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Optometry Coding & Billing Alert

3 FAQ Answers Clear Up Your Gonioscopy Confusion

Key: Get to know payer-specific rules before adding 92020 to another claim

With only one code for gonioscopy, reporting it to carriers is a snap, right? Not so fast.

When you perform a gonioscopy without general anesthesia, bilateral rules and reimbursable diagnoses can complicate the coding process. Tackle your coding dilemmas with these expert answers to your top gonioscopy questions.

Question 1: Is 92020 Inherently Bilateral?

Most insurance companies, including Medicare, consider 92020 (Gonioscopy [separate procedure]) a bilateral procedure code, says **Diane McVinney, CPC,** billing manager at the Jones Eye Institute at the University of Arkansas for Medical Sciences in Little Rock. This means that you cannot report the code twice when you perform a gonioscopy on each eye.

Although CPT doesn't specifically describe the procedure as bilateral in the code descriptor, most insurers do follow Medicare's lead. The Physician Fee Schedule Database assigns 92020 a bilateral surgery indicator of "2," which means that Medicare has set the relative value units (RVUs) for gonioscopy based on performing it bilaterally.

Example: Palmetto GBA's 2007 guidelines state that you cannot report 92020 bilaterally using modifiers 50 (Bilateral procedure), LT (Left side) or RT (Right side).

Tip: If you perform the gonioscopy on just one eye, your carrier may require you to indicate that you did not perform the full bilateral procedure. To do so, append modifier 52 (Reduced services) to 92020.

Question 2: Which Dx Proves Medical Necessity?

The diagnoses that support medical necessity for the gonioscopies you perform depend on your payer's local coverage determinations (LCDs). Each carrier you bill to may have different policies regarding 92020 reimbursement, McVinney says.

"We have no Medicare policy on gonioscopy in Arkansas, but it would be important to see if your state has a policy. I would also try to obtain carrier-specific -rules- about gonioscopy for the top payers in the practice," she adds.

Where to look: In many cases, you can search for local medical review policies (LMRPs) or LCDs on the carrier's Web site.

For example, the gonioscopy LCD for HealthNow in New York lists 11 diagnostic indications that warrant a payable gonioscopy. The LCD goes on to state, "Gonioscopy for all other ocular diseases not listed above is not considered reasonable and necessary and will not be separately reimbursable under the Medicare program."

Trailblazer, on the other hand, offers 55 diagnoses on its LCD.

Remember: To support medical necessity for the test, merely linking an appropriate diagnosis code to 92020 isn't enough. You must document the diagnosis or clinical signs and symptoms in the patient's medical record.

Good records should always include these as well as what you saw.

Additionally: Check your payers- regulations about the frequency with which you can report 92020. You can report gonioscopy tests more often for certain diagnoses. HealthNow's LCD, for example, states, "For primary ACG acute attack

(ICD-9 code 365.22) gonioscopy may be paid every 24-48 hours until laser peripheral iridotomy (LPI), and then up to 4x within the first year, every six months thereafter for one year, and then annually." The carrier will pay for gonioscopies only one or two times per year for other covered ICD-9 codes.

Question 3: Can I Code an E/M Visit With 92020?

The Correct Coding Initiative (CCI) does not bundle 92020 with new patient (99201-99205) or established patient (99212-99215) office visit codes. CCI does, however, bundle 99211 with the gonioscopy code, so you cannot report a level-one visit together with the gonioscopy test.

Although CCI bundles gonioscopy with 99211, a modifier indicator of "1" says you-re allowed to report both services under the appropriate circumstances, says **Maggie M. Mac, CMM, CPC, CMSCS, CCP, ICCE,** consulting manager for Pershing, Yoakley and Associates in Clearwater, Fla.

CCI also allows you to report 92020 with both new and established patient ophthalmological service codes (92002-92014, Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program -).

At one time, CCI bundled 92020 with these codes, but CCI deleted those bundles in 1998.

"Special ophthalmological services such as gonioscopy may be reported in addition to E/M or eye codes, per CPT," McVinney says. "Having said that, it is important to watch how insurance companies pay and follow up when necessary."

Caution: CCI says you cannot report special ophthalmological services codes 92018 (Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete) and 92019 (- limited) with 92020.