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Optometry Coding & Billing Alert

Get Expert Answers For Your Most Common SLGT Coding Questions

Boost 92135 pay with this insider advice.

If you're using scanning laser glaucoma testing (SLGT) for early detection of eye disease, you've probably found that getting proper reimbursement for this newer technology is a challenge.

Take a look at these expert answers to ensure you're up to speed on how to avoid three common SLGT coding pitfalls:

Question 1: Should I report all SLGTs the same?

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

CPT has one code to describe all of the SLGTs: 92135 (Scanning computerized ophthalmic diagnostic imaging, posterior segment [e.g., scanning laser] with interpretation and report, unilateral). You would report this code for any scanning laser testing.

Question 2: How should I code if I only interpret 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 you perform.

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

Example: As the first optometrist in your area to buy SLGT equipment, you offer to do the test for other interested doctors on a referral basis. If you perform the evaluation for another doctor, then you would file 92135-TC only and let the referring doctor perform and file the 92135-26 portion, says **David Gibson, OD, FAAO,** a practicing optometrist in Lubbock, Texas.

"Assuming you as the tester may understand the results better than the referring doctor, you still probably wouldn't file the 26 portion even if you reviewed the results with the referring doctor," Gibson says. "You both can't file the 26 portion; only one per TC portion is allowed and filing the 26 portion shows your professional involvement with the patient. If a malpractice suit were to be filed, you could be attached to it as being professionally involved."

This scenario works in reverse if someone else has an SLGT -- also known as optical coherence tomography (OCT) or glaucoma diagnosis (GDx) -- and you send patients there for an evaluation, Gibson notes. You file the 92135-26 portion and prepare the interpretation and report.

If you see patients in a skilled nursing facility (SNF), 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.

Question 3: Can I report two codes if I perform SLGT on each eye?

Answer: Medicare considers 92135 to be inherently unilateral, meaning that the RVUs in the fee schedule represent the work done on only one eye. If you perform 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 you tested.

Carriers differ on how you should report a scanning laser test on both eyes. Medicare and many private carriers look 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. On the other hand, some carriers may want you to report one unit of 92135 with modifier 50 (Bilateral procedure) appended.

Another option is to append modifier 50 with a unit of 2 to bill for two eyes, says **Kennard Singh, CPC, CCS-P, CHCO,** from the SUNY College of Optometry in New York, N.Y. For some Medicare carriers, that is the correct coding. For example, Palmetto GBA specifies that to receive full bilateral reimbursement for all codes that, like 92135, are marked with bilateral indicator "3" in the Medicare Physician Fee Schedule, "the days/units (quantity billed) field must reflect '2' even when submitting CPT Modifier 50 or when submitting HCPCS modifiers RT and LT on the same detail line."

However: Some carriers disagree. For example, WPS Medicare says, "An indicator of '3' indicates the usual payment adjustment for bilateral procedures does not apply. If the procedure is reported with a modifier 50 and a "1" in the units field, or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a '2' in the units field), allowed amount is based on 100 percent of the Medicare Fee Schedule for each side."

Bottom line: Check your local carrier for its preference. There is no modifier 50 policy that applies to all Medicare carriers.