CODING AND BILLING FOR OPTOMETRY:

COORDINATING MEDICAL AND VISION INSURANCES FOR BETTER REIMBURSEMENTS

In order for today's optometric practices to thrive financially, they have to move beyond the world of routine vision insurance. It is difficult to cover chair costs and keep your doors open on $45-$70 reimbursements from routine carriers. But far too many optometrists are regularly accepting these lower reimbursements simply because they do not understand their coding and billing options.

The purpose of this article is to explain billing protocols that allow optometrists to collect fairer reimbursements for their time, decision making, risk, and expertise. In short, it's a crash course in coding and billing that has the power to help you and your practice increase insurance reimbursements if you are not currently following these guidelines.

These billing rules are standard billing procedures accepted by every major insurance company in the country. The only thing that makes these rules exceptional is the number of optometrists unfamiliar with them.

A large part of the coding and billing confusion arises from the fact that optometrists live in a dual world of medical and vision insurances that few other healthcare professionals encounter. Not understanding how to deal with this duality of payers, too many optometrists have taken the path of least resistance and file the majority of their annual exams to routine insurances, thereby losing thousands of dollars in lost income if they have provided medical care.

But optometric insurance billing does not have to be an "either-or" proposition. Instead, ODs need to take a "both-and" approach through the process of coordination of benefits. Optometrists have a unique opportunity with two types of insurances available for billing and, when appropriate, should move forward in filing claims to both insurances to significantly increase practice revenues.

Here is the basis for a successful insurance billing strategy which allows you to maximize your insurance reimbursements while minimizing your patients' financial responsibility: **When providing medical care, bill patients' medical health insurance first for a higher reimbursement. After the medical payer processes the claim, coordinate any remaining patient balances to their routine insurance for additional payment.** It's really that simple.

Considering that routine vision payers reimburse between $45 - 70 dollars for an exam and medical payers somewhere between $120 - $180, **you will collect two to three times more from medical health insurances.** Not only are medical-routine coordinations a huge boon to the practice, but coordinations are meant to reduce patients' out-of-pocket expenses as well, so in most cases coordinations are equally beneficial for patients.

However, based on your current office procedures, there may be some challenges that doctors will have to face when moving to a medical-routine coordination model.

BARRIERS TO A MEDICAL BILLING MODEL. Let's start by examining the main reason practices bill routine vision payers in the first place: It's simply easier. Medical billing requires a wider breadth of diagnosis codes, modifiers, and specialized filing rules. Medical exams require greater chart documentation, time, risk, and expertise. Medical insurances differ greatly from policy to policy, so understanding patient's benefits is not as straightforward as routine insurance. And finally, medical billing requires greater communication with patients. Over the years we have found offices who are not up to the challenge. But for doctors willing to put in the effort to overcome the barriers to medical billing, their reward will be a much larger bottom line and a more financially sound practice with monies available to reinvest in their business and their own futures.

What are the barriers optometrists face when implementing a medical-routine billing strategy? The answer varies from doctor to doctor, but today we will discuss two of the most common obstacles and explore resolutions for both. (We have made the assumption that you are already contracted with the medical payers in your area. If you are not, then credentialing moves to the top of your list because unless you're a network provider, you generally can't file medical claims.)

Barrier One: Some optometrists are uncertain what constitutes a medical exam vs a routine exam, especially at patients' annual visits.

Let's start by clearing up two misconceptions:

1. An annual exam does not mean it's automatically a routine exam.
2. Just because patients have routine vision insurance does not obligate you to file it as primary.

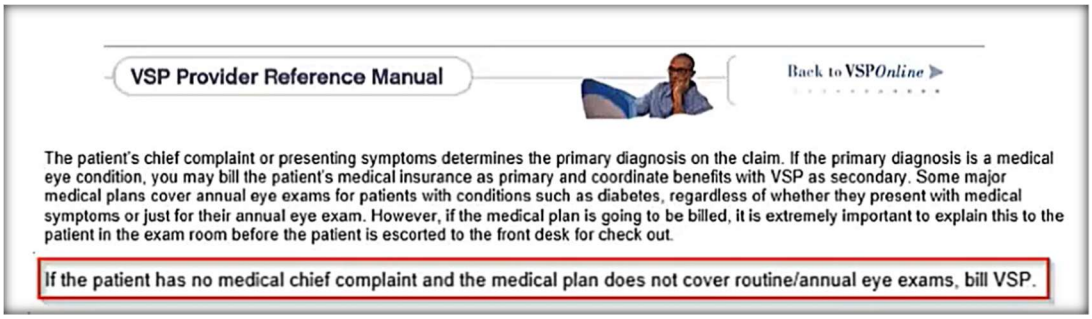
We're not sure what doctors have been taught at optometric school or if there is someone on the speaking circuit giving erroneous information, but we find doctors adhering to these two beliefs religiously as if they were canonical law. They are not.

However, doctors seeking clarification on medical vs routine billing might be surprised to find a very good resource in the largest routine vision payer in the industry, Vision Service Plan. Per VSP's provider manual, how you bill the exam is driven by the patient's chief complaint. The chief complaint should be the primary diagnosis on the claim, and this determines whether you bill routine or medical. If patients present with no medical complaints or symptoms and have no risk factors or eye diseases that need to be addressed during this visit and your care is primarily refractive in nature, then these exams are routine. On the other hand, if patients present with medical symptoms or have a history of risk factors or diseases that must be monitored and evaluated, then these exams are clearly medical in nature.

The bottom line is this: **The patient's chief complaint drives the reason for the visit.** To bill patients' medical insurance as primary, the chief complaint must be medical and reflected in the primary

diagnosis in the first position in the exam. The patient's medical conditions, symptoms, or risk factors should be recorded in the presenting reasons for the visit in the record, and you should perform and document objective testing as well as your treatment plan. Solid chart documentation is critical when billing medical exams, and doctors should follow the standard SOAP format in charting.

Here's another important consideration: **Some patients' medical insurances cover an annual routine eye examination.** In these cases, VSP guidelines say to bill the patient's medical payer first and then coordinate with their routine plan. This allows you to capture the higher reimbursement from medical carriers, even for routine exams. Check with the medical payers in your area to see which ones offer coverage for an annual routine office visit.



VSP summarizes their policy in one easy sentence: If the patient has no medical chief complaint and the medical plan does not cover routine/annual exams, bill VSP. Otherwise, bill the medical payer. Other routine payers do not have VSP's extensive policy manual, and many don't address medical billing at all, inferring they're leaving billing decisions up to the physician. But since most doctors are VSP providers and VSP is the largest routine payer in the country, their fair and helpful guidelines can serve as a good rule of thumb when deciding how to handle medical versus routine office visits at your practice.

Barrier Two: Patient education is critical in medical billing, but doctors and staff are often ill-prepared to explain the difference between medical and routine care, leaving patients confused as to why their office visit was billed to their medical insurance.

If your office has been in the habit of filing most annual exams to patients' routine insurance, then patient education will become a critical factor in allowing a medical billing model to succeed. Medical billing with coordinations will be a change for your patients, and you and your staff will need to spend the time to help patients understand the process. Coordination of benefits is meant to reduce patients' out-of-pocket expenses, so it will have a positive impact for most of your patients. Routine insurances usually pay for the refraction that most medical payers don't cover, and some will even pick up the patient's medical copay up to a certain limit. In fact, it is not uncommon for patients to owe little (usually their routine copay) or nothing when claims are coordinated.

The exception, however, is patients who have high deductibles on their medical plans. In these cases, the patient may want to have their office visit billed to their routine payer if their deductible is not met. These patients can be confused or even upset that you're billing their medical insurance, especially if you have not done a good job communicating with them throughout their visit.

In fact, patient education is so important in the medical billing model that OBS has developed two training videos for our clients to help them with this critical component of patient care. If you are an OBS client, please reference our office training videos on our website called "Medical vs Routine: Increase Practice Revenue through Coordinations of Benefits." In these videos we explain the finer points of patient education for both doctors and staff, discuss communication strategies, and offer sample scripting to ensure patients are not surprised at checkout to learn the claim will be filed to their medical payer first.

Please access training videos available on the OBS website for additional information.

That being said, patients have the right to dictate their care. In cases where patients with medical conditions wish to have their exam filed to VSP, your staff can explain that VSP will not pay for the medical portion of their office visit and offer them two options: 1) File to their medical plan first and then coordinate with their vision insurance the routine portion of their care or 2) have them return later in the week for a second visit to complete a medical follow-up. **Regardless of their choice, patient education by the doctor and support staff is critical to ensuring medical billing goes smoothly.**

FILING SECONDARY CLAIMS. After the medical payer processes the claim, you can file the claim to the routine carrier for them to consider payment on any remaining patient balances. Your biller should know the coordination rules for each routine insurance since the method and manner of filing secondary claims varies by payer. (At the time of this writing, EyeMed appears to be eliminating their medical coordinations altogether.) In all cases, however, the patient's routine benefit must still be available, coordinations will exhaust their eligibility, and only exams that include a refraction can be coordinated. There are other considerations your biller will need to know, such as how to handle write-offs when the routine payer processes the exam and under what circumstances the patient will still owe any outstanding balances. If your biller has little experience in coordinating claims, then she will need to spend time reading provider manuals and making calls to insurance representatives until she is well versed in the process.

FINAL THOUGHT: If your staff is so busy that there is any question that appropriate follow up on claims will happen or that coordinations may not get filed, this might be the time to consider outsourcing your billing to experts who can help you through the process. If you have been billing most of your annual exams to routine insurances or have never coordinated claims, then outsourcing can more than pay for itself. In addition, you get to eliminate the expense of in-house billing and will often see increased revenues when your claims are being handled by dedicated professionals with the time, experience, and expertise to collect every insurance dollar due to your practice.