Editor’s Note
Upon occasion it is prudent to publish information about practice management and the administration of behaviorally oriented practices. This Viewpoint article is a type of practice management paper. There are a number of points that should be emphasized to the reader. The opinions are those of the author. The procedure codes that are described here appear to be applicable for the state of Tennessee. Coding policies vary from state to state. Other states may have different codes and each practitioner should investigate, through the state board of optometry, if these codes apply to your state.

Abstract
This paper documents a change in the billing procedures of a private practice in Tennessee. The change is not in the testing or therapy procedures that are employed but rather in the manner that the testing/therapy procedures are described. New ICD-9 codes are suggested for use. These codes better represent and better describe the functional activities that are used in the practice of optometric vision therapy.

Key Words
functional neurology, ICD-9 codes, orthoptics/pleoptics, therapeutic activities, therapeutic procedure, vision therapy

The importance of in-depth knowledge of the central nervous system in the practice of optometry is evidenced by the number of hours devoted to the subject in its professional curriculum. Although these didactic hours emphasize neuro-pathology, this knowledge is particularly helpful in the practice of vision therapy (VT). Optometrists utilize VT procedures to impact these neural networks to eventually improve areas of neural processing. Optometrists have traditionally documented VT in terms of procedures performed, rather than in the underlying neurological systems being remediated.

The following chronological history of the changes that took place in my practice represents a case in point. The practice is devoted exclusively to the remediation, by means of VT, of all areas of visual dysfunctions. We traditionally billed the patient and submitted insurance claims, but most frequently received denials of coverage. In the fall of 2005, this pattern was changed. We had applied for prior approval of a VT program for a patient with multiple diagnoses. The primary diagnosis was Duane’s syndrome, Type 2 (ICD 378.71). The secondary diagnoses were binocular vision dysfunction, unspecified (ICD 368.30) and refractive disorders. We were fully expecting to receive a standard form letter stating that VT was not a covered service under the patient’s policy. Much to our surprise, we received a letter stating that the insurance company would pay for 26 VT sessions. They further instructed our office, to use specific CPT-9 codes. A copy of the letter is found on page 127.

These approved codes included (See the upper right hand corner of the letter): 97530: Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes 92065: Orthoptic and/or pleoptic training, with continuing medical direction and evaluation 97110: Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

The letter indicated that this insurance company would pay me for these three codes. Further, the insurance company indicated it was paying on the basis of a binocular dysfunction (ICD-368.30) and not the Duane’s diagnosis. (See the upper right hand corner of the letter, under service.)

We were aware that these 97000 codes are used by occupational therapists (OT), physical therapists (PT), and speech therapists (SLP). However, it was evident that the insurance company had not limited these codes to OT, PT or SLP. They are classified as neuro-rehabilitation codes. Medicare assigns these codes to OT, PT, and SLP, when ordered by a MD, DO or OD. We had never billed these codes for optometric services but were somewhat familiar with them because our office does provide OT services. To assure that we could legally use these codes we sent a copy of the insurance company’s letter to the Tennessee State Board of Optometry along with the definition of the 97000 codes and our proposed use of these codes. The State Board of Optometry approved the 97000 codes for use by optometry in Tennessee. These codes are, therefore, within the provisions of the practice of op-
with any procedure. For example, any procedure that includes balance or movement is now classified as:

- vestibular stimulation, vestibular stimulation with (linear, circular, or lateral) motion, or vestibular stimulation in multiple or dynamic positions, or stimulation of vestibular ocular reflex response (if vision is used while balancing).

If the procedure calls for red/green filters, this can documented as:

- monocular fixation in a binocular field.

If both the balance activity and the red/green filter activity are used together, the procedure could be described as:

- vestibular stimulation and stimulation of vestibular/ocular reflex while using monocular fixation in a binocular field to increase functional range of motion in lateral and functional fields (formerly written as R/G glasses on the balance beam).

What is the practical, clinical difference between documenting by procedure and documenting by neurological affect? The answer is, none. One is written for office staff to understand while the other is written for the insurance review and interaction with health care colleagues. This difference in the description is a translation of principles of neurological rehabilitation and biofeedback (VT). These are services that optometrists have been performing for years.

A good reference to assist with the language of neurology is Leigh and Zee’s *The Neurology of Eye Movements.* This text, written by two neurologists, describes the processes and neurology for VT. It gives an excellent theoretical base as to how and why VT works. The principles are described in neurological terms. It is my sense that as optometrists we must change our language to describe procedures differently, to improve our communications with other professionals.

Behavioral optometrists understand the neural associations between vestibular, tactile, proprioceptive, auditory systems, and vision. So this “change in paradigm” is not really a change in what we do or how we do it. This change brings optometry into the present and projects us into the future. Correct documentation, coding, and reimbursement are important for successful communication with insurance companies and other professionals.

Optometrists, especially the behavioral, the developmental, and the rehabilitative optometrists, have always been at the forefront in the understanding of visual functioning, except in the areas of documentation and reimbursement. A change in how we describe what we do should not be difficult to apply. We must, speaking in functional terms, move forward with central focus and peripheral awareness to improve our documentation and coding.

The College of Optometrists in Vision Development (COVD) is at the forefront of the American Optometric Association’s emphasis toward board certification. The COVD certifies competence in the area of VT. Fellows of COVD are board certified specialists, with adequate training and skills to insure the public of competent care. Reimbursement should be at an appropriate specialization level when we are dispensing specialized services.

References

October 27, 2005

JASON CLOPTON OD
600 East Veterans Drive
COOKEVILLE, TN 38501

Subscriber: LAURA D
Patient: 03/31/68
Date of Birth: 03/31/68
ID #: [Redacted]
Provider: JASON CLOPTON OD
Service: 9730, 92065, 97110 - VISION THERAPY FOR BINOCULAR DYSFUNCTION

Dear LAURA D,

When you need health care services, the last thing you want to worry about is your health care coverage. At Anthem, we want you to get the most from your benefits.

Based on the available information, and your health benefit plan, you have coverage for the above referenced service. You are covered for this service provided that:

- The information we received about this service is accurate;
- You are still eligible under the plan when the service is rendered;
- The premiums have been paid to the date the service is rendered.

Of course your deductible and co-payments apply before final payment can be made. Prior services received, but not yet filed with Anthem may affect this coverage determination. See your Schedule of Benefits regarding benefit maximums and limitations.

If your Anthem coverage does not change, this predetermination approval is valid for one year from the date of this letter. However, if your coverage with Anthem changes or renews before you receive this service, you should initiate a new predetermination. Your benefit renewal date is 01/01/06.

This letter does not address the need for precertification. To see if this type review is required for your service, please call the precertification phone number on the back of your Anthem ID card.

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Sincerely,

Medical Review Department
C: JASON CLOPTON OD

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