Optometry Coding & Billing Alert

You Be the Expert: Refraction for Medicare Patient

Question: A Medicare patient came in just to have his prescription updated. If I only performed a refraction, how should I code? Should I even bother submitting the claim to Medicare?

Arkansas Subscriber

Answer: Regardless of whether a patient is on Medicare, if you perform -- and charge for -- a refraction (92015, Determination of refractive state), you should code and submit a claim for it. If you do not charge separately for refraction, as many optometrists don't, Medicare does not want you to code for the service on the claim form.

Educate the patient to avoid collection problems. Some groups use inserts in statements, office handouts and flyers in the waiting room. Medicare considers refraction a noncovered service at all times and under all circumstances.

The patient is responsible for paying the service. As a noncovered service, refractions don't require an advance beneficiary notice, but you should inform the patient that refraction is noncovered and, as such, the patient will be responsible for payment.

When a patient who had a refraction checks out, bill or ask for payment then. You are not obligated to file a claim and wait for Medicare to deny it before collecting from the patient.

If you perform the refraction during a postoperative visit for cataract surgery, you may collect it. Or, as a sign of goodwill, include it along with other postoperative care (although you will not get paid for it, and most patients require several refractions after surgery).

Modifier GY: If the patient insists that you submit a bill to Medicare for a noncovered service like refraction, use modifier GY (Item or service statutorily excluded or does not meet the definition of any Medicare benefit), which notifies Medicare that you're aware that the service isn't covered, but you're billing simply to obtain a denial. Medicare will automatically deny the claim, and the EOB will state that the patient is liable for the charge.