris Stahlecker**, who spoke about this issue during the agency’s Nov. 9 HIPAA Version 5010 National Provider Call.

A caller phoned into the forum and said that her MAC told her that it would not enforce the restriction on the 5010 form that will prohibit practices from putting a P.O. box on 5010 forms as the place of service address. CMS, however, sang a different tune.

“That’s a very interesting comment for you to raise,” Stahlecker said. “The billing provider address line cannot be a PO box, and, no, CMS has not taken the position that that edit is going to be lifted at this time, so right now the edit is in place and the software that we have distributed to the MACs for them to be executing should cause a claim that comes in with a PO box to reject.”

Although the PO box issue has been a point of contention among practices throughout the healthcare industry, CMS has not formally issued anything that says you can use the PO box address. “We appreciate this difficulty,” Stahlecker added. “That said, we’re still not, as a payer, permitted to ignore such a requirement.” She noted that

CMS would have to “think very hard about impact” before such a change could be implemented. Until further notice, using a PO box will cause claims to reject, so you should stick with using a street address as the place of service address on your claims.

A second caller went even further in questioning CMS on this issue, noting that not only did her trading partner tell her that the PO box rejection would be suppressed, but would be “permanently turned off.” Stahlecker explained that this is the case when payers are paying one another, but not when paying medical practices. A “separate project is underway that is not between a provider to a payer — it’s something that’s being handled as separate from a HIPAA-compliant activity, and instead involves a flow going from a payer to a payer,” she said. In these transactions, because it is not an exchange between “covered entities,” Medicare can turn off the PO box edit and not be at-risk of violating HIPAA compliance.

Although some trading partners have interpreted that as meaning that all Part B MACs should turn off their PO box claim edit, CMS stressed the fact that this is not the case. Stahlecker reiterated the fact that the PO box issue is very real and will cause claim rejections as of Jan. 1.

## Paper Claims Can Still Use PO Boxes

One caller to the forum noted that when using paper forms, CMS recommends that Box 33 should be a physical address and not a PO box so it can be mapped to a 5010 form. However, “Providers are perfectly welcome to put a PO box on the 1500 form,” said CMS’s **Brian Reitz**. “What the NUCC recommends is just that — recommendations — there’s no force of law behind them.” □

## Build a Better Business

Streamline your collections system and get your deserved money faster with these practice management tips. *Optometrists*: Clip and give this monthly section to your claims specialist.

# Don’t Overlook Waiver Opportunities — 3 Steps Ensure Compliance and Patient Payment

**Hint: Documented financial hardship is your key.**

You’ve heard the mantra over and over — never waive a copay or deductible and don’t offer discounts! In many cases, that mantra is correct.

There are times, however, when you can offer patients with documented financial hardship a discount or waiver. Let our experts tell you the three steps to properly waiving patient fees based on financial hardship.

## 1. Understand the Exception to the Rule

Routinely waiving deductibles and copayments can violate several federal laws and regulations, including the federal False Claims Act, anti-kickback statutes, and compliance guidelines for individual and small group physician practices. Doing so may also violate payer contracts.

Even though the rule is that you shouldn't offer waivers and discounts, you can make exceptions based on financial hardship — if you follow a few guidelines.

“Waivers or discounts ... should be made only on the basis of demonstrated patient financial need,” says **Barbara Colburn**, president/CEO of B.C. & Associates Management Corp., a Wisconsin-based healthcare consulting/billing organization. According to Colburn, you must meet the following criteria:

1. You do not offer the waiver as part of any advertisement or solicitation
2. You do not offer waivers routinely to patients
3. You offer the waiver after determining, in good faith, that the individual is in financial need or after reasonable collection efforts have failed.

“In offices that I managed we always had the option of a financial hardship waiver but it was usually offered only after all other means of collecting were exhausted such as insurance, payment plans, etc.,” says **Marge McQuade, CMSCS, CMM**, a consultant and director of education for PAHCS in Florida.

**Note:** You can offer discounts to patient with no insurance who are self-paying without proving financial hardship. Offering waivers or discounts to insured patients, including Medicare patients, “may be suspect unless they are non-routine and related to genuine hardship,” Colburn says.

**Pointer:** “Have a financial policy in place about how you handle patients with financial hardships,” advises **Catherine Brink, CMM, CPC, CMSCS**, owner of HealthCare Resource Management, Inc., in Spring Lake, N.J. “This is very important since it ensures you don't ‘discriminate’ how you handle finances with your patients.”

## 2. Get It In Writing

Don't just take the patient's word for it when it comes to financial hardship. Before you agree to a debt write-off, the patient needs to be able to prove he is unable to pay.

“You need documentation that the patient has a financial hardship in order to waive or discount your fees,” McQuade says.

To prove financial hardship, you'll need to ask the patient to provide you with information such as income tax returns and W-2 and 1099 forms as proof of income and essential monthly household expenditures, such as mortgage/rent, utilities, insurance, and food.

You'll then use this information to determine whether the patient's earnings meet state and federal poverty guidelines.

“Make sure you work within the poverty guidelines for your state,” McQuade cautions.

**Official guidance:** The Office of the Inspector General (OIG) states “we do not believe it is appropriate to apply inflated income guidelines that result in waivers for beneficiaries who are not in genuine financial need.”

The patient and the physician should also sign a statement detailing that the practice reviewed proof of financial hardship and listing what charges the practice is waiving. Your practice should keep a copy and provide a copy to the patient as well.

“The provider should keep up with legal developments related to discounts and waivers of co-payments and deductibles,” Colburn explains.

**Key to success:** You also should only apply the determination of financial hardship to the particular visit or service you are billing for at the time, not to any future services.

## 3. Don't Avoid Collections If Waiver Is a No Go

If a patient applies for financial hardship but your practice deems that the patient does not meet the qualifications for a waiver, you should send a waiver denial form, such as the one on page 52. But don't let that stop your collections efforts and end up in a write off. You then need to proceed with billing the patient and letting him know you expect payment.

In the event that you cannot establish financial hardship, CMS requires that you make a “good faith attempt” to collect money from a patient. This might consist of sending two bills, followed by two phone calls, and a final notice. That cycle is up to your practice's discretion.

**Option:** “If a patient applies for financial hardship and doesn't qualify the next step would be offer a payment plan for the

*(Continued on next page)*

## You Be the Expert

### Dx for Post-LASIK Cataracts

#### Question:

*A patient who has had LASIK surgery now has cataracts. One of our optometrists performed topography to calculate the IOL power. The cataract diagnosis (366.16) is not listed as a covered code for that diagnostic service. Which diagnosis code should we use for the topography?*

Connecticut Subscriber

**Answer:** See page 31. □

patient depending on the amount the patient owes and at what point you are doing the waiver (after insurance, self pay with payment plan first, etc.),” McQuade says.

“For example, ask for credit card to keep on file that you would charge, say \$50 each month,” agrees Brink. “Have the patient

sign this financial agreement.” If the patient doesn’t have a credit card, then set up a financial payment plan signed by the patient stating that he will pay by check or cash by a certain day of each month and the amount he will pay plus the date the balance will be paid in full, Brink adds. □

## Reader Questions

### 92225-92226: Apply Initial EO Code to New Condition

#### Question:

*I'm confused about the extended ophthalmoscopy codes. Is 92225 for a new patient and 92226 for an established patient? Should I bill twice for both eyes?*

California Subscriber

#### Answer:

The extended ophthalmoscopy (EO) codes, 92225 (*Ophthalmoscopy, extended, with retinal drawing [e.g., for retinal detachment, melanoma], with interpretation and report; initial*) and 92226 (*... subsequent*), don’t correspond to new and established patients. CPT® does not intend for 92225 to be a one-time-only code, only to be used with new patients. Rather, report 92225 for the initial EO associated with new symptoms of a nonchronic condition for each eye.

**Example 1:** The optometrist sees a patient complaining of flashes and floaters in the right eye. He performs an initial EO (92225-RT), finding post vitreous detachment. He asks the patient to return in six weeks. At that visit, he performs a subsequent EO (92226-RT). A few weeks after that, the patient returns, now complaining of flashes and floaters in the left eye. Since this is a different eye and an initial EO was not performed, report 92225-LT.

**Example 2:** A physician refers a diabetic patient to your office for a consultation. The patient has diabetic retinopathy, a chronic condition. At the first appointment, the optometrist performs an initial EO (92225-50). He asks the patient to return in a year for a dilated exam, at which point he performs a subsequent EO (92226-50). He returns again in another year for another subsequent EO (92226-50).

Medicare reimburses both 92225 and 92226 unilaterally, which means that if the optometrist performs EO on both eyes, including the drawing and report, you can report the codes bilaterally and receive twice the payment you would have gotten for one procedure. Append modifier 50 (*Bilateral procedure*) or modifiers LT (*Left side*) and RT (*Right side*) to indicate the bilateral performance of the procedure.

Medicare may also have very specific policies about the requirements for these drawings. In most cases, you should have documented drawings that are 3-4 inches, using 4-6 standard colors with findings that are labeled. In addition, if a patient has glaucoma, the record should have a separate drawing with the optic nerve detailed.

**Crucial:** Before an optometrist performs an extended ophthalmoscopy, the medical record must support documentation of having performed a general ophthalmoscopy with findings that are indicative of medical necessity to perform the extended test. A general ophthalmoscopy is included in the eye examination and not separately billable. However, reporting an extended ophthalmoscopy without the general exam and subsequent need to perform the extended exam would likely trigger a denial or recoupment of monies following an audit.

**Watch for:** Occasionally, it may be necessary to append modifier 79 (*Unrelated procedure or service by the same*

## Are You Prepared for 2012 Coding Changes?

### Join Audio Conferences by Industry Experts on 2012 Coding Updates!

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physician during the postoperative period) to 92226, as this code is not considered “diagnostic,” if performed during a post-op period for an unrelated diagnosis. ❑

## 68761 With E/M? Check Documentation First

### Question:

*When my optometrist does a comprehensive exam (92004) and decides to insert punctal plugs on the same day, do I need the 25 modifier on the exam?*

Texas Subscriber

### Answer:

If you plan to report 92004 (*Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient ...*) separately, then yes, you would need to append modifier 25 (*Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*).

You should first check that your chart note supports billing the E/M with modifier 25. You have to prove that the E/M was a significant, separate service from the punctal plug insertion (68761, *Closure of the lacrimal punctum; by plug, each*) because every procedure has a small amount of E/M service already built into it.

**Tip:** Ask yourself whether the E/M documentation — which should also indicate medical necessity for the E/M and

subsequent procedure — would stand alone for payment if you hadn’t inserted the punctal plugs.

**Watch for:** You may determine that another coding option, such as ophthalmic exam codes 92002-92014, suits a particular service better than an E/M code. Always report the code that is most appropriate for your service.

**Most important:** There is a 10-day global period for punctal plug insertions. If the patient reports improvement later, and returns within 10 days to have permanent plugs placed, you may only bill for the insertion — not a separate office visit — because the plug insertion is the only reason for that visit.

However, if the patient returns after 10 days, you can bill an E/M code only if it is necessary for your provider to perform another E/M service. ❑

## Know When to Bill Secondary Payer

### Question:

*We have many patients with secondary insurance, some of which have deductibles on the secondary. In these cases, should we write off the amount of the deductible because it’s secondary, or do we bill the patient?*

Virginia Subscriber

### Answer:

Most practices do bill the secondary insurance on behalf of patients, but if the patient has a deductible on the secondary insurance, you can and should bill the patient that amount.

You can find out about secondary insurers by asking the patients for the information when they first present to your practice and fill out the financial information form. You will need to verify which insurance is primary — then bill that payer first, followed by the secondary insurer. Once you get the EOB from the primary payer, you’ll send your claim to the secondary, with a copy of the primary’s EOB attached.

After you’ve received both payments, you’ll make the appropriate adjustments depending on your participation with the insurance plan and billing guidelines. You should not write off deductibles, copays, or coinsurances. You’ll bill the patient for any remaining balance once you have both payments. Of course, individual payer contracts reign when determining where to collect.

**Hint:** Some secondary insurers pay the primary’s co-pay (including Medicaid as the secondary insurer), but many do not. Most experts recommend collecting the copay if you’re unclear on whether it will be covered, but if it’s later paid by a secondary insurer, it should be refunded back to the patient. ❑

## You Be the Expert

### Dx for Post-LASIK Cataracts

*(Question on page 29)*

#### Answer:

Some payers accept V45.69 (*Other states following surgery of eye and adnexa*), indicating previous LASIK surgery, as a covered diagnosis for corneal topography. However, some payers, such as Cigna, specify that V45.69 must be accompanied by diagnosis code 367.22 (*Irregular astigmatism*). Check with your payer to see if it has such limitations.

Corneal topography is an alternative method for determining IOL power in cases in which previous LASIK surgery makes it difficult to use an A-scan or IOL Master. Report 92025 (*Computerized corneal topography, unilateral or bilateral, with interpretation and report*) for the test. ❑

# Optometry Coding

## BILLING ALERT

We would love to hear from you. Please send your comments, questions, tips, cases, and suggestions for articles related to *Optometry Coding & Billing reimbursement* to the Editor indicated below.

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