Optometry Coding & Billing Alert

Capitalize on These Opportunities to Avoid 92135 Denials

Experts answer your top SLGT coding questions

Optometrists are beginning to use scanning laser glaucoma testing (SLGT) more often for early detection of eye disease. Unfortunately, getting proper reimbursement for this newer technology is still a challenge.

Take a look at these expert answers to ensure you-re up to speed on how to avoid the common pitfalls of SLGT coding and billing.

Question: Should I report all SLGTs the same?

Answer: There are several technologies that optometrists use to get diagnostic images through SLGTs. The trick is that you should not base your coding on the type of SLGT your physician uses.

CPT has one code to describe all of the SLGTs: **CPT 92135**. -This **CPT Code** is defined as -scanning computerized ophthalmic diagnostic imaging (e.g., scanning laser) with interpretation and report, unilateral,- so you would use this for any scanning laser testing,- says **Krystin Keller, CPC,** insurance specialist and billing manager at Five Points Eye Care in Athens, Ga., and consultant with Forch- Consulting Group.

Question: How do I code if my physician only interprets the SLGT results?

Answer: CMS divides the relative value units (RVUs) for 92135 into a technical component and a professional component. Therefore, you-ll need to append a modifier depending on which portion of the test your physician performs.

How it works: If your office only performs the test (technical component) and does not read the results, you should bill code 92135-TC (Technical component). If another office performs the technical component, however, and your optometrist does the interpretation and report, append modifier 26 (Professional component) to code 92135.

"In private practice, this would really only come into play if you did not have the equipment and you sent your patient over to a different office that does have the actual equipment to do the test and then returns your patient to you to continue treatment,- Keller says.

If you are seeing patients in a skilled nursing facility, you would also separate the professional and technical components and bill only for the technical component. The SNF would bill for the professional component, and you would receive payment for the professional services directly from the SNF.

In dollars: In Medicare's 2006 fee schedule, the total unadjusted RVUs for 92135 are 1.16. Multiplying that by the conversion factor of 37.8975 means that an optometrist performing both the technical and professional components would earn about $44.

The technical component alone is worth 0.65 RVUs, so if your office only performed the technical component, you would receive about $25 for the service. You would earn 0.51 RVUs for just the professional portion -- about $19 for that service.

Question: Can I report two separate codes if the physician performs SLGT on each eye?

Answer: Medicare considers 92135 to be inherently unilateral, Keller says, meaning that the RVUs in the **Fee Schedule** schedule represent the work done on only one eye. If your optometrist performs an SLGT on only one eye, report one

unit of 92135 and append the alphabetic modifier RT (Right side) or LT (Left side) to indicate which eye the optometrist tested.

Carriers differ on how you should report a scanning laser test on both eyes. Medicare and many private carrierslook for 92135 reported on two lines of the billing form, each with a -1- in the units field and with the LT and RT modifiers appended. However, some carriers may want you to report one unit of 92135 with modifier 50 (Bilateral procedure) appended.

Question: Is documentation the key to getting SLGTs paid?

Answer: Yes, documentation is one key to successfully getting paid for SLGTs. You must have a documented reason for the laser scan in the patient's record, and the reason must demonstrate medical necessity.

For example, if a patient presents with increased intraocular pressure, an SLGT may help determine whether the patient is in the early stages of glaucoma, a circumstance that supports medical necessity. There should be documented medical necessity for each eye, since each is a separate test and payment.

Tip: Make sure you also have a written request for the tests in your documentation and an interpretation and report in your records, Keller says. To bill code 92135, you must include in the medical record a written interpretation and report that includes any findings and observations from the imaging report.