Codify
BY AAPC

Optometry Coding & Billing Alert

Document Medical Necessity to Solidify Your OCT Billing

Bonus: Learn when you can -- and should -- report 92135 more than once

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

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

Rely on Documented Order and Necessity

For you to code 92135 and get paid, you must include a documented order for OCT in the patient's chart.

"Our Medicare carrier 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," says **Becky Zellmer, CPC, MBS, CBCS**, provider educator and chart reviewer for Prevea Health in Green Bay, Wis.

"The key to being reimbursed is to use the correct diagnosis with the procedure," notes **David Gibson, OD, FAAO**, a practicing optometrist in Lubbock, Texas. "The key to keeping the reimbursement in the case of an audit is the documentation."

Make sure the documentation includes the reason you ordered 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 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 symptom constitutes medical necessity, and you should report 92135.

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

In addition: For you to submit 92135, you must document a written interpretation and report that details any findings and observations 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 care.

Modify Your Thinking on Bilateral OCT

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

When you perform the scan bilaterally, you can report the procedure bilaterally, Zellmer says. You must report 92135 either on two lines with modifiers RT (Right side) and LT (Left side) appended or on one line with modifier 50 (Bilateral procedure) appended.

Remember: Most Medicare carriers prefer 92135-50, whereas private carriers reimburse more consistently with the RT and LT modifiers. Check with your carriers to find out if they have a preference for reporting bilateral services. Either way of reporting is technically correct, says Gibson.

Caution: Be sure to document 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.

More modifiers: Code 92135 can be split out into technical and professional components if an optometrist doesn't own the OCT equipment, Zellmer says. The owner of the machine would report 92135-TC (Technical component) for the technical component only, and the physician who interprets the test would report 92135-26 (Professional component).

Watch Out for Local Coverage Differences

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

Example: Any carrier that follows Correct Coding Initiative (CCI) edits will consider 92135 and 92250 (Fundus photography with interpretation and report) to be bundled. "They are mutually exclusive, and it would not be appropriate to bill for both in the same visit," says **Sara Root, CPC**, coder for the Fletcher Allen Health Care in Burlington, Vt.

If both tests are for the same problem, then you cannot unbundle them using modifier 59 (Distinct procedural service), says **Alberta Craven, LPN, COMT, CHC**, certified compliance officer for EyeAmerica/DoctorsVisionCenter in Rocky Mount, N.C.

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.

Beware: Modifier 59 is on the Medicare and HHS Office of Inspector General's "hit list for overuse, and using modifier 59 could cause a red flag for an audit. It would be better to do the second test on a separate follow-up visit," Craven adds.