The Use of CPT CODES in Optometric Vision Therapy

Richard Soden, O.D./Allen H. Cohen, O.D.

ABSTRACT

When billing for vision therapy services, practitioners must be consistent and fully understand the policies, procedures, and the coding system utilized by the insurance industry. This article reviews some relevant topics as they relate to the billing of vision therapy services under major medical insurance. In addition, the use of pre-authorization for vision therapy coverage is discussed.

KEY WORDS

orthoptics, vision therapy, CPT-4 coding, ICD-9-CM coding, medical necessity, pre-authorization

Vision therapy (or visual therapy or orthoptics) is a treatment modality that has been recognized by major medical insurance carriers for some two or more decades. Indeed, there was a time when virtually the only optometric services for which a patient could receive third party reimbursement were in this area of care. However, as medical costs have increased at a rapid rate and more people have availed themselves of vision therapy, many insurance companies are reviewing their reimbursement trends to assure that only "medically necessary" services are being rendered. "Medically necessary" or "medical necessity" means that the services or supplies provided are appropriate and required for the symptoms, diagnosis, and treatment of the patient's condition and are within the standards of good practice accepted by the organized medical community within a given location. "Medical practice" is a generic term which encompasses health care practitioners whose services are covered. Each insurance company may have its own definition of "medical necessity" and may have developed its own standards to assure that a service meets its definition.

Recently, some practitioners have found that individual claims for vision therapy services have been questioned. Inquiries have required reports ranging from the specifics of testing and estimation of the number of visits anticipated, to copies of the actual patient record.

In the interest of fiscal responsibility, one cannot question the carrier's right or motives to determine that the services are appropriate and the costs reasonable. However, there are times when an insurance company will deny payment for incorrect reasons. These include, but are not limited to, the following:

a. An unfamiliarity with optometric vision therapy
b. The carrier's lack of knowledge of scientific evidence for the efficacy of this treatment modality
c. The failure of the insurance company to apply freedom of choice laws
d. Non-optometric consultants rendering opinions and advice in an area with which they have little expertise and familiarity.

In general, most insurance companies will rectify situations when they become aware that a claim has not been appropriately considered. This sometimes requires individual action by the practitioner and can include supplying literature on the efficacy of vision therapy[1,2] or requesting the intervention of the national or state optometric organization's legal or informational resources. However, claims are frequently questioned or denied because the optometrist did not fully understand the intricacies and rules of the system by which claims are processed. Appropriate insurance codes may not have been used. As a result, services that are covered by the patient's policies may not have been processed properly.

As optometry has increasingly become part of the mainstream of health care, an additional responsibility has been added in terms of providing optimal patient services; namely, that the practitioner be thoroughly knowledgeable and conversant with third party procedures so that the patient is reimbursed for all medically necessary services provided by his health care policy. Our goal in this article is to give the reader a basis and rationale for using the proper and appropriate insurance codes for diagnostic and therapeutic interventions in optometric

vision therapy. This will ensure that claims are expedited with minimal problems for the patient, the carrier and the optometrist.

CPT CODING[3]

"Current Procedural Terminology" (CPT) is a compilation of the descriptive terms and identifying codes for reporting medical services and procedures. This system was designed by the medical profession to provide a uniform language that accurately describes medical services, and diagnostic, therapeutic and surgical procedures. Currently, the fourth edition of the book is in use;[3] both practitioners and insurance carriers refer to this as CPT-4 coding. Sections within this book include guidelines for using specific codes, as well as other information needed to provide an effective means for nationwide communication among health care providers, patients and third party carriers. Each procedure or service is identified with a five-digit code. The use of this code accurately identifies the type of service rendered by a practitioner. This book is updated annually as new procedures are developed, old ones become obsolete, or existing procedures need to be modified to reflect changes in professional practice. The American Optometric Association has published its own version of this book[4] which extracts information particular to eye and vision care.

While CPT codes are used to specify all optometric procedures, we shall limit the discussion to the use of these codes first to diagnostic testing in vision therapy and then to treatment and related services in this area.

DIAGNOSTIC TESTING

Binocular Dysfunctions

CPT breaks down primary examination services into the following categories: comprehensive, extended, intermediate, brief, limited and minimal. Different codes are used in several of the categories depending on whether the patient is considered "new" or "established." The precise definition of these is found in the CPT book[3] (page xiv) and the reader is referred to this source for further clarification.

The intake or initial examination for the potential vision therapy patient is usually billed as a "comprehensive" level of service. This designation presupposes that customary testing of the visual system is carried out, including basic sensori-motor testing. Consequently, procedures such as cover testing, pursuits, saccades and fusional ranges are included under this code in addition to an eye-health evaluation and other procedures generally associated with this level of service. The intermediate, brief and limited descriptions are usually reserved for vision therapy progress evaluations according to the extent of the testing performed. When testing is required beyond the basic sensori-motor evaluation in order to make a differential diagnosis or to determine if vision therapy is an indicated treatment modality, the CPT designation is 92060; "Sensori-motor examination with medical diagnostic evaluation, separate procedure"[3] (page 26) and is included in the Specialized Ophthalmological Services section of the book[3] (pages 26-28).

This single code, 92060, is to be used for secondary testing of all binocular dysfunctions such as strabismus and amblyopia, anomalies of accommodation and convergence as well as ocular motility deficiencies, including pursuits and saccades. Consequently, there is no recognition that diagnostic regimens can vary in time and complexity, i.e., a strabismic amblyope's diagnostic workup usually requires more testing than that of a convergence insufficiency. This becomes a problem because insurance companies develop a profile on each practitioner's fees. A profile reflects the usual and customary fee that is charged by the practitioner for a particular CPT code. Our experience is that most third party carriers advise the practitioner to charge the same fee for a given code in order to maintain profile consistency. A potential problem exists with this situation. An insurance company's profiled fee for a sensori-motor exam for a more complicated case (e.g., a strabismic) may be based upon the fee for a less complicated case (e.g., an accommodative/convergence anomaly). The practitioner needs to make a distinction between these two while still using the CPT format. This can be accomplished by either of two mechanisms.

The first involves billing different fees for different testing situations while still using CPT code 92060. As previously stated, this could affect the practitioner's profile and require a narrative explaining the extensive level of testing performed. The second mechanism involves the use of modifiers[3] (pages3-5). This concept is built into the CPT system and informs the carrier of unusual circumstances requiring more testing than the practitioner's profile would indicate. Modifiers are two digit codes which are recorded after the standard CPT code on an insurance form. By designating the strabismic/amblyopic evaluation discussed above as "92060-22," the practitioner is informing the insurance company that the services performed were greater than usually required for sensori-motor testing (CPT 92060). Modifiers are not included in the insurance company's determinations of the practitioner's profile. Often, these claims are processed by a claim's supervisor as opposed to a claim's processor. This may result in increased scrutiny of the claim as well as a possible request for additional information prior to the claim being considered.

Visual Perception

Visual-perceptual evaluations, if medically necessary, can be billed utilizing specific CPT-4 codes. These codes are 95881 and 95882, which are listed in the "Neurology and Neuromuscular Procedure" section of CPT[3] (page 54) and may be appropriate for extensive testing for developmental and cognitive deficits. The specifics of these codes are as follows:

a. CPT Code 95881 - Assessment of higher cerebral function with medical evaluation, developmental testing.
b. CPT Code 95882 - Assessment of higher cerebral function with medical evaluation, cognitive testing.

Since these codes are listed under the neurological section of CPT-4, optometrists may be asked to justify their use of these services. This is in spite of the fact that the listing of a service or procedure and its code in a particular section of the book does not restrict its use to a specific specialty. In addition, when utilizing these codes, care must be taken to assure that the testing was not performed for educational or remedial purposes since these usually are not covered by major medical insurance companies.

Case Conferencing

After the diagnostic testing is complete, a discussion of the results and treatment recommendations should take place

with the patient and/or his agent. CPT-4 specifies two codes for this purpose. They are as follows:

a. CPT code 98900 - Medical conference by physician regarding medical management with patients and/or relative, guardian, or other (may include counseling by a physician), approximately 30 minutes[3] (page 60).
b. CPT code 98902 - Same as above, except lasting approximately 50 minutes[3] (page 60).

CPT-4 does not indicate whether this conference has to be performed on the same day as the diagnostic testing. Practitioners should use these codes only if conferencing is standard office procedure and should not use conferencing simply because they know the insurer covers it. All billing should be consistent with the practitioner's policy for all patients and not be based upon knowledge of a given company's payment policy.

The practitioner should keep in mind the use of a CPT-4 code does not automatically guarantee coverage by the carrier. The services rendered must be medically necessary for the given diagnosis or diagnoses and the services must be covered under the insurance policy.

Therapy

Once the diagnosis is made and it is decided that vision therapy is required, it should be coded appropriately. CPT-4 contains one code for therapy: 92065, "orthoptic and/or pleoptic training, with continuing medical direction and evaluation"[3] (page 26). This code should be utilized for vision therapy sessions. Most insurance companies also require dates of services for all treatments rendered, as well as the appropriate ICD-9-CM[5] diagnostic code or codes. If practitioners bill their patients on a monthly basis, the date or dates of services should be listed on the insurance form. Neither dates of future visits nor missed visits should be included on any insurance form.

In those instances where home therapy is recommended, periodic progress evaluations should be coded at the appropriate examination level (intermediate, limited, etc.) which is consistent with the office's billing policy. Other practitioners may wish to utilize CPT code 92065 for home therapy progress visits. In both instances, the diagnosis and the date(s) of service should be indicated on the insurance form and the practitioner's office record should indicate the services performed and the progress made.

Special Services

The CPT section entitled "Special Services and Reports" includes codes 99000 through 99090[3] (pages 61-63). It must be pointed out that the use of these codes does not guarantee payment to either the patient or the practitioner. This section lists a number of services and the pertinent ones for practitioners rendering vision therapy include the following:

a. CPT code 99070 - Supplies and materials (except spectacles) provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)[3] (page 63). This code may be appropriate for items such as Brock strings, loose lenses, prisms, stereoscopes, etc. Practitioners may be required to describe the material supplied to the patient as well as the reason it is being prescribed.
b. CPT code 99080 - Special reports such as insurance forms or the review of medical data to clarify a patient's status--more than the information conveyed in the usual medical communication or standard reporting form[3] (page 63). This code may be appropriate for reports written to insurance companies requesting detailed progress information. This code should not be utilized when filling out standard insurance forms or short reports for carriers. Some insurance companies will pay for progress reports; however, carriers are increasingly asking for copies of office records instead of detailed reports and may not reimburse practitioners for extensive narratives.

There are other codes in this section that may be appropriate; we'd suggest that practitioners read this section carefully to determine if there are any other appropriate codes for their use.

PRE-AUTHORIZATION

For the purpose of this article, pre-authorization is the mechanism to determine if an insurance company will cover vision therapy. Pre-authorization does not imply that a practitioner has to accept assignment when it is granted; rather, it merely serves as a vehicle to determine if a particular service is covered by the patient's contract. Your inquiry can approximate the number of visits you estimate will be needed for the successful completion of the case. Frequently, the insurance company will inform you if your estimate falls within the company's guidelines. If your time projection is in excess of the carrier's, the company should advise the number of sessions that will be covered before requesting a progress report. Frequently, the insurance company will cover a specific number of vision therapy visits and consider additional ones based on the progress made and the medical necessity. On the pre-authorized request, you can also indicate your fee for the therapy and inquire whether it is within the carrier's "usual and customary fee" for the service. Generally, the company will not reveal its "usual and customary fee" for a service; however, they usually will advise whether your fee is within their determination of "usual and customary."

Each clinician should determine what his/her own pre- authorization request form should include. Generally, the insurance company will answer all of your questions. Figure 1 includes a sample list of pre-authorization questions. If a practitioner chooses to request pre-authorization, he should remember that there will be a time interval between the submission of the pre-authorization request and the initiation of therapy. Also, both the patient and the practitioner should remember that pre-authorization does not automatically mean the acceptance of assignment for the entire vision therapy program unless agreed upon by both parties.

SUMMARY

Insurance companies are increasingly scrutinizing all health care claims, including vision therapy. Practitioners must fully understand the appropriate CPT-4 codes regarding this modality and effectively deal with problems in this area. By utilizing the appropriate CPT-4 code or codes for vision therapy in conjunction with the concept of pre-authorization, optometrists rendering vision therapy may find insurance carriers processing claims more efficiently.

Sample Pre-Authorization Form

Re: Patient Name:
Insurance Company:
Policy Number:
Policy Holder's Name:

To Whom It May Concern:

The above patient was recently examined in this office. The diagnostic examination revealed the following medical diagnoses and their appropriate ICDA codes:

1.
2.
3.
4.

The treatment for the above problem(s) is Orthoptic/Visual Therapy (CPT code 92065). This treatment is specific for the neuromuscular anomaly and is not for routine eye care or glasses. This therapy consists of in-office treatment sessions and it is anticipated that ___ sessions will be needed to ameliorate the above diagnosed problems.

My patient has requested that I accept assignment of benefits for my services. Please supply me with the following information:

1. Is this medical treatment a covered service?
2. Did the patient meet his/her deductible?
3. If not, how much is remaining?
4. What is the patient's copayment?

A prompt response would be greatly appreciated. Thank you.

Very truly yours,

I grant permission to_____Insurance Company to release the above information to_____

Signature

Figure 1.

At all times, the following should be kept in mind when billing an insurance company for any claim:

a. The use of a CPT code does not guarantee payment.
b. Clinical procedures used should be consistent with established office policy and should not be geared to a specific insurance company's reimbursement policy.
c. The practitioner should always bill his/her regular and customary fee for a service. The fee should not be based on prior knowledge of the dollar amount that the carrier pays. This will allow for a stable insurance profile.
d. In general, the more knowledgeable the practitioner and his/her staff regarding insurance codes and procedures, the more equitably will the practitioner and patient be treated by the carrier.

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Corresponding authors:
Richard Soden, O.D.
Allen H. Cohen, O.D.
516 Hawkins Avenue
Lake Ronkonkoma, NY 11779

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