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Compliance, Coding, and Reimbursement For Keratoconus
John Rumpakis, OD, MBA

Contact lenses, a fundamental part of virtually every optometric practice, are also a hotbed of frustration for many on the medical coding and reimbursement side of things. Generally, when a practitioner is considering the fitting of a specialty contact lens, it is typically predicated on the presence of a specific medical condition or refractive complication caused by a corneal condition.

Basic Essentials

In order to know how to properly document your medical record and to use the proper CPT code to describe the appropriate services provided, you must understand and keep up with the current definitions of the contact lens fitting codes as described in the CPT. Just because you are fitting contact lenses doesn't mean that you can forget or ignore the fundamental concepts of medical necessity or the requirements of the Chief Complaint in your medical record. Be familiar with the requirements for the appropriate use of the 920XX and 992XX codes for your office visits that get coded *in addition* to your contact lens services.

The process starts with you making the appropriate diagnosis using whatever clinical means you deem necessary. Keep in mind that the ICD-10 requires the highest level of specificity, stability, and laterality in your diagnosis for keratoconus. Remember that a diagnosis is just the starting point for further caring for the patient. Everything you do with the patient after establishing the diagnosis must be based on the medical necessity you specify in the record.

The ICD-10 codes for keratoconus are as follow:

H18.601 – H18.609 – Keratoconus, Unspecified
H18.611 – H18.619 – Keratoconus, Stable
H18.621 – H18.629 – Keratoconus, Unstable

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Coverage

Insurance benefits for specialty contact lenses vary greatly, so know your policies and how to use an Advanced Beneficiary Notice (ABN) properly. Oftentimes, practices find it beneficial to send a letter of medical necessity to the patient's insurance carrier. The letter should be sufficiently detailed to demonstrate the failure of less invasive therapies and that a specialty contact lens is the most appropriate therapy at this stage of the care. Despite all of your efforts, the patient may simply not have coverage for keratoconus treatment and will have to pay out of pocket in accordance with his/her policy guidelines. In situations where you have a documented reason why the carrier may not pay, then an ABN or its equivalent would be appropriate to use. Remember that an original ABN form is only to be used for Medicare Part B patients. However, you can adapt the ABN for use with commercial carriers. With any Medicare Part C (Medicare Advantage) plans, please contact the carrier and use its own specific form it has for this purpose. When using the ABN or its equivalent, please take heed and use the appropriate modifier –GA, -GX, -GY, or –GZ appended to the CPT or HCPCS code to indicate to the carrier that the patient has received appropriate disclosure of personal financial responsibility and has attested to that with their signature on the ABN form.

The CPT Defines It For Us – Keratoconic Lens Fits

"The prescription of contact lens includes specification of optical and physical characteristics (such as power, size, curvature, flexibility, gas-permeability). It is NOT a part of the general ophthalmological services. The fitting of a contact lens includes instruction and training of the wearer and incidental revision of the lens during the training period.[1]

Coding the proper type of contact lens fit is critical to your reimbursement success, so using the proper code and following the rules are essential to your success.

- 92072[2] – Fitting of a contact lens for management of Keratoconus, Initial Fitting. Please report materials IN ADDITION to this code using either 99070 or the appropriate HCPCS Level II material code. This is a BILATERAL code. Please keep this specific quotation of the CPT in mind: "For subsequent fittings, report using evaluation and management service or general ophthalmological services."
  That means for every visit following the initial fitting visit, you will use a 9921X or 92012 code to follow the keratoconic cornea. Again, keep in mind that you are not following the contact lens, you are following the keratoconic cornea, and the contact lens is the treatment paradigm.

[1] Current Procedural Terminology (CPT) 2016 – American Medical Association, Pg. 594
[2] Current Procedural Terminology (CPT) 2016 – American Medical Association, Pg. 592

Refining And/Or Modifying Your Fit

In most cases, "incidental revision of the lens during the training period" and "with medical supervision of adaptation" are accomplished at the first post-contact lens-dispensing visit. Once the proper vision and comfort criteria are met and you are either at the point where you have ordered the final lenses or provided the patient with their contact lens prescription, the patient can now be considered fit for the contacts. Again, should complications arise, the most appropriate way to bill for office visits is using the established patient ophthalmologic (9201X) or evaluation and management (9921X) codes. Please keep in mind that you are following the keratoconic disease state and not the contact lens. Many individuals are giving away thousands of dollars per year by including this "free care."

What Does The Claim Form Look Like?

Coding for the initial fitting visit would look like this:

	Dates of Service		Place of Service	Type of Service	Procedures, Services, Supplies (Explain Unusual Circumstances)	Diagnosis Code	Charges	Days or Units
	From MM/DD/YY	From MM/DD/YY			CPT-HCPCS - Modifier			
1	1/31/2016		11		92072	A	$134.76	1
2	1/31/2016		11		92025	A	$38.25	1
3	1/31/2016		11		V2599 (Annual Supply)	A	$1,000.00	4
4								
5								
6								

The first and subsequent follow-up visits could be coded like this:

	Dates of Service		Place of Service	Type of Service	Procedures, Services, Supplies (Explain Unusual Circumstances)	Diagnosis Code	Charges	Days or Units
	From MM/DD/YY	From MM/DD/YY			CPT-HCPCS - Modifier			
1	2/6/2016		11		99213	A	$73.14	1
2								
3								
4								
5								
6								

The code may not always be a 99213. I am using that for this example only. The level of 9921X code used should be commensurate with the appropriate history, exam, and medical decision elements you have in the medical record. You could also use the 92012 code for the visit instead of the 9921X.

Coding For Materials

It is important that you follow the carrier-specific guidelines that they may have for submitting the materials you are prescribing. The HCPCS Level II codes are the Health Care Procedural Coding System (HCPCS) subset of codes that describe the materials used. Most typically, you will be using one of the following codes for the lens materials:
V2513 – Contact Lens, Gas Permeable, Extended Wear, Per Lens
V2531 – Contact Lens, Scleral, Gas Permeable, Per Lens
V2599 – Contact Lens, Other Type (This is the most commonly used code for hybrid lenses.)

Since carriers have different policies regarding materials, it is important that you find out specifically if the specific carrier you are working with requires information regarding the company, brand, lens type, and number of units used. Since the coding for the lenses is generally per lens, most claim submissions on initial fit will show two units. Sometimes (particularly with V2599) you should submit a copy of your invoice with your claim form to the carrier.

Bottom Line

The rules provide that you are entitled to get paid 100% of the time, although in today's world, it may be by the patient rather than the carrier due to the changing health care environment. Bottom line: You should never be giving something away when you are entitled to get paid for your professional medical services and the materials used to treat the disease state. The health care system today and coverage of particular services is in a very dynamic state. Navigating this terrain can be difficult, frustrating and confusing. Keep one thing in mind: Patients need and deserve the proper care whether they have coverage or don't, whether they have a high deductible or don't; those things are not in the doctor's control. Stay above the fray. Simply be their doctor, provide the very best care possible, follow the CPT and ICD rules, pay mind to your contracted carrier policies, and don't worry about the things you cannot control.