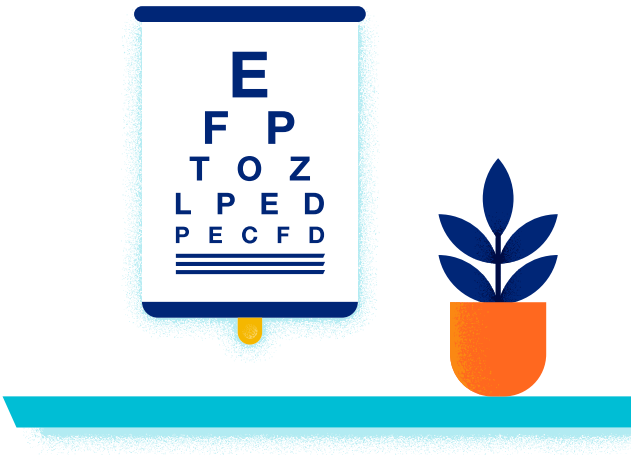
Vision coding principles

To better support medical necessity for services reported, and to decrease claim denials, UnitedHealthcare | March Vision Care recommends following these principles when coding for patient's eye exam encounters.



1. List the principal diagnosis, condition, problem, or other reason for the medical service or procedure.

The principal diagnosis is the primary condition or disease identified by a healthcare provider as the main reason for a patient's encounter. The principal diagnosis should always be as specific as possible. However, if at the end of an encounter no clear diagnosis can be established, it is acceptable to code sign(s) and/or symptom(s) for the clinical impression.

Use diagnosis codes specific to the patient being seen, using the same code for every patient is not considered correct coding.

2. Assign the code to the highest level of specificity.

ICD-10-CM Official Guidelines for Coding state that a diagnosis is based on "the highest degree of [clinical] certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit". You do not need a "final" diagnosis.

3. For office and/or outpatient services, never use a "rule-out" statement (a suspected but not confirmed diagnosis).

Code symptoms if no definitive diagnosis is yet determined instead of using rule-out statements.

4. Be specific in describing the patient's condition, illness, or disease.

When applicable, report laterality, stage, or eyelid. Claims may be denied due to lack of specificity.

If possible, avoid using unspecified codes and use the most appropriate and specific code to they symptom, diagnoses, or condition.

5. Distinguish between acute and chronic conditions, when appropriate.

When two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

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6. Identify secondary diagnoses, or other chronic complaints only when treatment is provided.

Secondary diagnoses describes those conditions that coexist at the time of the encounter, or develop subsequently and impact the management of the patient's care.

7. Bill appropriately for a routine examination versus medical visit.

E/M codes should not be used to bill for routine eye examinations including new patient eye examinations. Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted or performed. Similarly, it would not be warranted to bill for services if medical necessity is not established by standards of medical or optometric practice.

8. Use CPT code modifiers to help describe a service accurately.

Modifiers help achieve the following:

- Define whether the procedure is necessary
- How many doctors attend to the patient
- If there were any procedures in the past
- The location of the procedures such as right eye only, left eye only, or bilateral eyes

Using modifiers in the wrong way, or not including appropriate modifiers can cause claim denials.

Other helpful tips:

- All information on the visit(s) must be substantiated in the patient's medical record, which should be available on request.
- Report only diagnosis codes that pertain to that day's encounter. Do not report ICD-10-CM codes that no longer exist or were not assessed during the visit.
- Use a trained certified coder to help you stay current with coding guidelines and decrease common coding errors.