# SAVVY CODER

# Tricks of the Trade: Coding for a Pediatric Ophthalmology Practice

There are many marvelous moments when you work with children. At the slit lamp, for example, glimpsing the wonder and delight in a child's eyes is its own reward. But if your practice is to receive the financial rewards that it is due, you'll need to navigate some nuances of reimbursement that are particular to pediatric ophthalmology.

## Medical or Vision Exam? Prevent Copay Confusion

Insurance benefits for children often differ from those for adults, and this goes beyond the fact that many of the former are eligible for Medicaid. The Affordable Care Act (ACA), for instance, requires health plans to provide additional benefits for children.

**Vision screening, vision exams, and medical exams.** The ACA requires health plans to cover routine vision screening and vision exams for enrollees younger than 19. The screening falls under the ACA's category of preventive care, meaning that the patient's family won't be charged for it. A vision exam, on the other hand, can involve a copay or co-insurance, but these are often much lower than they would be for a medical exam.

**Conflating the two exam types causes copay confusion.** When parents take their child for a vision exam, and later return to the same office for a medical exam, they are often surprised when they are charged a lot more for the second visit than for the first.

**Train staff to tell the difference.** Ensure that staff members who schedule appointments know how to differentiate a medical exam from a vision exam. They should determine the specific reason for the visit, as that is the first step in ascertaining which type of exam it will be.

**Provide staff with scripts.** Be sure that front-desk staff talk to patients about copays when an exam appointment is first made. You can help by providing them with scripts that explain the following:

1. **If the practice does not participate with the patient's insurance,** the child's guarantor (often the parent) will be responsible for all charges. Offer a fee estimate per the No Surprises Act (see aao.org/surprise-billing).

2. **If the appointment recall or request is for medical services** and the insurance has a known copay or requires co-insurance, notify the guarantor that they will be responsible for that payment. However, if the insurance has a high deductible that won't be met at this visit, notify the guarantor that they will be responsible for all allowed charges and offer an estimate of the contracted fee.

3. **If the appointment recall or request is for a routine vision exam** and the insurance plan does not cover this service, inform the guarantor that the charges will be their responsibility, and offer a fee estimate. If the plan does cover a vision exam, verify that the patient is eligible for it. (Note: many plans limit eye exams to one per year. Although the ACA requires plans to cover pediatric vision exams, some plan types, such as short-term plans, don't have to comply.)

4. **If the insurance plan details are unknown,** inform the guarantor that the practice will obtain eligibility and benefits information before the appointment and will contact them about their financial responsibility.

5. **If it is unclear whether an appointment will be for a medical or a vision exam**—because, for example, the appointment request is vague ("needs eye exam")—take these steps.
• Verify the specialist office copay for a medical exam.
• Confirm that the patient is eligible for a vision exam. If so, verify the copay.
• Quote each copay amount to the family and ask them to be prepared to pay the greater amount.

**Educate families in the exam lane.** Later, when the patient is in the exam lane, the physician and allied health staff can explain the difference between medical exams and vision exams.

## Use of E/M Codes

Ensure that all physicians and support staff in your practice are formally trained in the current E/M require-

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ments, which underwent major changes in 2021 (see "Coding Resources").

**Determine what level of MDM your documentation supports.** You have to document only a medically relevant history and an exam, and you can use the complexity of medical decision-making (MDM) to determine the level of E/M code. MDM complexity depends on three factors: 1) the problems addressed, 2) the data reviewed and analyzed, and 3) the risk of complications and/or morbidity and/or mortality. When at least two of those factors meet or exceed the same level of MDM, that would determine the overall level of MDM. The following examples showcase a few of the category definitions:

**The problem category** would point to a low level of MDM if, for example, just one stable chronic illness is evaluated, whereas a chronic illness with progression points to moderate level.

**The data category** would meet MDM of moderate complexity if, for example, you review incoming chart notes and imaging or testing done elsewhere, along with obtaining information from an *independent historian.* (Note: this term refers to someone other than the patient, such as the parent of a patient who is too young to talk to the physician.)

**The risk category** may point toward moderate complexity MDM if, for

example, it involves highly sensitive care, such as treating amblyopia in a developing child, and if diagnosis or treatment of the patient is significantly limited by social determinants of health (SDOH; for more on SDOH and E/M coding, see the July 2022 Savvy Coder at aao.org/eyenet/archive).

**What about Eye visit codes?** When you use Eye visit codes, remember that the guidelines are not the same as for E/M codes. If, for example, you bill for Eye visit code 92004, it is recommended that you perform and document all 12 exam elements. If you are unable to perform an element—because, for example, of the patient's age or trauma—document the reason for the omission. You also must document the initiation of diagnostic and treatment programs.

**Tip.** The 92004 code's definition states that the exam "often includes, as indicated: biomicroscopy, examination with cycloplegia or mydriasis, and tonometry." Based on this, auditors historically looked for a notation of dilation, and still do. If you do not dilate, document why it was contraindicated.

**Check the payer's policy on medical ICD-10 codes.** Insurance plans that include a routine vision exam may flag Eye visit codes that are linked to a medical ICD-10 codes and either deny the claim or reimburse it as a vision exam. Some plans require use of HCPCS codes S0620 and S0621 instead of Eye visit codes. These HCPCS codes include the refraction in their descriptor, which means that they aren't billable separately from the vision exam.

## Sensorimotor CPT Code 92060
The standard eye exam includes a basic sensorimotor assessment. However, to bill for CPT code 92060, a more advanced sensorimotor exam must be performed to test for conditions such as strabismus, nystagmus, amblyopia, torticollis, and craniofacial syndromes.

**How do you document that the test was delegated to staff?** When the sensorimotor test is delegated to ancillary staff, a physician order must be documented. The order should include: 1) the test(s) to be performed, 2) in which eye(s), and 3) the medical necessity. The physician should also complete

an interpretation and report of the test results.

**What if the physician performs the test?** When the test is not delegated, no order is needed. But, in case of a future audit, the documentation should make it clear that the physician performed the test. (Many practices make a note that the physician performed the test when the findings are documented.)

**How do you document the findings?** Documentation requirements for CPT code 92060 include multiple measurements of ocular alignment in different fields of gaze and/or at different distances. You also need to document at least one sensory test on patients who are able to respond, such as stereo rings, stereo fly, and/or the Worth 4-dot test.

**Can you bill the same day as an eye exam?** Suppose you perform a sensorimotor exam and an eye exam on the same day. Commercial payers that follow Medicare's rules will reimburse you for both CPT code 92060 and an E/M code or Eye visit code, even if they had the same date of service. However, due to the 92060 descriptor's "separate procedure" language, some commercial payers will not cover the service when performed the same day as an exam.

For more guidance on CPT code 92060, see the November 2021 Savvy Coder at aao.org/eyenet/archive.

## Exams Under Anesthesia
In some cases, it is necessary to perform an exam under anesthesia (EUA).

**Watch for bundling.** The EUA CPT codes 92018 and 92019 are bundled with most surgeries. So, for example, if an EUA reveals an embedded conjunctival foreign body, you shouldn't bill for both the EUA and foreign body removal. If you do, the payer will likely pay you only for the lowest valued service.

**No facility rate for ASCs.** When an EUA is performed in an ambulatory surgery center (ASC), there is no allowable facility rate for that service. So while the payer will pay the physician for the service, it won't pay the ASC for use of the facility.

**MORE ONLINE.** For more on MDM and EUA, see this article at aao.org/eyenet.