

To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

Table of Contents

To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP. i

1.0 Description of the Procedure, Product, or Service..... 1

 1.1 Definitions 1

2.0 Eligibility Requirements 1

 2.1 Provisions..... 1

 2.1.1 General..... 1

 2.1.2 Specific 1

 2.2 Special Provisions..... 2

 2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age 2

3.0 When the Procedure, Product, or Service Is Covered..... 3

 3.1 General Criteria Covered 3

 3.2 Specific Criteria Covered..... 3

 3.2.1 Specific criteria covered by Medicaid 3

 3.2.2 Medicaid Additional Criteria Covered..... 4

4.0 When the Procedure, Product, or Service Is Not Covered..... 4

 4.1 General Criteria Not Covered 4

 4.2 Specific Criteria Not Covered..... 4

 4.2.1 Specific Criteria Not Covered by Medicaid..... 4

 4.2.2 Medicaid Additional Criteria Not Covered..... 4

5.0 Requirements for and Limitations on Coverage 4

 5.1 Prior Approval 4

 5.2 Prior Approval Requirements 4

 5.2.1 General..... 4

 5.2.2 Specific 4

 5.3 Limitations..... 4

6.0 Providers Eligible to Bill for the Procedure, Product, or Service 5

 6.1 Provider Qualifications and Occupational Licensing Entity Regulations..... 5

 6.2 Provider Certifications 5

7.0 Additional Requirements 5

8.0 Policy Implementation/Revision Information..... 6

Attachment A: Claims-Related Information 8

 A. Claim Type 8

B.	International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)	8
C.	Code(s).....	8
D.	Modifiers.....	9
E.	Billing Units.....	9
F.	Place of Service	9
G.	Co-payments	9
H.	Reimbursement	9

Related Clinical Coverage Policies

Refer to <https://medicaid.ncdhhs.gov/> for the related coverage policies listed below:

1.0 Description of the Procedure, Product, or Service

Ocular photodynamic therapy (OPT) is a treatment approved by the Food and Drug Administration for age-related macular degeneration (AMD), pathologic myopia, and ocular histoplasmosis. OPT is a two-step procedure involving the intravenous injection verteporfin (Visudyne®), a photosensitive drug. After injection, the verteporfin is activated by illumination with a non-thermal laser light at the wavelength that corresponds to the absorption peak of the drug. The light reacts with the photosensitive chemical in verteporfin, and the abnormal vessels are destroyed with no damage to the normal ones.

1.1 Definitions

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term “General” found throughout this policy applies to all Medicaid policies)

- a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
- b. Provider(s) shall verify each Medicaid beneficiary’s eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.2 Specific

(The term “Specific” found throughout this policy only applies to this policy)

- a. **Medicaid**
None Apply.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.

2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <https://medicaid.ncdhhs.gov/>

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

Medicaid shall cover ocular photodynamic therapy for beneficiaries with age-related macular degeneration (AMD), pathologic myopia or ocular histoplasmosis. **OPT is only covered in conjunction with the drug verteporfin.**

a. Age-Related Macular Degeneration

Ocular photodynamic therapy is indicated for age-related macular degeneration when prior to treatment, a fluorescein angiogram shows predominantly classic subfoveal Choroidal Neovascularization (CNV) where the area of classic CNV occupies at least 50 percent of the entire lesion with a greatest linear dimension that is equal to or less than 7000-7500 microns.

Note: These criteria are intended to apply only to the first treatment. Further treatments will depend on clinical evidence of deterioration as demonstrated by persistent fluorescein leakage from CNV.

b. Ocular Histoplasmosis or Pathologic Myopia

Ocular photodynamic therapy is indicated for ocular histoplasmosis or pathologic myopia when prior to treatment, there is subfoveal CNV leakage secondary to ocular histoplasmosis or pathologic myopia, and the anticipated treatment result is better than the absence of treatment.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

Medicaid shall not require prior approval for ocular photodynamic therapy.

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

5.2.2 Specific

None Apply.

5.3 Limitations

- a. Beneficiaries may receive up to five treatments per eye per year with a maximum of ten treatments per eye during a 2-year-period.
- b. Separate reimbursement is not allowed for intravenous infusion services.
- c. Providers must maintain documentation including fluorescein angiogram and submit to NC Medicaid or its fiscal agent upon request.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

None Apply.

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

8.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 2001

Revision Information:

Date	Section Revised	Change
07/01/04	Section 8.3	The CPT and HCPCS codes covered under the policy were revised.
09/01/05	Section 2.0	A special provision related to EPSDT was added.
12/01/05	Section 2.2	The web address for DMA's EDPST policy instructions was added to this section.
12/01/06	Sections 2 through 5	A special provision related to EPSDT was added.
03/01/07	Section 8.3.1	Revised CPT information to reflect current codes
03/01/07	Section 8.3.2	Revised HCPCS information to reflect current code. (J3395 end-dated 12/31/2004. J3396 effective 01/01/2005.)
05/01/07	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age
4/24/12	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
05/01/2017	Attachment A, Section B	Added new ICD 10 codes to the policy.
11/01/2017	Attachment A, Section B	Added new ICD 10 codes to the policy.
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."
03/15/2019	All Sections and Attachments	Updated policy template language.
12/04/2019	Table of Contents	Updated policy template language, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP."
12/04/2019	Attachment A	Added, "Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
08/01/2020	Attachment A, Section B	Revised the ICD-10 Codes table headings for clarity
08/01/2020		Policy posted 08/04/2020 with a amended date of 08/1/2020
8/15/2023	All Sections and Attachments	Updated policy template language due to North Carolina Health Choice Program's move to Medicaid.

Date	Section Revised	Change
		Policy posted 8/15/2023 with an effective date of 4/1/2023.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

A. Claim Type

Professional (CMS-1500/837P transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

*If an ICD-10 diagnosis code is labeled as a combination code it must be submitted along with the matching combination code to be accepted			
Combination Codes	Individual Codes		
B39.4 & H32	H442A	H442D2	H35.31
B39.5 & H32	H442A1	H442D3	H35.3210
B39.9 & H32	H442A2	H442E	H35.3211
	H442A3	H442E1	H35.3212
	H442B	H442E2	H35.3213
	H442B1	H442E3	H35.3220
	H442B2	H44.20	H35.3221
	H442B3	H44.21	H35.3222
	H442C	H44.22	H35.3223
	H442C1	H44.23	H35.3230
	H442C2	H35.051	H35.3231
	H442C3	H35.052	H35.3232
	H442D	H35.053	H35.3233
	H442D1	H35.059	
		H35.32	

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. List only the code. Use only the tables needed and delete the rest.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Code
67221
67225
J3396

Note: OPT procedures are covered only in conjunction with the drug verteporfin.

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service

D. Modifiers

Providers shall follow applicable modifier guidelines.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

F. Place of Service

Inpatient, Outpatient, Office.

G. Co-payments

For Medicaid refer to Medicaid State Plan:

<https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices>

H. Reimbursement

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>