healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	General Ophthalmological Exams		
Policy Number:	PO-RE-083v1		
Effective Date:	8/1/2020	**Last Approval Date:**	12/18/2023

I. Policy Description

This reimbursement policy outlines the guidelines for the reimbursement of comprehensive ophthalmological exams and intermediate ophthalmological exams for service codes 92012 and 92014. The policy is based on clinical practice, coding standards, and the Current Procedural Terminology (CPT) guidelines.

Policy Scope

Service codes 92012 and 92014:

1. Comprehensive Ophthalmological Exam:
   - A comprehensive ophthalmological exam is a detailed evaluation and management service that includes a comprehensive assessment of a patient's visual system, medical history, visual acuity measurement, intraocular pressure measurement, external examination, slit-lamp examination, fundus examination, and other necessary components.
   - A comprehensive ophthalmological exam will be reimbursed when it includes the initiation or continuation of a diagnostic or treatment program.
   - If another comprehensive ophthalmological exam has been billed for the same patient within the past six months, the comprehensive exam should be recorded as an intermediate ophthalmological exam for reimbursement purposes.

2. Intermediate Ophthalmological Exam:
   - An intermediate ophthalmological exam is a less comprehensive evaluation and management service compared to a comprehensive exam. It includes a limited assessment of a patient's visual system, medical history, visual acuity measurement, and other necessary components.
   - If a follow-up visit does not involve the initiation of a diagnostic or treatment program, the provider should use the intermediate ophthalmological exam CPT code for reimbursement purposes.

Reimbursement Guidelines:

1. Comprehensive Ophthalmological Exam:

- The reimbursement for a comprehensive ophthalmological exam will be allowed if it meets the following criteria:
    - The exam includes the initiation or continuation of a diagnostic or treatment program.
    - If another comprehensive ophthalmological exam has been billed for the same patient within the past six months, it should be recorded as an intermediate ophthalmological exam for reimbursement purposes.
- Reimbursement will be based on the applicable CPT code for an intermediate ophthalmological exam.

2. Intermediate Ophthalmological Exam:
    - If a follow-up visit does not involve the initiation of a diagnostic or treatment program, the provider should use the intermediate ophthalmological exam CPT code for reimbursement purposes.
    - Reimbursement will be based on the applicable CPT code for an intermediate ophthalmological exam.

Note: It is important for providers to accurately document the nature of the visit and the reason for the examination to ensure proper reimbursement.

In Scope Lines of Business:

Medicaid, Child Health Plus, Personal Wellness Plan (HARP), Essential Plans, Leaf and Leaf Premier Plans, Pro Plus EPO Plans, Signature PPO, Signature HMO, 65 Plus Plan (HMO), Increased Benefits Plan (HMO), Life Improvement Plan (HMO D-SNP), CompleteCare (HMO D-SNP), Connection Plan (HMO D-SNP), Senior Health Partners (MLTC)

II. Applicable Codes

Code	Description	Comment
92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient	
92014	Ophthalmological services: medical examination and evaluation with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits	

III. Definitions

Term	Meaning

IV. Related Policies

Policy Number	Policy Description
N/A	N/A

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Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

VI. Revision History

Revision Date	Summary of Changes

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York

State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.