Optometry Coding & Billing Alert

Diagnostic Tests: 92133 Basics: Avoid These Pitfalls and Keep OCT Coding on Track

Documentation, modifiers, and knowing your bundling rules can be worth nearly $45 each time.
There may be just one code that describes optical coherence tomography (OCT) optic nerve imaging procedures, but that doesn't mean your coding will always be cut-and-dried.
Follow these four steps when reporting 92133 (Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve), and you'll avoid most of the common coding pitfalls.

1. Rely on Documented Order and Necessity
Many Medicare carriers will cover 92133 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 92133.

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 92133, 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 physician should still document the test order and the reason for the test.
In addition: For you to submit 92133, your physician 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.

3. Modify Your Thinking on Bilateral OCT
An OCT test is inherently bilateral. The fee allotted for 92133 accounts for what is involved in scanning both eyes.
When your optometrist performs the scan bilaterally, you should only report the code once. Do not report 92133 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.
Code 92133 has a bilateral modifier indicator of "2" in Medicare's Physician Fee Schedule. This means that the usual bilateral payment adjustment does not apply. Medicare (and payers who follow Medicare rules) will only reimburse the allowable amount for a single code - $44.93 for 92133 (1.32 RVUs multiplied by Medicare's 34.0376 conversion factor.
More modifiers: Code 92133 can be split into technical and professional components if your physician doesn't own the OCT equipment. You would report 92133-TC (Technical component) for the technical component only and 92133-26 (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 92133. You may find some contractor-specific requirements associated with the code. For instance, many contractors have their own rules for reporting 92133 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 92133 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 92133 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 (Distinct procedural service) 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.