

Back to the Basics—Coding for Refractions Using CPT Code 92015 (Tip: Rules Vary!)

CPT code 92015 *Determination of refractive state* was first published in 1992. Since then, the code has been separately billable in addition to any level of Evaluation and Management (99XXX) or Eye visit code (92XXX).

Rules vary. In some cases, ophthalmologists have been able to bill the payer; in others, they can collect payment from the patient. The confusion lies in which payers cover it and which don't. Unless a payer has a published policy for 92015, the key is to check the remittance advice.

Four Billing Tips

1. The refraction is never part of a global surgical package.
2. There is nothing to stop you from billing for a refraction whenever it is performed—whether it is done for pathology or for a new prescription—though under some plans you might not get paid for it.
3. When refraction is covered, frequency of coverage is typically limited to once a year or once every two years, depending on the plan.
4. An autorefraction is not billable until it is refined.

Payer Policies on Refractions

Coverage and rules vary. Coverage, or lack thereof, varies by payer. It is imperative that you don't take the rules of one payer and apply them to all payers.

Medicare Part B or Medicare Fee-for-Service (FFS). Medicare Part B and Medicare FFS don't cover refractions. Consequently, an Advance Beneficiary Notice of Noncoverage (ABN) is not required, and the patient is responsible for payment.

Medigap. Some Medigap or Medicare supplemental plans may cover refraction. Others deny it when it is not a plan benefit, in which case payment is the patient's responsibility.

Medicare Advantage. Medicare Advantage plans—also known as Part C plans—may provide the patient with vision benefits, which can include refraction for routine eye exams. Coverage varies by carrier and plan.

Commercial insurance. Coverage by commercial payers also varies based on the plan. Some have an allowable with a vision diagnosis, others with a medical diagnosis. Some bundle the refraction with any office visit. Best practice is to carefully review the commercial participating provider contract for refraction coverage. Noncovered refractions may be considered provider contractual adjustments, in which case you won't be able to get the patient to pay for it.

Vision plans. Many employers offer separate vision insurance, such as the plans offered by VSP or EyeMed. Typically, vision insurance covers refractions that are done to identify potential refractive errors, such as myopia, hyperopia, and presbyopia.

Medicaid. Medicaid coverage varies by state. In some states, Medicaid provides vision coverage for the refraction. In other states, Medicaid only includes coverage for children. In some states it is appropriate to bill Medicaid patients; in others, the fee must be written off.

Waiver of liability? When payment is considered the patient's responsibility, commercial insurers may require a waiver of liability. Tricare and other governmental agencies may have their own unique waiver of liability forms.

Refraction Q and A

Q. Is it appropriate to bill the medical exam to the medical insurance and the refraction to the vision plan? **A.** It depends. First, approval must be given by the payers and the patient. If the payer hasn't posted information about this on its website, ask for permission and get the response in writing, which you should then document.

Q. Are there published RVUs for 92015? **A.** Yes. For 2021 the RVU total is 0.57 or 0.58 if the service is provided in a facility or in a nonfacility (i.e., your office), respectively.

Q. Should use of the Optiwave Refractive Analysis (ORA) system in cataract surgery be billed as 92015? **A.** Probably not. It would be better to use an unlisted code or a code created in-house to track this procedure, which isn't covered by insurance.

MORE ONLINE. For three scenarios in which you can charge a cataract patient out of pocket for ORA, see this article at aao.org/eyenet.