Optometric Billing & Coding Masterclass

Student Note Handout (Fill-In Outline)

Designed to mirror the course structure so learners can track key ideas, capture examples, and apply concepts without reproducing the full lecture content.

How to Use This Handout

Skim prompts before each segment • Jot definitions, thresholds, and code choices • Mark uncertainties to ask live • Capture 1–2 takeaways per lesson

Disclaimer

Educational use only. Verify payer policies, CPT/HCPCS guidance, LCDs/NCDs, and state law before billing. CPT® is a registered trademark of the AMA.

Instructor: ODs on Finance • Presenters: Chris Lopez, OD; Andreas Zacharopoulos, OD

Introduction & Foundations of Optometric Billing

Introduction: Course Overview, Mindset & Key Concepts

- Define your billing goal for this course (clinical confidence? capture? audit-proofing?).
- What is the difference between CPT, HCPCS, ICD-10, and payer policy?
- "Medical necessity" — your working definition + what proves it in your chart.
- List 2 habits that cause undercoding in your clinic and how you'll fix them.

Quick Checks

☐ Know where payer policies live

☐ Know your refraction policy

☐ Have a written I&R template

☐ Track KPIs monthly

☐ Train front desk on med vs vision language

Term	Your Short Definition	Where to check policy

Notes:

Introduction & Foundations of Optometric Billing

Basics – 92 Codes (92002/92004/92012/92014)

- Eye visit structure: required elements you must document for each level.
- What counts as "initiation of diagnostic/tx program"? List 3 examples.
- When would you NOT use a 92-code even if you dilated?
- One-line rule to choose 92004 vs 92014 in your workflow.

Code	New vs Est.	Scope (intermediate/comprehensive)	Your trigger	Common pitfalls
92002	New	Intermediate		
92004	New	Comprehensive		
92012	Est.	Intermediate		
92014	Est.	Comprehensive		

Notes:

Introduction & Foundations of Optometric Billing

99-Codes – MDM Overview

- MDM uses 2 of 3: Problems • Data • Risk — write one clinic example for each.
- Time vs MDM: when will you intentionally code by time? What will you include?
- Documenting Risk: phrases that prove prescription drug management or surgery decisions.
- Your rule for stable chronic illness vs exacerbation.

Quick Checks

☐ Link each special test to a Dx

☐ State change vs stable

☐ Record why you ordered/withheld a test

☐ Name the med + decision (start/continue/change/stop)

MDM Element	Your clinic example today
Problems	
Data (review/order/interpret)	
Risk (drug/surgery/monitoring)	

Notes:

Introduction & Foundations of Optometric Billing

99-Problems List — Documenting What You Addressed

- For each patient today, list 1–2 problems you addressed (not just observed).
- Undiagnosed new problem w/ uncertain prognosis — write 2 eye-care examples.
- Acute vs chronic vs severe chronic: your thresholds (IOP target? macular changes? corneal size/depth?).

Problem Category (examples)	Your example	Doc phrase you'll use
Self-limited/minor		
Stable chronic illness		
Acute uncomplicated		
Stable acute illness		
Chronic illness w/ exacerbation		
Severe exacerbation/progression		
Undiagnosed new problem (uncertain prognosis)		

Notes:

Introduction & Foundations of Optometric Billing

99-Glaucoma Examples (Apply MDM)

- For a new glaucoma suspect, which MDM Problem level fits and why?
- Baseline tests you order + how you phrase I&R (Data → Impression → Plan).
- When does Risk hit "moderate" without changing meds?

Visit scenario	Problems	Data	Risk	MDM level
New suspect: thin CCT, borderline IOP				
Established: at target, stable testing				
Worsening VF, consider SLT				

Notes:

Introduction & Foundations of Optometric Billing

99-Retina Examples (Apply MDM)

- Early dry AMD vs wet AMD — which Problem level and why?
- When to pair OCT retina with photos; when to separate by visit?
- Verbiage for medical necessity when ordering OCT mac.

Condition	Problem level	Risk note	Test(s) & I&R cue
Early dry AMD			
Intermediate dry AMD			
Wet AMD (new)			
DR w/ edema concern			

Notes:

Introduction & Foundations of Optometric Billing

S-Codes — Routine Exams & When They Fit

- List which payers in your region require S-codes (and where you verify).
- Cash-pay policy: S-code vs 920x4 with discount?
- Refraction handling when S-codes include it — set expectations.

Quick Checks

☐ Know your S0620/S0621 fee

☐ Single written cash/self-pay policy

☐ Staff script for routine vs medical

Notes:

Diagnostic Testing & Procedures

Special Testing — Part 1 (Ordering & Necessity)

- Default I&R template: Data • Impression • Plan (one line each).
- Unilateral/bilateral rules — laterality & modifiers.
- Top 5 tests you order most + primary Dx each supports.

Test	Code	Laterality note	Primary Dx trigger	I&R cue
OCT Mac	92134	U/B		
OCT RNFL	92133	U/B		
Fundus photos	92250	B (use -52 if one eye)		
Gonioscopy	92020	B (use -52 if one eye)		
Pachymetry	76514	U/B		

Notes:

Diagnostic Testing & Procedures

Special Testing — Part 2 (Frequency & Bundling)

- Multiple tests same day → which one is paid at 100%? What to split to a follow-up?
- Policy: Photos + OCT same day — when OK vs separate?
- Payer-specific frequency rule to post for staff.

Quick Checks

☐ Always link test → Dx

☐ Use -TC/-26 correctly when splitting

☐ Avoid fishing; justify medical necessity

☐ Know LCD/NCD for glaucoma testing frequency

Notes:

Diagnostic Testing & Procedures

Interpretation & Reports (I&R) — What to Include

- Complete one sample I&R now (pick any test done this week).
- Phrases for unreliable tests that still convey usable info.
- Where does the Dx link go in your EHR for each test?

I&R Component	Your exact phrasing today
Data (reliability + findings)	
Impression (what it means/changed?)	
Plan (next step/interval)	

Notes:

Diagnostic Testing & Procedures

Modifiers — Make the Claim Payable

- Go-to lines for modifier -25 (what makes E/M separate from the procedure?).
- Laterality set: -RT/-LT/-50/-52 and eyelid -E1–E4 — when to apply each.
- Split testing: when to use -TC vs -26.

Quick Checks

☐ -25 for significant, separately identifiable E/M

☐ Co-manage: -54/-55/-79/-24

☐ Medicare: -GA/-GY

Scenario	Code(s)	Modifier(s)	Doc requirement
Unilateral B-scan both eyes	76512	-50	State both eyes tested
Fundus photo one eye	92250	-52	Bilateral code, one eye only
E/M + plugs same day	99213 + 68761	-25 on E/M	No overlap of work

Notes:

Diagnostic Testing & Procedures

Procedures — Part 1 (Core Office Procedures)

- Differentiate special test vs procedure — your one-sentence rule.
- Which procedures include the office visit (global) vs allow 99/92 + code?
- Consent/ABN triggers for high-ticket items.

Procedure	Code	Uni/Bi	Global?	Pair E/M?	Note cue
Epilation	67820	Uni	—	No	
Punctal Plugs	68761	Uni	10-day	Usually No	
Amniotic Membrane	65778	Uni	None	No	
D&I (Lacrimal)	68810/68801	Uni	10 vs —	No	

Notes:

Diagnostic Testing & Procedures

Procedures — Part 2 (FB Removal & Therapeutic CL)

- When FB removal pays less than E/M — your decision rule.
- Rust ring + 65222: why 65435 is usually bundled — how you'll document.
- Therapeutic CL (92071/92072): when you can bill with office visit.

Scenario	Preferred coding	Why
Small corneal FB, uncomplicated	99213 or 65222	
Conj FB + Corneal FB same eye	65205 + 65222-51	
Therapeutic soft CL for abrasion	99213 + 92071-RT	

Notes:

Specialized Protocols & Condition Management

Comanagement — Cataract/YAG/Laser

- Map surgeon op codes → your post-op -55 mirror.
- What is/isn't billable during global (and which modifiers allow it).
- Transfer-of-care checklist to use every time.

Quick Checks

☐ Have surgeon's code set

☐ Know 90- vs 10-day global

☐ Document unrelated Dx for -24/-79

Notes:

Specialized Protocols & Condition Management

Special Protocol — AMD / DR / Plaquenil / Glaucoma / Dry Eye

- For each protocol: visit cadence • tests • default MDM level • when to escalate.
- Define stable vs progressing language for OCT/VF comparisons.
- Plaquenil: baseline timing + tech-only flow with -TC/-26.

Condition	Cadence	Default tests	Default MDM	Escalate when…
Early/Intermediate/Wet AMD				
Mild/Mod/Severe DR				
Plaquenil monitoring				
Low/High-risk Glaucoma suspect				
Dry eye (aq/MGD)				

Notes:

Administrative & Compliance Essentials

Practice Management: Medical vs Vision + Team Workflow

- Exact staff script for med vs vision expectations at: phone • check-in • chair • check-out.
- Refraction policy (e.g., 92015-GY to Medicare first, then secondary).
- 3 bottlenecks slowing medical care + one fix each.

Quick Checks

☐ Posting of fees & policies

☐ I&R audit checklist

☐ Monthly KPI dashboard (tests/visit, 92 vs 99 mix)

Notes:

Administrative & Compliance Essentials

Billing Medical vs Vision — Examples (BONUS)

- Chief complaint controls intent: if medical complaint/diagnosis drives the visit, consider medical E/M or 92-code; if routine wellness/vision-only, consider S-codes/vision plan.
- Always document medical necessity: link tests and refraction to diagnoses; capture I&R for ordered tests.
- Set expectations up front: use a clear staff script to explain medical vs vision coverage and refraction policy.
- Refraction handling: note when 92015 (or vision benefit) applies and how you'll communicate self-pay.

Examples	Scenario / CC	Findings that drive MEDICAL necessity	Pathway (Medical vs Vision + CPT/E/M)	Refraction? (Y/N & handling)	Tests / Modifiers	Patient Script (1–2 lines)	Notes

Quick Checks

☐ CC states medical concern ☐ Dx linked to each test ☐ Refraction policy explained ☐ ABN/GY used when appropriate ☐ I&R completed for testing

Administrative & Compliance Essentials

Screening Photos — Proper Use & Coding of Photos and Imaging for Screening Purposes

- Define your clinic policy: what counts as screening (no medical complaint/diagnosis) vs diagnostic (linked to a covered diagnosis)?
- When using photos for screening, how will you communicate patient-pay vs plan-covered? Draft your staff script.
- Document medical necessity for *diagnostic* images: link Dx, include I&R (Data • Impression • Plan).
- Decide when to bundle imaging with comprehensive exams vs schedule as a separate service to avoid frequency conflicts.
- Set frequency rules: annual wellness photos vs diagnostic follow-up intervals (note payer-specific limits).

Use-Case Decision Matrix

Scenario	Screening or Diagnostic?	Code Candidate(s)	Dx Link (Y/N, which)	I&R needed?	Patient Pays or Plan?	Notes/Policy
Annual wellness, no complaints						
Diabetes, no retinopathy found previously						
Glaucoma suspect baseline						
Dry AMD monitoring						
Acute red eye visit						
High-risk meds (e.g., Plaquenil)						

Operational Details & Documentation

Step	Your Clinic Phrase / Requirement	Owner
Staff script (screening vs medical explanation)		
Consent/Financial responsibility acknowledgement		
Dx linkage in EHR for		

diagnostic images		
I&R components captured (Data • Impression • Plan)		
Frequency rules posted for staff (by plan/payer)		
ABN/GY usage when applicable		

Imaging Options & Laterality/Modifiers (Clinic Rules)

Imaging Type	Typical Code(s)	Uni/Bi Rule	Common Modifiers	When to Separate from Other Testing	Notes
Fundus photos					
Widefield photos					
Remote retinal screening (store/forward)					
Anterior segment photos					

Quick Checks

☐ Screening explained and documented ☐ Dx linked for diagnostic imaging ☐ I&R completed for diagnostic ☐ Financial responsibility clear ☐ Frequency conflicts avoided

Section Notes

Administrative & Compliance Essentials

Audits • ABNs • KPIs

- Top 3 audit risks based on your current patterns.
- When you'll use ABNs (e.g., 65778-GA) and who handles forms.
- Pick 5 KPIs to track monthly (target ranges).

KPI	Your target	Owner	Where you'll pull it
% 99-codes (vs 92-codes)			
Special tests/100 exams			
I&R completion rate			
Refraction capture rate			
Denied claims rate			

Notes:

Billing/Coding Case Examples

Simple Cases (1–10) — Your Answers

- For each case: pick code pathway (92 vs 99), circle MDM drivers, and list one sentence of medical necessity.
- Note where a refraction or special test is justified.

Case	Your Code(s)	MDM Drivers (P/D/R)	Why (1 line)
Cataract / SCH / Allergy / Cellulitis / Abrasion			
Dry eye / Bleph / Mild GLC / Mild ARMD / PVD			

Notes:

Billing/Coding Case Examples

Complex Cases (1–10) — Your Answers

- For each complex case: define Problem severity, name the Risk phrase, and commit to the level.
- Document any procedure vs E/M decision and your rationale.

Case	Your Code(s)	Problem Severity	Risk Phrase	Rationale
FB / KCN / Iritis / Ulcer / RD				
BRAO / Late AMD / Severe GLC / Papilledema / NAION/Toxic				

Notes:

B&C Pearls & Mastery Mindset

Refraction • After-Hours • Misc. Clarifications

- Refraction workflow for medical vs vision (include -GY when needed).
- After-hours policy: self-pay vs payer, and how to set expectations.
- Three definitions to memorize: morbidity • risk • major/minor surgery.

Topic	Your policy / phrasing to use with patients & staff
Refraction & 92015	
After-hours billing (99050/051/058/060)	
Comorbidity documentation	

Notes: