Several diagnostic tests exist to diagnose and monitor glaucoma. Some—the assessment of IOP, for example—are a component of an ocular examination. Other glaucoma tests, often prompted by the results of the earlier eye examination, are stand-alone services with unique CPT codes and separate reimbursement. This article discusses considerations of reimbursement for gonioscopy.

LOCAL COVERAGE
The indications for gonioscopy include, but are not limited to, glaucoma, hypotony, occlusive disorders, diabetic retinopathy, ruberosis, aphakia, an intraocular foreign body, and a subluxated or dislocated lens (Figure 1). The AAO’s Preferred Practice Patterns discusses the usefulness of gonioscopy in glaucoma for “careful evaluation of the anterior-chamber angle to exclude angle closure or secondary causes of IOP elevation such as angle recession, pigment dispersion, peripheral anterior synechiae, angle neovascularization, and trabecular precipitates.” Some Medicare administrative contractors publish detailed local coverage decisions with an extensive list of the approved indications for gonioscopy. Check your Medicare administrative contractor’s Web site to determine if such a local coverage decision exists in your area.

DOCUMENTATION
Several well-known glaucoma specialists have developed various methods for documenting gonioscopic findings. The most popular, the Shaffer system, is based on the width of the angle recess; chart notations range from slit (0° angle) to grade 4 (45° to 35° angle). The Van Herick system grades angles from 1 (extremely narrow or closed) to 4 (wide open). This method compares the peripheral depth of the anterior chamber to corneal thickness. Scheie used Roman numerals, grades I to IV, to classify the angle’s depth based on visualized structures (ie, grade IV = only Schwalbe’s line visible). The Spaeth grading system describes the configuration of the anterior chamber angle. It utilizes a series of capital letters (A to E) to describe the iris insertion, followed by angular approach (0° to 50°) and then small letters to describe the peripheral iris’ configuration. An example of this documentation is D40r. Each letter correlates to a descriptor. In this example, D means deep with ciliary body visible, and r stands for regular.

FREQUENCY
How frequently a test may be performed and filed for reimbursement is a common concern expressed by physicians. The AAO’s Preferred Practice Patterns suggests that gonioscopy be repeated periodically and mentions every

Reimbursement Considerations for Gonioscopy

A discussion of coverage, coding, and billing.

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Figure 1. The pigment in the angle that is common in pseudoexfoliation is observable in this image obtained with the RetCam Shuttle (Clarity Medical Systems, Inc., Pleasanton, CA).
1 to 5 years. Repeat testing is indicated when medically necessary for new symptoms, progressive disease, new findings, unreliable prior results, or a change in the treatment plan. In general, additional testing is warranted when the information garnered from the eye examination is insufficient to assess the patient’s disease adequately. In other words, if a patient has a history of glaucoma (or other indicated condition) and the ocular examination reveals an unstable or worsening condition, then more extensive testing may be justified. We would not expect a claim to be filed for a patient with stable visual fields who presents with no complaints or for someone with a controlled condition.

Medicare utilization rates provide a useful benchmark for physicians. The 2006 Centers for Medicare & Medicaid Services Part B Extract Summary System data reveal a utilization rate for opthalmologists of 3% for gonioscopy. This percentage represents the occurrence per 100 Medicare-paid eye examinations (ie, for every 100 ocular examinations paid for by Medicare to opthalmologists, there were three paid claims for gonioscopy). Glaucoma specialists and those who serve a large number of patients with glaucoma, especially those with narrow-angle glaucoma, will likely have a higher utilization rate.

CODING

CPT code 92020 is unique. It describes gonioscopy (separate procedure). Gonioscopy is one of three ophthalmic diagnostic tests with the “separate procedure” designation. The CPT manual’s discussion of separate procedures states:

Some of the procedures or services listed in CPT that are commonly carried out as an integral component of a total service or procedure have been identified by the inclusion of the term, “separate procedure.” The codes designated as “separate procedure” should not be reported in addition to the code for the total procedure or service of which it is considered an integral component. However, when a procedure or service that is designated as a “separate procedure” is carried out independently or considered to be unrelated or distinct from other procedures/services provided at that time, it may be reported by itself or in addition to other procedures/services.

The justification for an eye examination or consultation in addition to gonioscopy as a separate procedure is satisfied by two different diagnoses: one for the examination and another for the test. In this way, the “unrelated or distinct” stipulation is met. For example, filing the office visit with a diagnosis of cataract (366.16) and the gonioscopy with angle-closure glaucoma, subacute (365.21), satisfies the provision. We have noticed that third-party payers commonly overlook this requirement for gonioscopy reimbursement, so some claims may be paid for an examination with gonioscopy when the same ICD-9 code is used for both services.

Gonioscopy is defined by the Centers for Medicare & Medicaid Services as bilateral, so reimbursement is for both eyes. Unlike most other ophthalmic diagnostic tests, gonioscopy is not subdivided into a technical and a professional component, because no portion of the test can be delegated to a technician. The 2008 national Medicare Physician Fee Schedule allowable is $23.99. This amount is adjusted in each area by local wage indices. Other payers set their own rates, which may differ significantly from the Medicare published fee schedule. In addition, Medicare bundles gonioscopy with external photography (92285) and laser trabeculoplasty (65855).

The classic global surgical package includes postoperative follow-up care. Certain services associated with surgery are not considered part of the package and are reimbursed separately. In Medicare’s regulations, the global surgical package does not include diagnostic tests. For that reason, should it be medically necessary to perform gonioscopy during the postoperative period, the test is reimbursed. For example, following keratoplasty for ocular trauma, the patient develops goniosynechiae, which the surgeon follows carefully using gonioscopy. The postoperative eye examination would not be billed, but gonioscopy would be. No special modifiers would be required on the claim to obtain reimbursement for gonioscopy in this situation. In contrast, gonioscopy 1 day after uneventful selective laser trabeculoplasty, absent any complaint by the patient, would likely be viewed as prophylactic and not medically necessary.

CONCLUSION

Gonioscopy continues to be an important diagnostic tool for the ophthalmologist and optometrist, but it appears to be underutilized based on the prevalence of glaucoma and the frequency of paid claims for this test for Medicare beneficiaries. We encourage you to reconsider your usage of this test and your billing patterns for it.

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