Optometry Coding & Billing Alert

Gonioscopy: Are These 92020 Myths Holding Back Your Reimbursement?

Get ready to learn the truth behind postoperative tests, bilateral billing, and more.

With gonioscopy CPT® code 92020 (Gonioscopy [separate procedure]) consistently one of the top 25 procedures billed by optometrists, there are certain to be some myths and misconceptions along the way. Read on and see if one of these myths is affecting your practice, and get our expert advice to bust the myth.

Myth 1: Gonioscopy is included in the global surgical package, and so a postoperative gonioscopy can't be billed.

Reality: Gonioscopy is a diagnostic test, designed to determine whether glaucoma, if present, is open-angle or closed-angle. CPT® code 92020 describes both indirect and direct procedures. Optometrists use gonioscopy to examine the visually inaccessible anterior chamber angle, the eye's drainage apparatus (the trabecular network), and its anatomic relation to the adjacent iris. During the more common indirect gonioscopy, the physician uses a mirrored goniolens and biomicroscope to examine the anterior chamber angle opposite the direction of view. The direct method of gonioscopy uses a dome-shaped contact lens to eliminate internally reflected light so the doctor can directly visualize the angle with a gonioscope.

Medicare allows diagnostic tests to be performed in the global period of a previous surgery, especially if the gonioscopy is unrelated to the condition for which the surgery was performed. You should not need to include any special modifiers on the claim, say experts. The documentation of a chief complaint other than the fact that the patient is being seen for postoperative care would have to be noted, or documentation that the fellow eye requires the services would need to be present.

Myth 2: You can bill once for each eye the optometrist tests.

Reality: It doesn't say so in the CPT® descriptor, but Medicare considers gonioscopy inherently bilateral, and most insurers follow Medicare's lead. That means that the reimbursement for 92020 automatically covers the work done in testing both eyes.

If the optometrist performed gonioscopy in both eyes, you would just report 92020 once, with no bilateral or LT/RT modifiers.

However: If the optometrist performs gonioscopy in just one eye, your carrier might want you to indicate that by appending 52 (Reduced services) to 92020.

Myth 3: You can't report gonioscopy separately from an eye code or E/M code.

Reality: Gonioscopy (92020) is listed as a separate procedure in CPT®. It can't be billed in addition to a more comprehensive service, such as a routine eye exam. If the gonioscopy is performed routinely, CPT® will bundle the procedure into the eye exam.

If routine (performed even though the patient doesn't have a sign, symptom or known diagnosis that it medically warrants), it should not be billed separately. It must also be medically necessary. A screening is not covered, but a gonioscopy is covered, because the patient is a diabetic, for example. Diabetic patients can develop rubeosis iridis (neovascularization of the iris), and gonioscopy is a primary diagnostic technique for this condition. It's also appropriate to code gonioscopy separately when the optometrist notes that a patient has an anatomically narrow angle, 365.20 (Primary angle-closure glaucoma, unspecified).

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