Collecting for Refractions: Two Best Practices

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We all know that patients who need updated eyeglass prescriptions require refractions. Patients know this is typically an uncovered expense and are most often prepared to pay this cost at the time of service. Refractions get a little trickier, however, for surgical specialists who perform refractions as part of the patient's surgical evaluation.

These circumstances give rise to many questions. If the patient was referred by an optometrist and the optometrist already completed the refraction as part of the exam, does the surgeon charge for the service again? What if the patient came for a surgical evaluation but the specialist determined no need for surgery at that time? What if the patient is self-pay and will already have the expense of the full exam and testing to worry about? What if the patient has a commercial insurance plan that could potentially pay for the refraction?

Medicare, of course, does not pay for refractions. Although the logic to this is perplexing, at least its position is clear, allowing us to move forward and develop policies to best address the situation at hand. Although I am certainly not an expert, I can share practices that are working well within our clinic for dealing with these questions.

Best Practice #1: Communications

The first rule of our practice is communication. All patients receive and sign a fees consent form, which explains that a refraction is a necessary part of the surgical evaluation and might not be covered by their insurance plan. The technicians take this a step further in the exam room by ex-

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plaining that they are getting ready to refract the patient and why that refraction is important to the patient's care. Upon check-out, patients again hear from our patient registration specialist about how they received a special test that day and why we need to collect for that refraction upon leaving the clinic. For the most part, this three-step approach works well and we receive very few complaints. Granted, we refined this process over time—in the beginning we quietly had patients sign the consent form with no further explanation, then had to deal with the frustrated phone calls later. The multi-step communication approach has worked well in decreasing confusion and easing the minds of those left paying for refractions out-of-pocket.

Best Practice #2: Develop a Collections Policy

Suppose your communication strategy is in place. What is your practice's refraction collections policy? This gets even trickier as every office will develop a policy based on the individual nuances within its own patient base. Again, I can only share what is working well within our practice, but our chosen policies are supported by research about best practices from around the country.

For starters, we collect for refractions at the time of service for all Medicare patients. Since Medicare universally denies coverage for refractions, this one is pretty much a "gimme." For our commercially covered patients, we explored a few different approaches and finally determined that the method resulting in the fewest insurance refunds and the highest collections rate is to bill refraction charges directly to the patient's commercial carrier. Some commercial payers cover refractions, some don't, and some appear to decide coverage depending on what day of the week it is. If the plan does not cover the refraction, the cost is then billed to the patient. Although charge amounts can vary from practice to practice, the Centers for Medicare and Medicaid Services (CMS) does assign a value to CPT 92015 of approximately $56 (2007).

This value continues to fluctuate from year to year, but practices can feel comfortable using CMS guidelines to justify charges that are comparable to other practices within their geographic areas. Commercial plans covering refractions will already have a set allowable fee, so individual practice contracts should be reviewed to determine what those payment amounts will be.

For those patients having both a primary and secondary insurance plan we let the primary plan establish which route we'll take. If the primary plan is Medicare, we collect for the refraction at time of service, as a lot of secondaries will follow the primary plan's denial. For these patients we do, however, still submit the refraction code to both Medicare and the commercial secondary so the denial (or payment for that matter) is a part of the patient's billing record. In the rare instances these plans actually pay for a refraction when we had previously collected payment from the patient, we simply refund the patient and call it a day.

Whether your office collects for refractions up front, submits all charges to insurance, or adopts a hybrid approach, charging and collecting for refractions should become commonplace within your practice. Especially in these times of creative revenue generation, even an extra $20,000 to $40,000 per year in refraction collections is well worth the time it takes to implement a solid and consistent collections policy. AE

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This same type of time study can be performed on all staff who handle patients during their visit, such as receptionists, technicians, surgery schedulers, and check-out staff. Performing this type of study on these positions will not only help you to realize how their time is being consumed, but also to identify reasons for logjams in the movement of patients though your facility—which ties back to doctors having no patient ready to examine, which, as we've already seen, detracts from having an efficient practice. AE

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