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Optometry Coding & Billing Alert

Get to Know Payer Specifics for Gonioscopy

3 FAQs clear up your 92020 coding to improve your claims' success.

With only one code for gonioscopy, reporting it to carriers is a snap, right? Not so fast.

When your optometrist performs a gonioscopy without general anesthesia, bilateral rules, and reimbursable diagnoses can complicate your coding process. Tackle your coding dilemmas with these expert answers to your top gonioscopy questions.

Question 1: Is 92020 Inherently Bilateral?

Most insurance companies, including Medicare, consider 92020 (Gonioscopy [separate procedure]) a bilateral procedure code. This means that you cannot report the code twice when your optometrist performs a gonioscopy on each eye, explains **Raequell Duran, CPC,** president of Practice Solutions, a coding, compliance, and reimbursement consulting firm based in Santa Barbara, Calif.

Although CPT doesn't specifically describe the procedure as bilateral in the code descriptor, most insurers follow Medicare's lead. You can find the bilateral surgery indicators in the fee schedule, says **Sylvia Conrad,** insurance coordinator with Your Eye Solution in Jacksonville, Fla. Check column Z of the database, marked "Bilat Surg." The fee schedule assigns 92020 a bilateral surgery indicator of "2," which means that Medicare has set the relative value units (RVUs) for gonioscopy based on the optometrist performing the procedure bilaterally.

Example: Palmetto GBA's 2010 guidelines state that you cannot report 92020 bilaterally using modifier 50 (Bilateral procedure), LT (Left side), or RT (Right side).

Tip: If the optometrist performs the gonioscopy on just one eye, your carrier may require you to indicate that the physician did not perform the full bilateral procedure. To do so, append modifier 52 (Reduced services) to 92020.

Question 2: Which Diagnoses Will Prove Medical Necessity?

The diagnoses that support medical necessity for the gonioscopies your optometrist performs depend on your carrier's local coverage determinations (LCDs). Each payer you bill may have different policies regarding 92020 reimbursement. In many cases, you can search for local coverage decisions (LCDs) on the insurer's Web site.

Remember: To support medical necessity for the test, merely linking an appropriate diagnosis code to 92020 isn't enough. Your optometrist must document the diagnosis or clinical signs and symptoms in the patient's medical record.

Example: A patient is in for a routine exam and has no complaints. The optometrist finds intraocular pressures of 30 mm Hg in both eyes along with suspicious cupping. He performs gonioscopy and visual fields but does not find glaucoma.

Report 9208x (Visual field examination, unilateral or bilateral, with interpretation and report ...) and 92020 linked to ICD-9 code 365.01 (Borderline glaucoma [glaucoma suspect]; open angle with borderline findings).

Other diagnoses that many insurers accept to prove medical necessity for gonioscopy include:

• 190.0-191.9 -- Malignant neoplasm of eye or brain

• 198.3 -- Secondary malignant neoplasm of brain and spinal cord

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• 224.0 -- Benign neoplasm of eyeball, except conjunctiva, cornea, retina and choroid

• 225.1 -- Benign neoplasm of cranial nerves

• 362.31 -- Central retinal artery occlusion

• 362.35 -- Central retinal vein occlusion

• 364.00-364.9 -- Disorders of iris and ciliary body

• 365.00-365.9 -- Glaucoma

• 379.32-379.34 -- Aphakia and other disorders of lens

• 921.3 -- Contusion of eyeball

• 996.51 -- Mechanical complication of prosthetic corneal graft

• 996.53 -- Mechanical complication of ocular lens prosthesis

• 996.69 -- Infection and inflammatory reaction due to other internal prosthetic device, implant and graft.

Question 3: Can I Code an E/M Visit With 92020?

The Correct Coding Initiative (CCI) does not bundle 92020 with new patient (99201-99205) or established patient (99212-99215) office visit codes. CCI, however, bundles 99211 with the gonioscopy code, so you cannot report a level-one visit with the gonioscopy test. A modifier indicator of "1" indicates you're allowed to report both services under the appropriate circumstances.

CCI also allows you to report 92020 with both new and established patient ophthalmological service codes (92002-92014, Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program ...). At one time, CCI bundled 92020 with these codes, but CCI deleted those bundles back in 1998.

Important: CCI indicates that you cannot report special ophthalmological services codes 92018 (Ophthalmological examination and evaluation, under generalanesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete) and 92019 (... limited) with 92020.

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