Successful Vision Therapy Practice in a Managed Care Environment

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Abstract

Managed care has impacted the practice of all health care professions. The author uses his experience and knowledge to present a system for the successful practice of optometric vision therapy in accord with the rules and regulations of managed care. A key component is to fully inform patients of services that will not, or may not, be reimbursable under their particular plan; this understanding should be documented before any services are provided. The author's system starts with the initial appointment, progresses to further diagnostic services and the conference appointment, and finally to the provision of vision therapy.

Key Words

evaluation and management codes (E/M), international classification of diseases codes (ICD- 9-CM), managed care, optical plan, optometry, orthoptics, physician's current procedural terminology codes (CPT), unlisted codes, vision plan, vision therapy

INTRODUCTION

The logistic and fiscal management of virtually all health care practices has increasingly become a major challenge. This has occurred, certainly in part, because of the gradual decline of the fee-for-service model and the emergence of, and patient and doctor dependence on, the managed care model, particularly over the past two decades.[1] While the fee-for-service method remained relatively unchanged for many years, managed care has been the opposite; its overall health care and reimbursement policies are subject to change because of federal and state governmental mandates, and health care marketplace conditions. This challenge becomes more complex when specialty services, such as vision therapy (VT), are involved.

As the managed care model has developed, a number of variations have emerged such as the Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Individual Practice Association (IPA), etc. Indeed, consumers are often confused by the "alphabet soup" that describes these variations.[1] For the purposes of this article, the following definition of managed care will be used:

> *A managed care organization may be a physician group, health plan, hospital or health system, i.e., any organization that is accountable for the health of an enrolled group of people. In contrast to organizations that provide services at a discount, but do not attempt to coordinate care, managed care organizations actually have the responsibility for the health of enrollees and as a consequence, seek improvements in both the results and cost-effectiveness of the services provided. Most managed care organizations still care for those with traditional indemnity insurance in addition to patients insured under managed care health insurance products.*[2]

In terms of ophthalmic care, there are basically two types of plans. One is the optical (or vision plan) which usually only provides for routine eye examinations, refractions and optical corrections. These plans most frequently do not cover the diagnosis and treatment of non-optical problems.

Thus, there is a myriad of plans which fit under the umbrella of the second type, i.e., managed care, or, as it is sometimes termed, "medical insurance." These provide reimbursement for the diagnosis and treatment of illness, sickness, accident or disease and they usually exclude optical care. A basic tenet of these plans is that covered diagnostic and treatment services must be "medical necessary." In most cases, the International Classification of Diseases (ICD-9-CM)[3] codes are sufficient to document the medical necessity. The Physician's Current Procedural Terminology (CPT) or Evaluation and Management (E/M)[4] codes are acceptable for defining diagnostic and treatment services. Many of the treatment codes have established protocols and fee reimbursement schedules. The practitioner is responsible to provide support documentation for the diagnosis as well as the treatment for which payments are requested. In many of these plans, VT services are included to various degrees.

In 1997 Wright expressed his opinion that optometry should not seek to include VT as a covered service in managed care.[5] This viewpoint has been increasingly espoused by some optometrists and practice consultants. Indeed, I have experienced anecdotal claims that, when the fee-for-service model is applied to VT, overhead goes down and profit goes up. In this article I will present the opposite view; that it is feasible and beneficial for the optometrist and the profession to incorporate and use the requirements and protocols of managed care plans to develop a vibrant, vital and economically feasible VT practice. The following are some the reasons that underlie my view:

1. Third party reimbursement for health care is here to stay
2. Other health care providers and patients often perceive services that are covered by these plans as more "legitimate" than non-covered services.
3. New practitioners are able to develop and grow their VT practices more easily.
4. Group practices comprised of optometrists who provide primary care services as well as VT can continue to benefit from the advantages of third party reimbursement.
5. A larger pool of patients will benefit from VT; this will help many more patients and educate more people about the benefits of VT. Additionally, since there will be more interaction with other health care providers within the referral system, these practitioners will also be educated about the benefits of VT.
6. Those practitioners who provide specialty services for acquired brain injury, vestibular problems, visual problems associated with systemic disease, no-fault insurance and workers compensation are often obliged to participate in third party reimbursement.

The remainder of this article is offered as a comprehensive method and guide for the inclusion of optometric VT services in managed care plans. The goal is to provide a general method that is in accord with the most common rules and policies of these plans, in a manner that is honest and financially feasible for the patient and optometrist. Thus, a key requirement for patients enrolled in managed care plans is to make absolutely certain they understand, before any optometric services are initiated, that some or all of these services might not be reimbursed by the plan. The proposed method includes first, a discussion of a written fee policy and the diagnostic services that are usually included. This is followed by an office sequence that proceeds from making the initial appointment to further required diagnostic services, then to the delivery of VT.

OFFICE BASICS

A fee policy document

First and foremost, the practitioner should develop a written policy of how the practice's fees for all VT services and necessary equipment were derived. This must be consistent for all patients, be they fee-for-service, covered by indemnity plans, or members of a plan where the practitioner is a panel provider. The policy is beneficial from at least two instances: it serves to establish a sense of rational planning and organization for the office staff who are involved with billing: it is an informational document for medical insurance administrators who are sometimes unaware of the optometric management aspects of VT. A reader of the policy should be able to follow the management plan from the initial visit to the case completion.

Basics for diagnostic examinations

1. **Consultation examination (CPT 99241-99245)**
   The particular code depends on the level of complexity of the examination.
   a. Most insurance companies define a consultation examination as a request for your evaluation of a patient by another health care provider. Its purpose is to obtain additional information that can be incorporated into the patient's existing management plan. The coding of this examination is based on the same criteria for other examination/management (E/M) services. A report to the referring practitioner is required. That provider's Unique Physician Identification Number (UPIN) must be indicated when billing for this service.
   b. A confirmation consultation , similar to the consultation examination, has codes that vary according to the level of complexity (CPT (99271-99275) These consultations are usually used when a patient, family member or other caregiver seeks a second opinion. In this instance a referral from another health care provider is not required, nor is a report.
   c. Both the consultation examination and confirmation consultation are generally reimbursed at a higher rate than a comprehensive examination. (See below for the discussion of the comprehensive examination.) I don't recommend using the confirmatory consultation code because these codes are more likely to undergo audit; the difference in the fee between the confirmatory examination and a comprehensive examination may not warrant the office's administrative time and effort that an audit entails.
2. **Refractive analysis (CPT 92015)**
   This service is almost never covered by medical insurance plans. Most optometrists directly charge the patient for this service.
3. **Comprehensive exam (CPT 92004)** is a level of care that is reimbursed based on the complexity of the diagnosis and the examining sequences performed in order to reach a management decision. A thorough understanding of the coding of this service is important and it is recommended that the reader contact the insurance companies for their guidelines.
4. **Sensory Motor Examination (CPT 92060)**
   This code covers the evaluation of classical ocular motor and binocular vision dysfunction. However, it is a very limited code and does not account for the complexity and time required for the standard optometric evaluation of, for example, a learning disabled[6,7] or acquired brain injured[8,9] patient. Thus, it is financially feasible to use this code for **a** patient with an uncomplicated convergence insufficiency; however, this is generally not so for a patient with acquired brain injury, whose convergence insufficiency is accompanied by, e.g., nystagmus and accommodative disorders
5. **Assessment of Higher Cerebral Function (CPT 96115)**
   This code contains a systematic approach to evaluate the intactness of

higher cerebral functioning. However, it again does not account for the complexity and level of time required for the standard optometric evaluation of a learning disabled[6,7] or acquired brain injured patient.[8,9] This code does not reimburse for reviewing previous evaluations performed by other professionals such as the school psychologist or neuropsychologist and other related educational professionals. Further, it does not reimburse for conferencing with parents, spouses and extended family to discuss treatment and management options.

6. **Intermediate level, E/M levels, and other specialized codes**
   The sensory motor exam (92060) is described as a special exam procedure in the CPT manual.[4] Thus, it may be billed as a separate procedure code along with the appropriate level of either an intermediate examination code or the appropriate E/M code. The intermediate or E/M codes represent the professional time associated with evaluating the data from the sensory motor or assessment of higher cerebral functioning examinations, as well as additional evaluations that may be performed in order to determine a diagnosis and management plan. With most medical plans it is acceptable to bill for both on the same day; however, the optometrist should be knowledgeable about which insurance plans allow for this and which deny payment for both codes on the same visit. It is very important that the documentation is precise.
7. **Unlisted Codes**
   These comprise services that do not have a specific CPT code description but are included as a billing code in the CPT manual. They are used for services that do not meet the description of the specifically listed CPT codes. When using these codes for billing, they should be designated as "unlisted" and be accompanied by an appropriate description. My perception is that these codes are not utilized to the extent they might be in billing for VT diagnostic and therapeutic services. For example, I use the unlisted CPT code 99199 with a description of the developmental vision/visual perceptual analyses to bill for these testing batteries. My experience is that these batteries have never been covered by managed care plans. The diagnostic code that I find appropriate for these cases is: V41.90, Learning Related Visual Problems. The most common VT related diagnostic services that I find fall under this category are:

   Developmental vision evaluation
   Visual perception evaluation
   Learning disability evaluation
   Sports vision evaluation
   Conferences and reports
   Review of reports by other health care providers

A PROPOSED OFFICE MANAGEMENT SEQUENCE

What follows is the sequence and policies used in my group practice. There are three other optometrists, and we offer full scope optometric care. Two of us specialize in all aspects of rehabilitative optometry. This includes providing care for patients with acquired brain injury, vestibular dysfunction, neuromuscular disease, strabismus and non-strabismic anomalies of binocular vision, low vision and children with learning-related vision disorders. We utilize certified vision therapists and vision therapy assistants in the diagnosis and therapy of these conditions. These ancillary personnel always work under the supervision of an optometrist.

The initial appointment

The receptionist determines the reason for seeking care. Basically, the callers have been referred for a consultation by another health care provider, or for the evaluation of self-determined visual problems. The receptionist obtains the patient's health care insurance status and informs the callers of fees for which they will be responsible.

A case in point is when the appointment is being made for a potential learning-related vision problem. The receptionist makes it clear that medical plans *do not* reimburse for examinations for learning-related vision problems, and that the financially responsible person must assume the fee payment. After the appointment is made the responsible person is sent a package. This includes a patient history check off form and a summary of the office's fee policies. In order to avoid any misunderstanding, there is also a letter that reinforces that the fee for this examination must be paid by the responsible person. See Appendix A.

At the completion of the initial examination allot time to give your impressions and propose the next sequence of diagnostic testing along with the reasons they are required. Discuss which of the recommended services are covered and which are not covered by the particular plan. A form is prepared that summarizes this information. The responsible party is required to read, understand and sign the form before appointments are made for subsequent services. Appendix B is the template for the form given after the initial examination regarding further necessary services for investigation of a learning related visual problem. It can be adapted for other services.

After the form is signed, the patient is scheduled for at least two of the following:

1. A sensory motor examination
2. A visual developmental/perceptual examination
3. A visit to evaluate the data from the above tests with the option of further testing as appropriate
4. A conference appointment with the patient and responsible family members. Following is a further discussion of this appointment.

The Conference Appointment Overview

This visit is, in my opinion, a key factor in the determining the success of the VT program. It is here that the patient and significant others should be made to fully understand the nature of the vision problem, and how and why the proposed rehabilitative program is a reasonable and feasible way to address it. The optometrist's communication style should be clear, concise and respectful of all who attend. I present the following as important points for this key appointment:

1. Do not participate in this conference unless you have fully reviewed your data and have organized your information.
2. Leave appropriate time for your presentation and questions.
3. For minors, the optometrist should strongly encourage both parents to attend. At the conclusion of the conference the family must make both time and financial commitments; the attendance of both parents is paramount to make or reject these commitments.

4. Other professionals who are involved in the patients care should be encouraged to attend.
5. The presentation of the important clinical findings should be related to the patient's overall problems, chief complaints and other involved professionals' assessments. The findings should be expressed in layman's terms and technical terms should be avoided. For example, use a computer model to discuss how visual information processing can be considered to include input, integration and output.
6. Present the treatment plan's goals in detail along with the responsibilities of the patient, family, or others in terms of home supplemental procedures.
7. Do not denigrate other health care professionals whose recommendations are different than yours; rather, support yours with logic and confidence.
8. Control any discussions, but don't dictate. The conference should last no more than one hour.

Discussion of fees

Allow ample time to review fees and office policies. Patients, and/or their responsible family members often are more comfortable discussing the financial aspects with the optometrist than with ancillary personnel. Be receptive to questions or concerns, but inform the responsible parties that the staff will be helpful and supportive in arranging for their insurance and financial needs. There are special considerations for patients with and without medical insurance.

Be very knowledgeable about the policies on allowable services for those plans in which you participate. For patients who are members of these plans, enumerate the services that are covered and those not covered. When questions are raised about non-covered services that, in your professional judgment, are deemed necessary, emphasize that it is the plan that has made this decision and not your office. The patient and responsible parties must understand that they must pay for non-covered services.

Further, do not inappropriately change or modify the diagnosis or treatment plan so that these services are covered. This can constitute fraud. Use the diagnostic code that most truly reflects your assessment. Using an inappropriate code can have further consequences. For example, consider a patient with learning-related visual problems that include ocular motor control and inefficient fusion control. However, your assessment indicates that the core problems are developmental delays in the motor and or visual processing systems. In this instance the unlisted code V 41.90 should be used. If you used the listed codes, reimbursement for VT by an insurer or by the patient will be less; these codes do not account for the complexity and intensity of treatment that should be specified in your office policy document.

For patients not enrolled in a plan in which I participate, I offer several options for payment. They can pay at each VT visit. A second method is to make a per case payment. Finally, if the patient elects to use a professional finance plan, I agree to absorb the one year interest charge. The rationale is that, in these cases, I receive the total fee when VT is initiated; this reduces my overhead costs.

A special case is those patients whose visual problems are the result of accidents, and who have no insurance, and cannot afford VT. These patients are often in the process of litigation. In these cases I accept a legal lien, with the caveat that they are still responsible for eventual payment.

Scheduling Therapy Sessions:

1) At the conclusion of the conference I inform the responsible parties that my staff will request pre-authorization of VT when the plan requires this. See Appendix C. Upon authorization, the responsible parties are sent an information packet and forms to sign. The information packet clearly documents the patient's treatment responsibilities, type of visits, equipment and materials required and their payment responsibilities. There are also legal and waiver forms. When we receive all required signed forms, the vision therapist arranges the schedule of VT appointments. This procedure avoids any type of misunderstanding and acts to firmly commit all parties to the VT program.
2) In the event that pre-authorization is not provided, unless I perceive a blatant error, the responsible parties are informed that they should pursue the issue with the plan. Our office will provide them with an official copy of the diagnosis and treatment plan and offer guidance, but will not become directly involved in the issue.

Coding VT Treatment Services

Most insurance companies including Medicare, recognize CPT 92065 (orthoptic treatment) as the code for office based VT. It is viewed as an independent procedure. We schedule appointments of 30 minutes.

It is customary at each session for the doctor to evaluate overall progress and the progress of techniques that are assigned for home use. Modifications are appropriately made in both of these components of the VT plan. The most appropriate code for this service is CPT 92012 (Intermediate Examination). We allow about 15 minutes for this service.

Some patients require extensive supplemental home-based VT. I develop a comprehensive plan, and there is a one-time fee based on the time spent in crafting the plan. An additional fee is for the services of the vision therapist who monthly demonstrates new techniques as determined by the degree of progress. Neither of these services is usually covered by medical insurance plans, so that they are to be paid by the patient. For these services I also use the unlisted code CPT 99199, with the description: development of home therapy program or demonstration of home therapy program.

Documentation of Visual Therapy Services

Careful and complete documentation for all optometric services is essential in dealing with managed care plans, and this is particularly true for VT. It is not unusual for plan administrators and workers to be unfamiliar with this area's diagnostic and therapeutic regimens. Consequently, I recommend the SOAP (Subjective, Objective, Assessment, Plan) model for documenting all of my diagnostic and treatment notes, which is the generally accepted format.

The documentation for a VT visit (CPT 92065) is recorded by the vision therapist. The notes should clearly show that the techniques used are in accord with the doctor's treatment plan; the vision therapist should record the patient's performance on each technique.

I recommend that the documentation for the doctor's Intermediate Examination (CPT 92012) be recorded on a separate sheet from the recording of the VT visit. It

should include the evaluation of the VT session, the home supplemental VT, and any appropriate modifications in the treatment plan. There should also be pre-programming of the techniques for the next VT session.

Both levels of documentation should have the date of service, patient's name, name of the provider of the services, and should be clearly signed by the provider.

CODING EXAMPLES FOR BILLING

Following are examples of cases that are common in VT practices. The fee for each service is that which is consistent with the written office policy.

1. **Basic Binocular Vision Dysfunction Evaluation**
   a. Consultation Exam (CPT 99244) or comprehensive exam (CPT 92004)
   b. Refractive analysis (CPT 92015)
   c. Sensory motor examination (CPT 92060)
   d. Intermediate examination (CPT 92012) or E/M level
   e. Conference and report (Use Unlisted Code)
2. **Developmental Vision Evaluation**
   a. Consultation Exam (CPT 99244) or comprehensive exam (CPT 92004)
   b. Refractive analysis (CPT 92015)
   c. Sensory motor examination (CPT 92060)
   d. Intermediate examination (CPT 92012) or E/M level.
   e. Developmental vision analysis which includes the assessment of motor development, visual perceptual processing skills, review of testing by other health care providers and educational testing, conference with family and reports (Unlisted Code CPT 99199).
3. **Treatment**
   a. Out-of-office therapy planning fee
   Each in-office therapy visit (Use Unlisted Code)
   Orthoptic therapy (CPT 92065)
   b. Intermediate exam (CPT 92012)
   c. Out-of-office therapy demonstration as appropriate (Use Unlisted Code)
   d. Materials
   e. Reevaluation as appropriate (CPT 92012)

THE SUCCESSFUL VT PRACTICE

There are basically two aspects that are key for all optometric services, and particularly for VT. There should be a blending of the provision of high quality services with office policies and administration in a manner that assures the doctor a fair measure of fiscal return. Thus, fees should be set that are commensurate with the doctor's training, experience, responsibility, along with the importance and complexity of the services that are provided. Further consideration must be given to the office overhead costs that include wear and tear on equipment and materials loaned or dispensed for supplemental home based VT. The overall financial goal is that the "net flow income" from VT services (the income per hour which considers all pertinent factors) should, at a minimum, equal the per hour income the office generates when providing optometric primary care examination and treatment services. This is more easily accomplished with fee for service VT patients, but can also be achieved for those patients enrolled in a medical plan when there are clearly defined and consistently used office policies and procedures.

SUMMARY

All aspects of conducting a successful vision therapy practice have not been presented in this article. However, the basic components follow:

Create an office policy document, which gives the rationale for your diagnostic and treatment fees for all services. The fees must be consistent for all patients

Establish fees to cover materials dispensed to your patients that are associated with the treatment plan.

Allow adequate time to explain to the responsible parties the reason for the fees for which they will be responsible. Have a letter that summarizes these services and fees, and have the responsible parties sign it before any services are provided.

Be thoroughly familiar with the policies and procedures of plans in which you participate.

Understand and appropriately utilize the unlisted CPT codes.

Use the most appropriate diagnostic codes when billing plans. Do not modify your diagnosis or treatment plan in order to have your services covered.

Make certain that all services are fully and properly documented and are signed by the provider.

CONCLUSION

I have presented the basics of what some 38 years of experience has indicated are needed to conduct a successful VT practice for all patients. The rules and regulations for managed care have changed from year to year, and the optometrist must be informed and understand these changes. I have not fully addressed all areas of this complex and challenging aspect of optometric practice; the interested reader is referred to a chapter by Wright[10] for further information about coding for VT, another by Sanet[11] for developing fees, and article by Press[12] that presents templates for letters sent to the responsible parties and managed care plans.

Optometry fought to have its services included in medical care plans, first at the state, and then at the federal levels. At this time participation in one or more of these groups is the rule, rather than exception in all types of optometric practices. Indeed, these plans have enhanced the profession and its practitioners. The key to flourish in this environment is the ability to be knowledgeable of the rules and regulations of these plans. With a willingness to be flexible, the practitioner can then maximize the opportunities, and honestly and intelligently address the challenges that are part of every plan.

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APPENDIX A.
Templet for requesting information and explaining fee responsibility before the initial examination of a potential learning related vision problem

Date_____
Patient's Name_____
Dear_____

Thank you for requesting our evaluation of the degree to which visual problems are contributing to _____'s learning difficulties. The consultation we've scheduled for _____ on_____ at _____(am, pm) will take 45 minutes to one hour. As you were previously informed, medical care plans do not reimburse for this type of consultation. Therefore, please be prepared to pay a fee of $_____ at the time of this visit.

In order for us to be fully informed, please complete the enclosed patient history form. Also, make copies of testing results from your child's school along with other evaluations that you feel will be helpful to us. Please return all of these documents to us at least three days prior to the appointment, so that the doctor can thoroughly review all the information.

If you have any question, call us at _____, and speak to _____.

Sincerely,
Eye Vision Associates

APPENDIX B.
Templet explaining the services, fees and agreement to proceed for a learning related vision problem.

Date_____
Patient Name_____
Dear_____

Our initial consultation indicates that there are visual problems than can affect your child's learning ability. In order to make this determination, a number of additional specialized visual tests are required. However, as we have already informed you, **medical insurance plans do not include the assessment of learning related vision problems**. Consequently, all specialized testing is your financial responsibility.

The specialized testing comprises a complete Developmental Vision and Visual Perception Evaluation. The total fee for this testing is _____ and will require a minimum of three office visits. This battery of testing includes:

Evaluation of oculo-motor and visuo-motor development

Evaluation of visual perceptual processing skills

Evaluation of supportive motor development

Conferencing with family and other interested parties to discuss the results of the evaluations and the recommended treatment plan

A narrative report summarizing the results of the evaluations and further recommendations for the appropriate therapy and management

Your signature acknowledges that you have been informed of the testing to be done and your financial responsibility. We will then arrange the next appointment.

If you have any questions, please feel free to call _____ at _____.

Dr. Allen H. Cohen

Patient or Guardian Signature:
_____
Date:_____

APPENDIX C.
Templet for pre authorization request to insurer for Vision Therapy

To Whom It May Concern:
Patient's name_____
Policy holder_____
Policy number_____
Employer_____

We recently examined the above named patient. The diagnostic examination indicated the following condition(s) with the indicated ICD-9-CM codes:

_____
_____
_____

The treatment for the above condition(s) is ORTHOPTIC/VISUAL THERAPY. This treatment is specific for the diagnosed neuromuscular anomaly(s) and IS NOT for routine eye care or glasses. The therapy consists of in-office treatment sessions and it is anticipated that _____ sessions will be required. The fee for each session is_____.

The patient has requested that I seek pre-authorization for my services. Please provide the following information:

Is the treatment a covered service?

What is the insured's annual deductible?

Has the deductible been met?

If not, what is the remaining balance?

A prompt reply will be greatly appreciated.

Allen H. Cohen, O.D.

I grant permission to_____Insurance Company to release the above