A FREE GUIDE FROM COLLECTIVE REVENUE

Optometry Billing 101

Survival Guide for Practice Owners

How your practice actually gets paid, where the money slips away, and what to ask your team, in plain English.

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Collective Revenue

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Start here

You don't have to be a coder. You do have to know the game.

Most practice owners never got a single class on billing. You learned to care for eyes, and then one day you owned a business whose cash flow depends on codes, claims and conversations at the front desk.

This guide won't turn you into a biller. It will help you see how the money moves, spot problems early and ask your team the right questions.

Hannah Boyd CEO & Founder, Collective Revenue

TWO NUMBERS EVERY OWNER SHOULD KNOW

~60%

of an optometry practice's revenue typically comes from **patients** (materials, copays, deductibles, non-covered services), making the patient your biggest payer.

~40%

is the commonly cited risk of **never collecting** a patient balance once the patient walks out the door. Collect at the visit.

YOUR THREE SURVIVAL RULES

1. **Money is won or lost before the exam.** Scheduling and verification set up every claim that follows.
2. **The chart is the claim.** If the documentation doesn't support the code, the payment isn't safe.
3. **What you don't measure leaks.** Aging, denials and write-offs need an owner's eyes every month.

Every claim takes the same seven steps.

Problems show up downstream but start upstream. Trace each one back to its step and fix it there.

	STEP	WHAT HAPPENS	WHERE MONEY LEAKS
1	Pre-visit SCHEDULING	Capture demographics and **every** insurance. Check eligibility, ideally while the patient is still on the phone. Set payment expectations.	Wrong plan billed, missing referral, surprised patients.
2	Check-in FRONT DESK	Re-confirm address, birth date, guarantor and insurance. Scan cards front and back. Get financial and assignment forms signed. Collect what's due.	Name or ID typos, a top cause of rejections.
3	Charge capture DOCTOR & EHR	Every service is documented and coded. Reconcile charges against the day's schedule so no visit slips through.	Services performed but never billed.
4	Claim submission BILLING	Confirm the diagnosis supports each procedure, scrub the claim and send it through the clearinghouse. Review transmission and rejection reports daily.	Rejected claims nobody notices.
5	Payment posting BILLING	Post each EOB or electronic remittance. Compare payments to contracted allowables. Separate contractual write-offs from avoidable ones.	Underpayments and "clean-up" write-offs.
6	A/R & denials BILLING	Correct, resubmit or appeal unpaid claims. Track denial reasons. Run insurance and patient aging at least monthly.	Timely filing limits quietly expire.
7	Patient collections FRONT DESK & BILLING	Collect at the visit. Send statements on a steady cycle and offer online or text-to-pay options.	Balances age into bad debt.

MEANWHILE, AT THE INSURANCE COMPANY

Adjudication checks patient and provider details → **processing** checks bundling, necessity and frequency → **payment** arrives with an EOB → your team **reconciles** it to the contract.

Two kinds of coverage. One patient.

Most of your patients carry both. Knowing which one to bill, and why, prevents more denials than any other single habit.

	Vision plan	Medical insurance
COVERS	Routine exam, refraction, glasses and contacts	Diagnosing, treating and managing eye disease, injury or symptoms
PATIENT PAYS	Copays, plus amounts over material allowances or after discounts	Copays, deductibles and coinsurance, up to an out-of-pocket maximum
FREQUENCY	Usually once per benefit period (often 12 months)	Whenever medically necessary
MATERIALS	Frame, lens and contact allowances or discounts	Generally not covered, with narrow exceptions (e.g., after cataract surgery)

The rule that decides it

The reason for the visit picks the payer, not the card in hand. "I need new glasses" points to the vision plan. Red eye, flashes, dry eye or a diabetic eye check point to medical. If exam findings change the picture, the doctor explains why before the patient reaches checkout.

FOUR TERMS YOUR WHOLE TEAM SHOULD BE ABLE TO EXPLAIN

Copay
A flat dollar amount due each visit.

Deductible
What the patient pays each year before the plan starts paying.

Coinsurance
The patient's percentage after the deductible is met.

Out-of-pocket max
The yearly cap on covered costs. Non-covered services don't count.

PLAN TYPES AT A GLANCE

HMO: in-network only; a PCP referral is often required.

POS: network-based and may require a PCP referral.

HDHP: high deductible; patients owe more up front, so collect at the visit.

Medicare Advantage: a private plan replaces Original Medicare. Bill the plan, not Medicare.

PPO: lower cost in-network; out-of-network costs more.

EPO: network only, except emergencies.

Medicare: 65+ and certain disabilities; refraction is not covered.

Medicaid: state-run; eligibility can change on the 1st of the month.

Your front desk is your billing department's first line.

INSURANCE VERIFICATION, EVERY TIME

1. **Gather.** Cards front and back, photo ID, the subscriber's name and birth date if different. Always ask about a secondary plan.
2. **Verify 3+ days ahead.** Active on the date of service? Routine *and* medical benefits? Referral needed? Are the doctor and practice in network?
3. **Know the money.** Remaining deductible, copay or coinsurance, and how close the patient is to the out-of-pocket max.
4. **Document it.** Rep name, date, time and call reference number, or save the portal screenshot to the chart.
5. **Tell the patient first.** Share expected costs or a needed referral before they arrive.

At check-in

Confirm demographics and insurance. Get the assignment of benefits signed; your claim attests it's on file.

Collect copays and estimated balances now. Part of an estimate beats nothing.

> *"How would you like to take care of today's balance?"*

At check-out

It starts in the exam lane: if the visit became medical, the doctor explains why.

Review the charges. If the visit's scope changed, collect the added copay before the patient leaves.

No Surprises Act: Good Faith Estimates

SELF-PAY & UNINSURED PATIENTS

Who: uninsured patients, and insured patients not using their coverage.

When: booked 3+ business days out, within 1 business day; booked 10+ out, within 3; on request, within 3.

Lasts: 12 months. Reissue yearly for recurring care such as myopia management.

How: verbally when scheduling, then in writing (paper or electronic).

Include: services with codes and charges if known, doctor's name, NPI and TIN, plus the four HHS disclaimers.

Risk: a bill $400+ over the estimate gives the patient dispute rights. Post the rights notice in-office and online.

Three code sets tell the payer one story.

CPT
WHAT YOU DID

Exams, tests and procedures. Maintained by the AMA.

ICD-10-CM
WHY YOU DID IT

Diagnoses. Updated every October 1. Code to the highest specificity; “unspecified” codes invite denials.

HCPCS II
WHAT YOU SUPPLIED

V-codes for frames, lenses and contacts. Some plans use S-codes for routine exams.

Eye codes
New: 92002 intermediate · 92004 comprehensive
Established: 92012 · 92014
Comprehensive means a complete visual system exam that starts or continues a diagnostic and treatment plan.

E/M codes
New: 99202–99205
Established: 99211–99215
The level is chosen by medical decision making *or* total time on the date of service. Bill whichever family the chart and payer policy support.

New vs. established: a patient is established if a doctor of the same specialty in your group has seen them within the past **three years**.

OWNER’S CHEAT SHEET: CODES YOU’LL SEE EVERY WEEK

CODE	WHAT IT IS	WATCH FOR
92015	Refraction	Not covered by Medicare or many medical plans. Collect from the patient.
92083	Visual field, extended	Needs a documented reason and an interpretation & report.
92133 / 92134	OCT, optic nerve / retina	Supported by diagnosis (e.g., glaucoma vs. retina); check frequency limits.
92250	Fundus photography	Without medical need it’s a screening, and the patient pays.
92310	Contact lens fitting	Usually not a medical benefit; vision plans may help.
65222	Corneal foreign body removal, slit lamp	0-day global; same-day exam may need modifier 25.
68761	Punctal plug, each	10-day global; follow-ups in that window are included.

Billing a diagnostic test?

It needs a written **order** before the test (reason, what, when) and an interpretation covering the **four R’s**: Reason, Results, Reliability and Recommendation. No symptoms and no order means it’s a screening, which is the patient’s responsibility.

Two letters can make or break a claim.

Modifiers add detail without changing what a code means. Missing or misused modifiers are one of the most common reasons claims deny. List pricing modifiers (26, TC, 50) before informational ones (RT, LT, E1–E4, 59).

Which eye or lid

RT / LT	Right eye / left eye
50	Bilateral procedure, same session
E1–E4	Upper left, lower left, upper right, lower right eyelid

Exam + procedure, same day

25	Significant, separate exam on the day of a minor procedure. Not billable if the exam only confirmed the need for the procedure.
57	The exam that led to the decision for major surgery

Surgery & co-management

55	Post-op care only, the classic co-management modifier
24	Unrelated exam during a post-op period
79	Unrelated procedure during a post-op period

Tests & unbundling

26 / TC	Interpretation only / technical part only
QW	CLIA-waived in-office lab test
59, XE, XP, XS, XU	Truly distinct services that normally bundle. Use sparingly; auditors watch these.

Medicare must-knows

An **ABN** (Advance Beneficiary Notice) lets a Medicare patient choose a service Medicare may not pay for, and accept the cost, *before* it happens. Without a signed ABN, you generally can't bill the patient if Medicare denies.

GA	Signed ABN on file; the service may be denied as not medically necessary.
GZ	Denial expected and no ABN was signed. The practice absorbs the loss.
GY	Never a Medicare benefit (refraction is the classic example). No ABN required, but tell the patient up front.

Medicare coverage rules live in **National Coverage Determinations** and your contractor's **Local Coverage Determinations**. Check the LCDs for tests like OCT, visual fields and fundus photos.

A denial is a message. Learn to read it.

Every adjustment on an EOB has a two-letter group code (who owns it) and a reason code (why).

CO
CONTRACTUAL

Your contract says write it off. Don't bill the patient.

PR
PATIENT OWES

Deductible (1), coinsurance (2), copay (3). Bill the patient.

OA
OTHER

Adjustments that fit neither, often from a prior payer.

PI
PAYER-INITIATED

The payer reduced it. Review it before accepting.

THE DENIALS YOU'LL SEE MOST, AND THE USUAL FIX

CODE	WHAT IT MEANS	USUAL FIX
16	Missing information or billing error	Correct the claim and resubmit
4	Modifier missing or doesn't fit the code	Add or fix the modifier
11	Diagnosis doesn't support the procedure	Check documentation and diagnosis linking
22	Another payer may be primary	Confirm coordination of benefits; bill the primary
27 / 28	Coverage ended or not in effect	Re-verify; bill the right plan or the patient
31 / 140	Patient not found, or name and ID don't match	Fix demographics against the card
50	Not medically necessary	Review the note and LCD; appeal, or use an ABN next time
96 / 204	Non-covered service	Bill the patient if your policy or ABN allows
97	Bundled into another service	Check edits; 59 only if truly distinct
197	Authorization or referral missing	Get it before the visit, every time
185	Rendering provider not eligible	Credentialing or enrollment problem; escalate
29	Timely filing limit expired	Usually unrecoverable; fix the process

Working a denial, step by step

1. Read the reason and remark codes, not just the dollar amount.
2. If it was your error, send a corrected claim. That's not an appeal.
3. Call the payer first. Many issues resolve by phone.
4. Appeal in writing, with records, by the payer's rules and deadline.

Then log the reason. Your top three denial reasons each month are your team's training plan.

Protect the practice you worked so hard to build.

THE LAWS, ONE SENTENCE EACH

HIPAA	Protect patient health information; share it without written authorization only for treatment, payment or operations.
HITECH Act	Puts teeth in HIPAA with audits and stiffer penalties for privacy and security failures.
False Claims Act	Billing claims you knew, *or should have known*, were false. No intent required; "I didn't look" isn't a defense.
Anti-Kickback	Nothing of value in exchange for referrals of federal program patients. A criminal offense.
Stark Law	No Medicare referrals for designated services to entities you have a financial relationship with. Significant civil penalties.

THREE CODING ERRORS THAT COST OWNERS MONEY

Over-coding

Billing a higher level than the chart supports. Invites audits and paybacks.

Under-coding

The most common optometry error: billing lower than the work supports. Quiet, steady lost revenue.

Not billing

Skipping billable services, like refraction, or missing charges. Lost revenue that may also break payer contracts.

Red lines for your team

- ✕ Never code what isn't documented.
- ✕ Never change a diagnosis so insurance will pay, even when a patient asks.
- ✕ Never waive patient balances case by case; use a written policy.
- ✕ Never open a chart you don't need for your job.

Know your write-offs

Contractual write-offs are unavoidable: the difference your contract says you accept.

Avoidable write-offs (no authorization, no referral, missed filing deadline) are a process breaking down. Review them monthly and fix the cause.

What to check, and when.

You don't have to do every task. You do have to know each one is getting done. Print this and keep it by your desk.

Daily

- [ ] Every visit on the schedule has charges entered
- [ ] Clearinghouse rejection report cleared
- [ ] Payments collected at the visit posted
- [ ] Upcoming patients' insurance verified

Weekly

- [ ] Denials worked: same day, same person
- [ ] Unbilled visits older than 3 days reviewed
- [ ] Insurance payments reconciled to bank deposits

Monthly

- [ ] A/R aging by payer. Our goal: 61–120 days ≤ 4% of total A/R; 121+ days ≤ 2.5%
- [ ] Top three denial reasons identified
- [ ] Write-off report reviewed: contractual vs. avoidable
- [ ] Credentialing dates due in the next 90 days

Yearly

- [ ] Fee schedule reviewed against allowables and contracts
- [ ] Code updates loaded (ICD-10 each Oct 1; CPT & HCPCS each Jan 1)
- [ ] Financial policy and GFE templates refreshed
- [ ] HIPAA and compliance refresher for the team

Five questions to ask your billing team this month

1. What percentage of our claims are paid on the first submission?
2. What percentage of our A/R is over 120 days, by payer?
3. What were our top three denial reasons, and what are we doing about them?
4. How much did we write off last month that wasn't contractual, and why?
5. Which unpaid claims are closest to their timely filing limit?

Survival is the minimum. Let's help you thrive.

Rather hand the billing to people who live it?

Collective Revenue is an optometry-only billing company. We're a small business, not a corporation, and we never outsource, so you work with people who know eye care billing and care about your practice.

Insurance Billing
Clean claims. Faster payments.

Credentialing
Get in network, and stay there.

VerifEYE
Know their coverage before they're in the chair.

A/R Clean Up
A fresh start for old balances.

YOUR NEXT STEP

Book a free 20-minute billing conversation

Book your call → or call 833-327-2726

Collective Revenue

OPTOMETRY'S PREMIER BILLING SERVICE

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