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Optometry Coding & Billing Alert

4 Tips Point the Way to Crystal-Clear OCT Coding

Learn when you can, and should, report 92135 more than once to gain $44.

When your optometrist performs optical coherence tomography (OCT) retinal imaging procedures, only one code describes this service, so your coding and getting paid should be easy, right? Not always.

There are four common pitfalls coders fall into when reporting 92135 (Scanning computerized ophthalmic diagnostic imaging [e.g., scanning laser] with interpretationand report, unilateral), experts say. Follow these tips to ensure your OCT coding doesn't end up trapped by any of the common mistakes.

1. Rely on Documented Order and Necessity

Many Medicare carriers will cover 92135 annually for glaucoma or glaucoma suspects (365.00-365.9), every six months for low tension glaucoma (365.12), and more frequently based on the patient's specific circumstance. For this reason, the diagnosis is key to getting reimbursed.

You should also check the documentation for the reason the optometrist orders the diagnostic OCT. The reason stated in the patient's record has to demonstrate medical necessity for payers to reimburse you on 92135.

Example: A patient presents with increased intraocular pressure (IOP) in her right eye (365.00). The optometrist orders an OCT to help determine if the patient is in the early stages of glaucoma. The presenting sign (increased IOP) constitutes medical necessity, and the optometrist should order 92135, says **David Gibson, OD, FAAO,** a practicing optometrist in Lubbock, Texas.

2. Don't Forget I&R for Clear Documentation

Don't miss: If the patient needs to come back for referral or scheduling reasons, the provider should document the reason he ordered the test in the previous dictations. If the provider does the OCT the same day, the optometrist should still document the test order and the reason for the test.

Documentation tips: "All that's needed is a note in the plan section of the patient's exam record, saying something like 'Order OCT, disc, OU, due to increased ocular pressure,'" says Gibson. "The optometrist should document which version of the test (macular, disc, anterior segment, 30-2, full field 120), which eye (OD, OS, or OU), and what signs or symptoms are present to justify ordering the test(s). You don't need a diagnosis yet; that's what the test is going to help you determine."

In addition: For you to submit 92135, your optometrist must include a written interpretation and report that details any findings and observations he made from the imaging report.

The interpretation of the test results should also include any issues of the test's quality, reliability of the findings, and any implications for treatment or further patient care.

Good idea: "I also like to add when I want to repeat the test while the case is fresh on my mind," notes Gibson. "Otherwise I won't have a clue when it's time to repeat the test."

3. Modify Your Thinking on Bilateral OCT

An OCT test is inherently unilateral. The fee allotted for 92135 accounts only for what is involved in scanning one eye.

When your optometrist performs the scan bilaterally, you can report the procedure bilaterally. You must report 92135 either on two lines -- one line with modifier RT (Right side) appended and the other line with LT (Left side) appended -- or on one line with modifier 50 (Bilateral procedure) appended.

Remember: Most Medicare contractors prefer 92135-50, whereas private carriers reimburse more consistently with modifiers RT and LT. Ask your contractor(s) which way you should be reporting bilateral services.

Caution: Be sure the optometrist documented the order for the scan of both eyes before coding the service bilaterally. There should be medical necessity for each eye because each is a separate test.

If you scan both eyes, "you must have a diagnosis in both eyes," says Gibson. "They can be different diagnoses in the two eyes, but you can't scan both eyes just because the right eye looks suspicious."

Example: If the ICD-9 codes you're reporting for each eye are different, report 92135-RT on line 1 of the claim form and 92135- LT on line 2, offers **Sylvia Conrad**, insurance coordinator with Your Eye Solution in Jacksonville, Fla.

Code 92135 has a bilateral modifier indicator of "3" in Medicare's Physician Fee Schedule. This means that the usual bilateral payment adjustment does not apply, and you should receive full reimbursement for both eyes. With 1.22 relative value units (RVUs) and a $36.0846 conversion factor, each successful 92135 claim could bring in $44.02 to your practice.

More modifiers: Code 92135 can be split into technical and professional components if your optometrist doesn't own the OCT equipment. You would report 92135-TC (Technical component) for the technical component only and 92135-26 (Professional component) if the provider interpreted the results.

4. Watch Out for Local Coverage Differences

Be sure to check your contractor's local policies before reporting 92135. You may find some contractor-specific requirements associated with the code. For instance, many contractors have their own rules for reporting 92135 at the same time as other tests, and some contractors have specific guidelines on how often you can perform OCT screenings on a patient.

Example: Any payer that follows Correct Coding Initiative (CCI) edits will consider 92135 and 92250 (Fundus photography with interpretation and report) bundled. They are mutually exclusive, and it would not be appropriate to bill for both in the same visit.

CCI bundles 92135 and 92250 with a "1" modifier indicator, which indicates you may separately report them, when appropriate, using modifier 59. For example, you can use modifier 59 when the optometrist performs the services on different eyes. Clear documentation is essential in the event of a payer review.

If both tests are for the same problem, you should not unbundle them using modifier 59 (Distinct procedural service).