

General Ophthalmological Services

Adjudication Guideline

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Billing

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1. Abstract

1.1 For Members

Billing rules are the adjudication standards based on official CPT, ICD, and regulatory coding guidelines.

A billing rule defines the minimum requirements to be met when a service is claimed for a Daman beneficiary in terms of frequency, duration etc.

These rules also specify the essential documentation required to support a claim and clarify the extent of coverage for a service under a particular insurance plan managed by Daman.

1.2 For Medical Professionals

General ophthalmology service codes are eligible for coverage under all health insurance plans administered by Daman, provided they are used appropriately for covered ophthalmic services.

To qualify, these services must be accurately coded in accordance with relevant clinical standards and supported by valid and corresponding ICD diagnosis codes.

Proper alignment between the procedure performed and the documented diagnosis is essential to demonstrate medical necessity and ensure compliance with coding guidelines. When these conditions are met, such services are typically recognized as reimbursable within the scope of the patient's insurance coverage.

2. Scope

This adjudication rules describes proper use of General Ophthalmological Services Codes defined by CPT codes, 92002, 92004 and 92012, 92014.

3. Adjudication Policy

3.1 Eligibility / Coverage Criteria

General ophthalmologic services codes when coded for covered ophthalmological services with appropriate ICDs codes listed under the requirements is covered for all health plans administered by Daman.

3.2 Requirements for Coverage

Specific ICDs codes to be reported to the highest level of specificity not of preventive nature.

3.3 Non-Coverage

The procedure will not be covered if the required ICDs codes are not reported or if the procedure is performed by anyone other than an ophthalmologist or the benefit does not exist.

3.4 Payment and Coding Rules

Please apply regulatory payment rules and regulations and relevant coding manuals for ICDs, CPT, etc.

- Ophthalmological Services Codes are selected based on
- Patient type as New or Established
- Service type as Intermediate and Comprehensive Services

Intermediate ophthalmological services:

Describe an evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis, including history, general medical observation, external ocular and adnexal examination and other diagnostic procedures as indicated; this may include the use of mydriasis for ophthalmoscopy.

Some examples of an intermediate ophthalmological service listed in CPT include:

- Review of history, external examination, ophthalmoscopy, bio microscopy for an acute complicated condition (e.g., iritis) not requiring comprehensive ophthalmological services; and
- Review of interval history, external examination, ophthalmoscopy, bio microscopy and tonometry in established patients with known cataract not requiring comprehensive ophthalmological services.

Comprehensive ophthalmological services:

Comprehensive ophthalmological services describe a general evaluation of the complete visual system. A new patient is defined as an individual who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the previous three years. An established patient is an individual who has received professional services from the physician or another physician of the same group practice within the previous three years.

- The service includes - history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination.

- It often includes, as indicated: bio microscopy, examination with cycloplegia or mydriasis, and tonometry.
- It always includes initiation of diagnostic and treatment programs.
- As stated above, comprehensive ophthalmological services include history, general medical observation, external and ophthalmoscopic examinations, gross visual fields, and basic sensorimotor examination.
- When performing an external examination, the physician generally examines the eye and adnexa, which may include but is not limited to the following: eyelids, lashes, eyebrows, alignment of the eye, and motility of the eye, conjunctiva, cornea, and iris.
- Ophthalmoscopic examinations are useful to examine the ocular media, the retina, and optic nerve. Examination of the visual field of each eye helps to detect any visual field defects. This is a very rudimentary test performed with a confrontation technique.

General Ophthalmological Services Codes VS. Evaluation and Management Codes

- When should a physician report the general ophthalmologic services codes versus the evaluation and management services codes?
- It is important to note that there is no mandate that states that the ophthalmology codes must be used instead of the E/M codes. As stated in the instructions for use of CPT, the physician should report the codes that most accurately identified the services or procedures performed, whether it is an E/M service code or an ophthalmology visit code.
- Specific procedures included under "General Ophthalmological Services" code should not be unbundled and billed with the E/M. Instead code the specific general ophthalmological service code.
- When E/M codes are reported, these general ophthalmological service codes (e.g., CPT codes 92002-92014) are not to be reported; the same services would be represented by both series of codes. Daman does not pay consultation/E&M and General ophthalmological service codes together.
 - There must be initiation of treatment or a diagnostic plan for a comprehensive service to be reported.
 - An intermediate service requires initiation or continuation of a diagnostic or treatment plan.
 - General ophthalmological services codes are for both eyes. They cannot be requested separately for each eye.
 - Whenever a General ophthalmological services code for new patients (92002 & 92004) is claimed, the patient's history should be checked to confirm the new patient's status.

- Follow-up of successfully fitted extended wear lenses is a part of the general ophthalmological services using 92012 and 92014 and is not a separately reportable service with these codes.
- When Contrast Sensitivity testing is used to evaluate abnormal vision, it is considered to be an incidental part of an eye exam or consultation; no separate CPT code describes the test.

The following procedures (with CPT 4 codes) can be reported separately (from general ophthalmological services codes):

- Computerized Corneal topography (CPT code 92025)
- The prescription of contact lenses
- Refraction service (CPT code 92015). Prescription of lenses, when required, is included in 92015.
- Special ophthalmological services which go beyond the services included under general ophthalmological services.
- Ophthalmic ultrasound, echography, diagnostic; corneal pachymetry, unilateral or bilateral determination of corneal thickness (CPT code 76514).

Adjudication Examples

Example 1

Question: Daman member underwent consultation for blurred vision of both eyes. Diagnosed as B/L cataract. Provider billed CPT4 code 92002 & 92225. What is the correct payment? Will Daman pay the claim?

Answer: Payment would be for code 92002. 92225 to be rejected as extended ophthalmoscopy and not required for diagnosing a cataract. Moreover, routine ophthalmoscopy is included in the code 92002. Extended ophthalmoscopy requires supporting documentation.

Example 2

Question: Daman member underwent consultation for conjunctivitis. Provider also billing E&M 99213 in addition to CPT4 code 92002. What is the correct payment?

Answer: The proper payment is CPT4 code 92002.

4. Denial Codes

Code	Code Description
PRCE-002	Payment is included in the allowance for another service
CODE-015	Activity/diagnosis is inconsistent with the provider type
CODE-010	Activity/diagnosis inconsistent with clinician specialty
NCOV-001	Diagnosis(es) is (are) not covered
NCOV-003	Service(s) is (are) not covered
PRCE-010	Use bundled code

5. Appendices

5.1 References

- <https://www.aapc.com/codes/cpt-codes-range/kup>, CPT® Codes and Search - Codify by AAPC
- <https://www.aao.org/practice-management/news-detail/e-m-level-3-4>
- <https://shafafiyaportal.doh.gov.ae/dictionary/guidance/DataStandardsPanel.xls>
- Article - Billing and Coding: Ophthalmology: Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography) (A57071)

5.2 Revision History

Date	Change(s)
13/01/2011	Creation of Adjudication Guideline-External Instruction Template.
01/07/2013	V2.0 New template
15/07/2014	V4.0 Disclaimer updated as per system requirements Restored Original effective date
27/12/2024	V5.0 Reviewed as per the system requirement
19/05/2026	V5.1 Template update References review and update

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