

***Issue Guidance***

***Instrument Based Vision Screening***

08/2019

**What is the Issue for Pediatricians?**

Members report some health plans will not pay for instrument-based screening or will bundle payment with the office visit. By considering the vision screen to be incidental to the office visits, payers may inappropriately discount the payment for services provided. Plans having coverage limitations restrict access to diagnostic services.

**Impact to Pediatricians**

Inappropriate bundling and non-payment adversely impacts the financial viability of the practice by reducing payment for services provided. Additionally, inappropriate bundling is counter to correct coding guidance. Payers who ignore correctly applied coding guidelines and CPT modifiers inappropriately underpay physicians for the services provided.

**AAP Action Taken**

* The AAP published the *Visual System Assessment in Infants, Children and Young Adults by Pediatricians* see [www.pediatrics.org/cgi/doi/10.1542/peds.2015-3596](http://www.pediatrics.org/cgi/doi/10.1542/peds.2015-3596) and the clinical

report *Procedures for the Evaluation of the Visual System by Pediatricians* at [www.pediatrics.org/cgi/doi/10.1542/peds.2015-3597](http://www.pediatrics.org/cgi/doi/10.1542/peds.2015-3597).

* The policy statement articulates the screening criteria and screening methods, and the clinical report explains the various evaluation procedures that are available for use by the pediatrician or primary care physician.
* The AAP sent letters to the national and largest regional commercial health plans informing them of the current AAP guidance on vision assessment and to provide benefits coverage and payment for vision screening and assessment as per the recommendations.
* UnitedHealthcare revised its age limits for instrument-based screening and now covers vision screening for children aged 1 through 3 years using instrument-based screening and allowing instrument-based screening in older children with developmental delays

See <https://www.aap.org/en-us/Documents/UHC_response_Vision_Screen_Dec2016.pdf>

**AAP Resources**

* The AAP letter on can be accessed on the private payer advocacy webpage at <https://www.aap.org/en-us/Documents/Ltr_Vision_Screen_policy_2016.pdf>

for AAP chapters, pediatric councils, and members to use in discussions with their payer contacts.

* Visual System Assessment in Infants, Children and Young Adults by Pediatricians is available at [www.pediatrics.org/cgi/doi/10.1542/peds.2015-3596](http://www.pediatrics.org/cgi/doi/10.1542/peds.2015-3596), and the clinical report Procedures for the Evaluation of the Visual System by Pediatricians is at [www.pediatrics.org/cgi/doi/10.1542/peds.2015-3597](http://www.pediatrics.org/cgi/doi/10.1542/peds.2015-3597).
* To address carrier bundling for vision screening, please see the AAP template letter attached below

**Key Takeaways**

AAP chapters and pediatric councils should:

* Encourage benefits coverage that aligns with the current AAP recommendations for instrument-based screening
* As noted in the AAP clinical report, instrument-based screening can be relatively quick and requires less attention from the child compared with traditional visual acuity screening. Further, as stated in the AAP documents, instrument-based screening is an approved technology that is endorsed by the United States Preventative Services Task Force (USPSTF).
* Advocate to payers to pay for the visual acuity screening (CPT code 99173) and instrument-based ocular screening (CPT codes 99174 and 99177) as a separately reported service, apart from the reported office visit and other preventive care services. Although these codes are not covered under Medicare, payers should pay, at a minimum of their published values.
* Clarify the fact that CPT guidelines indicate that services that are identified with specific codes should be reported separately from any other code and, therefore, they should not be “bundled” into any other code(s). This concept is found throughout CPT guidelines and for

Vision Screening: “Other identifiable services unrelated to this screening test provided at the same time may be reported separately [eg, preventive medicine services]” (*CPT 2019*, {professional edition}, page 739). This definition means that tests performed at the time of an E/M encounter are not to be paid as part of the E/M service, but rather are to be paid separately. The E/M codes in CPT were valued under the Medicare RBRVS fee schedule on the basis of the CPT guidelines; these values do not include any diagnostic tests or screens.

* Those separately reportable services that are not recognized by a carrier should be designated non-covered benefits and billable to the patient.

If AAP chapters or chapter pediatric councils have questions on coding for vision screening please submit to the AAP Coding Hotline at aapcodinghotline@aap.org. To report payment issues submit to the AAP Hassle Factor Form at <https://www.aap.org/en-us/professional-resources/practice-transformation/getting-paid/Pages/Hassle-Factor-Form-Concerns-with-Payers.aspx>



