Optometry Coding & Billing Alert

End 'Medical vs. Vision' Insurance Confusion

When your patient has both types of insurance, who gets the bill?

A patient presents for what you expect will be a routine vision exam, but then you find cataracts. Should you still report the service to the patient's vision plan or to his medical plan because the optometrist found a medical problem? Or both?

Follow these guidelines to ensure you don't get into hot water with your patient -- not to mention CMS.

Check CC and HPI for Clues

As for which plan you should report the provider's services to, you-ll base the decision on why the patient is in the office. The key factors are the patient's chief complaint (CC) and history of present illness (HPI).

"You should bill the medical plan if your complaint/diagnosis is medical, and vision if the patient came in for a routine eye exam and your diagnosis is for a routine eye exam," says **Vi Ballensky,** administrator for Inland Eye Center in Spokane, Wash.

Example: A patient arrives complaining of blurred vision of recent onset. Your case history reveals no history of amblyopia or other longstanding problem causing the blur. You find that cataracts are causing the blurriness. Report the office visit to the patient's medical insurance with the appropriate eye exam code (92002-92014, Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program -), and link it to the appropriate cataract code (366.xx).

As a secondary diagnosis, report 368.8 (Other specified visual disturbances [blurred vision NOS]). If, however, you find no cataracts or any other condition, including a refractive error, causing the blurred vision, report 368.8 as the primary diagnosis.

No Complaint? Look to S0620-S0621

A patient sees you for a routine eye exam and has no complaints. How should you code in this case, and which plan should you submit your claim to?

You-ll still code according to why the patient is there. If the patient comes in with no specific complaint, but you diagnose a medical problem, report the routine visit as the primary diagnosis and the medical condition as the secondary diagnosis. Bill that visit to the patient's vision carrier. Your diagnosis code must relate to the chief complaint -- so when the patient has no complaints, the visit is routine no matter what you find.

Check your codes: Many vision plans specify that you use HCPCS codes S0620 (Routine ophthalmological examination including refraction; new patient) and S0621 (- established patient) for a routine exam. Other plans may want the general ophthalmological services CPT codes 92002-92014. For example, Medicare does not accept the S codes, but many Blue Cross/Blue Shield plans use them. So check with your individual carriers to be sure which code set you should use.

Have Patient Return for Further Tests

Experts say: When you do find a medical problem during a routine exam, you might consider having the patient return on another day for further tests, rather than convert the exam from routine to medical. A patient who thought he had a routine screening with a $20 copay may be confused and upset when he sees a bill for a medical eye exam -- even if his out-of-pocket expenses are the same.

If there is a follow-up exam later, the medical condition will be the primary diagnosis and the bill goes to the patient's medical insurance.

Example: A patient with no complaint comes in for the routine eye exam that his vision insurance provides. You discover glaucoma. Bill the patient's vision insurance with S0620 or S0621, and link it to V72.0 (Examination of eyes and vision). As a secondary diagnosis, report the glaucoma (365.xx).

When the patient returns for further diagnostic tests -- such as 9208x (Visual field examination, unilateral or bilateral, with interpretation and report ...) and 92020 (Gonioscopy [separate procedure]) -- link the codes to the glaucoma diagnosis, and send the claim to the medical insurer.

Bonus: There are times when you should bill both the patient's medical plan and vision plan. "Our office has billed some visits to both medical and vision plans and gotten paid the contracted amount by both," says **Carolyn M. Osborne,** who handles patient accounts for William B. Shannon, MD, in Gastonia, N.C.

Caution: Only report to both plans when the carrier has instructed you in writing to do so. Also, when determining the service level for the problem visit, do not include physician work for glasses/contact lenses.

You shouldn't have a problem reporting noncovered services to a patient's secondary plan (for example, refractions, contact lens fittings, etc.), but you shouldn't submit an E/M code and/or an eye code to both of the patient's insurance plans unless instructed in writing to do so by both plans.