

**Table of Contents**

1.0	Description of the Procedure, Product, or Service.....	1
1.1	Computerized Corneal Topography.....	1
1.2	Sensorimotor Examination.....	1
1.3	Fitting of Contact Lens for Treatment of Disease.....	1
1.4	Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) .....	1
1.5	Ophthalmic Biometry .....	2
1.6	Fundus Photography .....	2
1.7	Electrophysiologic Retinal Testing.....	2
2.0	Eligibility Requirements .....	3
2.1	Provisions.....	3
2.1.1	General.....	3
2.1.2	Specific .....	3
2.2	Special Provisions.....	3
2.2.1	EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age .....	3
2.2.2	EPSDT does not apply to NCHC beneficiaries .....	4
2.2.3	Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age .....	4
3.0	When the Procedure, Product, or Service Is Covered.....	5
3.1	General Criteria Covered .....	5
3.2	Specific Criteria Covered.....	5
3.2.1	Specific criteria covered by both Medicaid and NCHC .....	5
3.2.2	Computerized Corneal Topography.....	5
3.2.3	Sensorimotor Examination .....	6
3.2.4	Fitting of Contact Lens .....	6
3.2.5	Scanning Computerized Ophthalmic Diagnostic Imaging.....	6
3.2.6	Ophthalmic Biometry .....	7
3.2.7	Fundus Photography .....	7
3.2.8	Electrophysiologic Retinal Testing.....	7
3.2.9	Medicaid Additional Criteria Covered.....	7
3.2.10	NCHC Additional Criteria Covered .....	7
4.0	When the Procedure, Product, or Service Is Not Covered.....	8
4.1	General Criteria Not Covered .....	8
4.2	Specific Criteria Not Covered.....	8
4.2.1	Specific Criteria Not Covered by both Medicaid and NCHC.....	8
4.2.2	Computerized Corneal Topography.....	8
4.2.3	Scanning Computerized Ophthalmic Diagnostic Imaging.....	8
4.2.4	Ophthalmic biometry .....	8
4.2.5	Fundus Photography .....	9
4.2.6	Medicaid Additional Criteria Not Covered.....	9
4.2.7	NCHC Additional Criteria Not Covered.....	9
5.0	Requirements for and Limitations on Coverage .....	9

5.1	Prior Approval .....	9
5.2	Prior Approval Requirements .....	9
5.2.1	General.....	9
5.2.2	Specific .....	9
5.3	Documentation Requirements.....	9
5.4	Limitations.....	10
5.4.1	Separate Procedures.....	10
5.4.2	Fitting of contact lens for treatment of disease and for management of keratoconus .....	10
5.4.3	Scanning Computerized Ophthalmic Diagnostic Imaging.....	10
5.4.4	Fundus Photography .....	10
6.0	Provider(s) Eligible to Bill for the Procedure, Product, or Service .....	10
6.1	Provider Qualifications and Occupational Licensing Entity Regulations.....	10
6.2	Provider Certifications .....	10
7.0	Additional Requirements .....	11
7.1	Compliance .....	11
8.0	Policy Implementation/Revision Information.....	11
Attachment A: Claims-Related Information .....		13
A.	Claim Type .....	13
B.	International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) .....	13
C.	Code(s).....	17
D.	Modifiers.....	18
E.	Billing Units.....	18
F.	Place of Service .....	18
G.	Co-payments .....	18
H.	Reimbursement .....	18

## **1.0 Description of the Procedure, Product, or Service**

Special ophthalmological services are special evaluations of part of the visual system, which go beyond the services included under general ophthalmological services or in which special treatment is given. Interpretation and report by the physician is an integral part of special ophthalmological services where indicated.

Special ophthalmological services include the following procedures:

### **1.1 Computerized Corneal Topography**

Computerized corneal topography describes measurement of the curvature of the cornea. An evaluation of corneal topography is necessary for the accurate diagnosis and follow-up of certain corneal disorders. The topology of the cornea is analyzed by computer software, and reports are produced for physician evaluation.

### **1.2 Sensorimotor Examination**

A sensorimotor examination is an evaluation of the function of the ocular muscle system. Vertical and horizontal prism bars or individual handheld prisms are used to measure ocular deviation. The exam may include qualitative and quantitative testing of ocular motility, accommodation and binocular function.

### **1.3 Fitting of Contact Lens for Treatment of Disease**

The primary purpose of fitting of contact lens for treatment of disease is to promote healing, decrease pain, aid in therapeutic drug delivery and help maintain ocular surface hydration. The contact lens is part of the rehabilitative process or treatment plan. The intention of the contact lens in such a case is not for visual function.

### **1.4 Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)**

The two forms of scanning computerized ophthalmic diagnostic imaging (SCODI) are confocal scanning laser ophthalmoscopy and scanning laser polarimetry. Confocal scanning laser ophthalmoscopy (topography) uses stereoscopic videographic digitized images to make quantitative topographic measurements of the optic nerve head and surrounding retina. Scanning laser polarimetry measures change in the linear polarization of light (retardation). It uses both a polarimeter (an optical device to measure linear polarization change) and a scanning laser ophthalmoscope, to measure the thickness of the nerve fiber layer of the retina. Although these techniques differ, the objective is the same, to provide more precise methods of observation of the optic nerve head and more accurately reveal subtle glaucomatous changes over the course of time than visual fields and disc photos. These testing devices use videographic digitized images to make quantitative topographic measurements of the optic nerve head and surrounding retina to allow for early detection of glaucoma and more sophisticated analysis for ongoing management.

Posterior segment SCODI allows for detection of optic nerve and retinal nerve fiber layer pathologic changes before there is visual field loss. Anterior segment SCODI is used to examine the anterior segment ocular structures of the eye for evaluation of narrow angle, suspected narrow angle, and mixed narrow and open angle glaucoma. Glaucoma causes many related eye and vision changes, including erosion of the optic nerve and the associated retinal nerve fibers, and loss of peripheral vision. A diagnosis of glaucoma usually relies on the analysis of all available clinical data. When these tests are appropriately used in the management of glaucoma or glaucoma suspect, therapy can be initiated before there is irreversible loss of vision.

### **1.5 Ophthalmic Biometry**

Ophthalmic Biometry (Optical Coherence Biometry - OCB) is an ophthalmic diagnostic test which utilizes a non-invasive, non-contact device to measure the corneal curvature, anterior chamber depth and axial length of the eye without ultrasound. The measurements are stored in a computer and automatically transferred to the intraocular lens (IOL) calculator program, allowing immediate and individualized computation of IOL implant options.

### **1.6 Fundus Photography**

Retinal eye screening via fundus photography provides early detection of retinopathy in diabetes patients. Because diabetic retinopathy is often asymptomatic, its presence can be noted only through direct evaluation of the retina. Fundus photographs allow a complete view of the posterior segment of the inner aspect of the eye to document alterations in the optic nerve head, retinal vessels and retinal epithelium. These photographs can be used to document base line retinal findings or track disease progression to prevent or decrease blindness due to diabetic retinopathy.

### **1.7 Electrophysiologic Retinal Testing**

Electrophysiologic retinal testing is done to diagnose specific disorders of the retina. The most commonly performed electrophysiologic test is the electroretinogram (ERG). Other electrophysiologic tests include electro-oculography (EOG), dark adaptometry, and special color vision testing.

The ERG measures the electrical response of the retina to flashes of light. The EOG measures the difference in the electrical potential between the front and back of the eye in response to dark and light. Dark adaptometry measures the period of time which passes before the retina regains its maximal sensitivity to low amounts of light when going from conditions of bright light to darkness.

## 2.0 Eligibility Requirements

### 2.1 Provisions

#### 2.1.1 General

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

- a. An eligible beneficiary shall be enrolled in either:
  1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
  2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC 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.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

#### 2.1.2 Specific

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

- a. **Medicaid**  
None Apply.
- b. **NCHC**  
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/>

**2.2.2 EPSDT does not apply to NCHC beneficiaries**

**2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age**

NC Medicaid shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

### 3.0 When the Procedure, Product, or Service Is Covered

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

#### 3.1 General Criteria Covered

Medicaid and NCHC 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 both Medicaid and NCHC

Although technical procedures are part of Special Ophthalmological Services, they do not constitute the complete service, an interpretation and report by the rendering provider is an integral part of the service and must be completed for each test provided. This report must address the findings, relevant clinical issues, and comparative data.

##### 3.2.2 Computerized Corneal Topography

Computerized corneal topography is indicated in the identification of deep or superficial corneal disorders causing irregular astigmatism and visual impairment.

Medicaid and NCHC shall cover computerized corneal topography when it is determined to be medically necessary, the beneficiary meets any of the following indications below and the results will assist in defining further treatment:

- a. pre-operative evaluation of irregular astigmatism for intraocular lens power determination with cataract surgery;
- b. monocular diplopia;
- c. diagnosis of keratoconus;
- d. post-surgical or post-traumatic astigmatism, measuring at a minimum of 3.5 diopters;
- e. suspected irregular astigmatism based on retinoscopic streak or conventional keratometry;
- f. post-penetrating keratoplasty surgery;
- g. post-surgical or post-traumatic irregular astigmatism;
- h. corneal dystrophies;
- i. complications of transplanted cornea;
- j. post-traumatic corneal scarring; **or**

- k. pterygium or corneal ectasia that cause visual impairment.

### **3.2.3 Sensorimotor Examination**

Sensorimotor examination requires the assessment of both eyes. It includes ocular alignment measurements in more than one field of gaze and inclusion of at least one appropriate sensory test in beneficiaries who are able to respond. Examples of sensory function testing include Worth 4 dot, Maddox rod, and Bagolini lenses.

Medicaid and NCHC shall cover sensorimotor examination when considered medically necessary for any of the following conditions:

- a. diplopia;
- b. exotropia;
- c. esotropia;
- d. hypertropia; or
- e. paralytic strabismus.

### **3.2.4 Fitting of Contact Lens**

- a. Medicaid and NCHC shall cover the fitting of contact lens for the treatment of disease for any of the following conditions:
  - 1. bullous keratopathy;
  - 2. dry eyes;
  - 3. corneal ulcers;
  - 4. corneal abrasions;
  - 5. keratitis;
  - 6. corneal edema;
  - 7. descemetocoele;
  - 8. corneal ectasis;
  - 9. Mooren's ulcer;
  - 10. anterior corneal dystrophy; or
  - 11. neurotrophic keratoconjunctivitis.
- b. The initial fitting of gas permeable contact lens is indicated for the management of keratoconus.

### **3.2.5 Scanning Computerized Ophthalmic Diagnostic Imaging**

Medicaid and NCHC shall cover SCODI to diagnose early glaucoma and monitor glaucoma treatment in beneficiaries with mild to moderate damage.

Glaucomatous damage is defined by one of the following criteria:

- a. glaucoma-suspect or mild glaucomatous damage (mild stage glaucoma):
  - 1. anomalous appearing optic nerve;
  - 2. intraocular pressure greater than 22 mmHg as measured by applanation;
  - 3. symmetric or vertically elongated cup enlargement, neural rim intact, cup to disc ratio greater than 4.0;
  - 4. focal optic disk notch;
  - 5. optic disk hemorrhage or history of optic disk hemorrhage;
  - 6. nasal step or small paracentral or arcuate scotoma; **or**
  - 7. mild constriction of visual field isopters



- b. moderate glaucomatous damage\_(moderate stage glaucoma):
  - 1. enlarged optic cup with neural rim remaining but sloped or pale, cup to disc ratio greater than 0.5, but less than 0.9;
  - 2. definite focal notch with thinning of the neural rim; **or**
  - 3. definite glaucomatous visual field defect, e.g., arcuate or paracentral scotoma, nasal step, pencil wedge, or constriction of isopters.
- c. advanced glaucomatous damage\_(severe stage glaucoma):
  - 1. severe generalized constriction of isopters (i.e., Goldmann 14e greater than 10 degrees of fixation);
  - 2. absolute visual field defects within 10 degrees of fixation;
  - 3. severe generalized reduction of retinal sensitivity;
  - 4. loss of central visual acuity, with temporal island remaining;
  - 5. diffuse enlargement of optic nerve cup, with cup to disc ratio greater than 0.8; **or**
  - 6. wipe-out of all or a portion of the neural retinal rim.

### **3.2.6 Ophthalmic Biometry**

Medicaid and NCHC shall cover the performance of Ophthalmic Biometry (Optical Coherence Biometry - OCB) when considered medically necessary and performed preoperatively for the purpose of determining intraocular lens power in a beneficiary undergoing cataract surgery. The provider who is performing the cataract surgery shall perform the OCB.

### **3.2.7 Fundus Photography**

Medicaid and NCHC shall cover fundus photography for examination of the retina to document disease process, plan treatment or follow the progress of diabetic retinopathy in beneficiaries with diabetes.

### **3.2.8 Electrophysiologic Retinal Testing**

Medicaid and NCHC shall cover electrophysiologic retinal testing when it is determined to be medically necessary, and the beneficiary meets any of the following indications below:

- a. confirmation of neurologic or ophthalmologic disease;
- b. unexplained visual loss;
- c. family history of poor vision;
- d. inherited visual disorders; or
- e. assessment of optic nerve function following trauma.

### **3.2.9 Medicaid Additional Criteria Covered**

None Apply.

### **3.2.10 NCHC Additional Criteria Covered**

For NCHC beneficiaries, age-appropriate modifications may be required at the discretion of the provider.

## 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 a Medicaid Beneficiary under 21 Years of Age.*

### 4.1 General Criteria Not Covered

Medicaid and NCHC 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 both Medicaid and NCHC

Medicaid and NCHC shall not cover special ophthalmological services when the criteria in **Subsection 3.2** are not met.

#### 4.2.2 Computerized Corneal Topography

Medicaid and NCHC shall not cover computerized corneal topography for any of the following:

- a. routine follow-up testing;
- b. repeat testing if not indicated by a change of vision as reported in connection with one of the listed conditions in **Subsection 3.2.2**;
- c. on the same date of service as keratoplasty; or
- d. services performed for screening purposes.

#### 4.2.3 Scanning Computerized Ophthalmic Diagnostic Imaging

Medicaid and NCHC shall not cover SCODI for the following:

- a. to further validate a diagnosis that has been confirmed through earlier detection;
- b. for beneficiaries with advanced glaucomatous damage; instead, visual fields must be performed;
- c. when performed in the absence of an indication as denoted by one of the diagnoses listed in **Attachment A, B**;
- d. when performed as screening; or
- e. SCODI of the optic nerve and SCODI of the retina are not covered on the same date of service.

#### 4.2.4 Ophthalmic biometry

Medicaid and NCHC shall not cover ophthalmic biometry (Optical Coherence Biometry - OCB) by partial coherence interferometry on the same date of service as ophthalmic biometry by ultrasound echography, A-scan.

#### **4.2.5 Fundus Photography**

Medicaid and NCHC shall not cover fundus photography for any of the following:

- a. to screen or evaluate retinal conditions other than diabetic retinopathy;
- b. when the final composite image captured does not include the entire Diabetic Retinopathy Study seven-standard field area (DRS 7); or
- c. when the final retinal images are graded using an automatic process only.

#### **4.2.6 Medicaid Additional Criteria Not Covered**

None Apply.

#### **4.2.7 NCHC Additional Criteria Not Covered**

- a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
  1. No services for long-term care.
  2. No nonemergency medical transportation.
  3. No EPSDT.
  4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

### **5.0 Requirements for and Limitations on Coverage**

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

#### **5.1 Prior Approval**

Medicaid and NCHC shall not require prior approval for Special Ophthalmological Services

#### **5.2 Prior Approval Requirements**

##### **5.2.1 General**

None Apply

##### **5.2.2 Specific**

None Apply.

#### **5.3 Documentation Requirements**

Although health records are not required to be submitted for payment of Special Ophthalmological Services, the records must be available upon request by NC Medicaid. Documentation must include all of the following:

- a. medical history;
- b. ophthalmologic examination findings;
- c. results of diagnostic tests or procedures; and
- d. when applicable, photographs including written interpretations.

## **5.4 Limitations**

### **5.4.1 Separate Procedures**

Special Ophthalmological Services include procedures and services that are designated as separate procedures. A separate procedure is one that is carried out as an integral component of a total service or procedure. The services or procedures designated as separate procedures must not be billed in addition to the total procedure or service of which it is considered an integral component. These services or procedures must be reported only when performed independently, unrelated or distinct from other procedures or services provided.

### **5.4.2 Fitting of contact lens for treatment of disease and for management of keratoconus**

Fitting of contact lens for treatment of disease is limited to four lenses per 365 days.

### **5.4.3 Scanning Computerized Ophthalmic Diagnostic Imaging**

- a. Pre-glaucoma beneficiaries or those with mild damage as describe in **Subsection 3.2.5.a** may receive one SCODI per 365 days.
- b. Beneficiaries with moderate damage as described in **Subsection 3.2.5.b.** may receive up to two SCODIs per 365 days OR one SCODI and one visual field per 365 days if medically necessary. When both tests are performed, only one of each test is covered per 365 days.

### **5.4.4 Fundus Photography**

Fundus photography studies are limited to one per 365 days for detection and interpretation of diabetic retinopathy in beneficiaries with a diagnosis of diabetes mellitus.

## **6.0 Provider(s) 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 or NCHC 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 a Medicaid Beneficiary under 21 Years of Age.*

### 7.1 Compliance

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

**Effective Date:** January 1, 1999

**Revision Information:**

Date	Section Revised	Change
09/01/2004	Section 5.0	Added medical necessity criteria and limitations relative to visual fields
09/01/2005	Section 2.0	A special provision related to EPSDT was added.
12/01/2005	Subsection 2.2	The web address for DMA's EDPST policy instructions was added to this section.
12/01/2006	Sections 2 through 5	A special provision related to EPSDT was added.
05/01/2007	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age
07/01/2010	All sections and attachment(s)	Session Law 2009-451, Section 10.31(a) Transition of NC Health Choice Program administrative oversight from the State Health Plan to the Division of Medical Assistance (DMA) in the NC Department of Health and Human Services.
01/15/2013	All sections and attachment(s)	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 1T-2 under Session Law 2011-145 § 10.41.
01/15/2013	All sections and attachment(s)	Deleted references to scanning laser glaucoma tests (SLGT).
01/15/2013	All sections and attachment(s)	Title of policy changed from Scanning Laser Glaucoma Tests to Special Ophthalmological Services.
01/15/2013	All sections and attachment(s)	Technical changes to merge Medicaid and NCHC current coverage into one policy.
01/15/2013	Section 1.0	Added description of Special Ophthalmological Services.
01/15/2013	Subsections 1.1 through 1.7	Included procedure descriptions.
01/15/2013	Subsection 3.2	Added this section

<b>Date</b>	<b>Section Revised</b>	<b>Change</b>
01/15/2013	Subsection 3.2.3	Added Medicaid covers fitting of gas permeable contact lens for the treatment of keratoconus initial
01/15/2013	Subsection 3.2.4 a	Added mild stage glaucoma
01/15/2013	Subsection 3.2.4 b	Added moderate stage glaucoma
01/15/2013	Subsection 3.2.4 c	Added severe stage glaucoma
01/15/2013	Subsection 4.2	Added specific non-coverage criteria
01/15/2013	Subsection 5.1	Added statement regarding no requirement for prior approval
01/15/2013	Subsection 5.2	Added documentation requirements.
01/15/2013	Subsection 5.3	Added limitations for special ophthalmological services procedures
01/15/2013	Subsection 5.3.4 b.	Removed remote site imaging for monitoring of active retinal disease
01/15/2013	Subsection 5.3.3c	Removed remote site imaging for monitoring of active retinal disease
01/15/2013	Subsection 5.3.4b	Removed remote site imaging for monitoring of active retinal disease
01/15/2013	Subsection 8.0	Moved to Attachment A: Claims Related Information
01/15/2013	Subsection 9.0	Moved to Section 8.0
01/15/2013	Attachment A, B	Added description of diagnosis codes that support medical necessity for SCODI and fundus photography
01/15/2013	All sections and attachment(s)	Replaced “recipient” with “beneficiary.”
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.
08/01/2017	Attachment A Section B	Deleted ICD 10 codes that were end-dated and replaced with appropriate ICD 10 codes.
11/01/2017	Attachment A Section B	2017 ICD 10 diagnosis codes were added under Fundus Photography.
01/01/2019	Subsection 3.2.4a.7.	Corrected spelling of word descemetocoele
01/01/2019	Attachment A, Section C	CPT code 92275 end dated 12/31/18 by CMS and replaced with CPT 92273 and 92274
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.

## 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 and NCHC:

### A. Claim Type

Professional (CMS-1500/837P transaction)

### 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.

Claims must contain one of the following diagnosis codes to support medical necessity for SCODI procedures:

ICD-10-CM Code(s)		
Service Provided SCODI		
H21.231	H40.1394	H40.41x4
H21.232	H40.1410	H40.42x0
H21.233	H40.141	H40.42x1
H21.239	H40.142	H40.42x2
H21.40	H40.143	H40.42x3
H21.41	H40.1494	H40.42x4
H21.42	H40.1510	H40.43x0
H21.43	H40.1511	H40.43x1
H21.521	H40.1512	H40.43x2
H21.522	H40.1513	H40.43x3
H21.523	H40.1514	H40.43x4
H21.529	H40.1520	H40.50x0
H21.551	H40.1521	H40.50x1
H21.552	H40.1522	H40.50x2
H21.553	H40.1523	H40.50x3
H21.559	H40.1524	H40.50x4
H35.451	H40.1530	H40.51x0
H35.452	H40.1531	H40.51x1
H35.453	H40.1532	H40.51x2
H35.459	H40.1533	H40.51x3
H35.89	H40.1534	H40.51x4
H36	H40.1590	H40.52x0
H40.001	H40.1591	H40.52x1
H40.002	H40.1592	H40.52x2
H40.003	H40.1593	H40.52x3
H40.009	H40.1594	H40.52x4

H40.011	H40.20x0	H40.53x0
H40.012	H40.20x1	H40.53x1
H40.013	H40.20x2	H40.53x2
H40.019	H40.20x3	H40.53x3
H40.031	H40.20x4	H40.53x4
H40.032	H40.211	H40.60x0
H40.033	H40.212	H40.60x1
H40.039	H40.213	H40.60x2
H40.041	H40.219	H40.60x3
H40.042	H40.2210	H40.60x4
H40.043	H40.2211	H40.61x0
H40.049	H40.2212	H40.61x1
H40.051	H40.2213	H40.61x2
H40.052	H40.2214	H40.61x3
H40.053	H40.2220	H40.61x4
H40.059	H40.2221	H40.62x0
H40.10x0	H40.2222	H40.62x1
H40.10x1	H40.2223	H40.62x2
H40.10x2	H40.2224	H40.62x3
H40.10x3	H40.2230	H40.62x4
H40.10x4	H40.2231	H40.63x0
H40.1110	H40.2232	H40.63x1
H40.1111	H40.2233	H40.63x2
H40.1112	H40.2234	H40.63x3
H40.1113	H40.2290	H40.63x4
H40.1114	H40.2291	H40.811
H40.1120	H40.2292	H40.812
H40.1121	H40.2293	H40.813
H40.1122	H40.2294	H40.819
H40.1123	H40.231	H40.821
H40.1124	H40.232	H40.822
H40.1130	H40.233	H40.823
H40.1131	H40.239	H40.829
H40.1132	H40.241	H40.831
H40.1133	H40.242	H40.832
H40.1134	H40.243	H40.833
H40.1210	H40.249	H40.839
H40.1211	H40.30x0	H40.89
H40.1212	H40.30x1	H40.9
H40.1213	H40.30x2	H42
H40.1214	H40.30x3	H47.10
H40.1220	H40.30x4	H47.11
H40.1221	H40.31x0	H47.12
H40.1222	H40.31x1	H47.143
H40.1223	H40.31x2	H47.149
H40.1224	H40.31x3	H47.9
H40.1230	H40.31x4	H53.40
H40.1231	H40.32x0	H53.411
H40.1232	H40.32x1	H53.412



H40.1233	H40.32x2	H53.413
H40.1234	H40.32x3	H53.419
H40.1290	H40.32x4	H53.421
H40.1291	H40.33x1	H53.422
H40.1292	H40.33x2	H53.423
H40.1293	H40.33x3	H53.429
H40.1294	H40.33x4	H53.431
H40.1310	H40.40x0	H53.432
H40.1311	H40.40x1	H53.433
H40.1312	H40.40x2	H53.439
H40.1313	H40.40x3	H53.451
H40.1314	H40.40x4	H53.452
H40.1320	H40.41x0	H53.453
H40.1321	H40.41x1	H53.459
H40.1322	H40.41x2	H53.481
H40.1323	H40.41x3	H53.482
H40.1324		H53.483
H40.1330		H53.489
H40.1331		Q15.0
H40.1332		
H40.1333		
H40.1334		
H40.1390		
H40.1391		
H40.1392		
H40.1393		

Claims must contain one of the following diagnosis codes to support medical necessity for fundus photography procedures:

<b>ICD-10-CM Code(s)</b>		
<b>Service Provided Fundus Photography</b>		
E10.10	E11.311	E13.329
E10.11	E11.319	E13.331
E10.21	E11.321	E13.339
E10.22	E11.3211	E13.341
E10.29	E11.3212	E13.3211
E10.311	E11.3213	E13.3212
E10.319	E11.3291	E13.3213
E10.321	E11.3292	E13.3291
E10.3211	E11.3293	E13.3292
E10.3212	E11.3311	E13.3293
E10.3213	E11.3312	E13.3311
E10.329	E11.3313	E13.3312
E10.3291	E11.329	E13.3313
E10.3292	E11.331	E13.3391
E10.3293	E11.339	E13.3392
E10.331	E11.3391	E13.3393

E10.3311	E11.3392	E13.3411
E10.3312	E11.3393	E13.3412
E10.3313	E11.341	E13.3413
E10.339	E11.3411	E13.349
E10.3391	E11.3412	E13.3491
E10.3392	E11.3413	E13.3492
E10.3393	E11.349	E13.3493
E10.341	E11.3491	E13.351
E10.3411	E11.3492	E13.3511
E10.3412	E11.3493	E13.3512
E10.3413	E11.351	E13.3513
E10.349	E11.3511	E13.3521
E10.3491	E11.3512	E13.3522
E10.3492	E11.3513	E13.3523
E10.3493	E11.3521	E13.3531
E10.351	E11.3522	E13.3532
E10.3511	E11.3523	E13.3533
E10.3512	E11.3531	E13.3541
E10.3513	E11.3532	E13.3542
E10.3521	E11.3533	E13.3543
E10.3522	E11.3541	E13.3551
E10.3523	E11.3542	E13.3552
E10.3531	E11.3543	E13.3553
E10.3532	E13.3551	E13.359
E10.3533	E11.3552	E13.3591
E10.3541	E11.3553	E13.3592
E10.3542	E11.359	E13.3593
E10.3543	E11.3591	E13.36
E10.3551	E11.3592	E13.37X1
E10.3552	E11.3593	E13.37X2
E10.3553	E11.36	E13.37X3
E10.359	E11.37X1	E13.39
E10.3591	E11.37X2	E13.40
E10.3592	E11.37X3	E13.41
E10.3593	E11.39	E13.42
E10.36	E11.40	E13.43
E10.37X1	E11.41	E13.44
E10.37X2	E11.42	E13.49
E10.37X3	E11.43	E13.51
E10.39	E11.44	E13.52
E10.40	E11.49	E13.59
E10.41	E11.51	E13.610
E10.42	E11.52	E13.618
E10.43	E11.59	E13.620
E10.44	E11.610	E13.621
E10.49	E11.618	E13.622
E10.51	E11.620	E13.628
E10.52	E11.621	E13.630
E10.59	E11.622	E13.638

E10.610	E11.628	E13.641
E10.618	E11.630	E13.649
E10.620	E11.638	E13.65
E10.621	E11.641	E13.69
E10.622	E11.649	E13.8
E10.628	E11.65	E13.9
E10.630	E11.69	O24.410
E10.638	E11.8	O24.414
E10.641	E11.9	O24.415
E10.649	E13.00	O24.419
E10.65	E13.01	O24.420
E10.69	E13.10	O24.424
E10.8	E13.11	O24.425
E10.9	E13.21	O24.429
E11.00	E13.22	O24.430
E11.01	E13.29	O24.434
E111	E13.311	O24.435
E1110	E13.319	O24.439
E1111	E13.321	O24.83
E11.21		O24.911
E11.22		O24.912
E11.29		O24.913
		O24.919
		O24.93
		O99.810
		O99.814
		O99.815

### 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.

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.

CPT Code(s)		
92025	92133	92270
92060	92134	92273
92071	92136	92274
92072	92250	92283
92132	92265	92284

**Note:** Bilateral means the procedure is expected to be done on both eyes and the payment amount accounts for both eyes. Unilateral means the procedure is for a single eye. Unilateral **or** bilateral indicates that the payment amount is the same regardless if one or both eyes are scanned.

**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**

Provider(s) 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/get-involved/nc-health-choice-state-plan>

For NCHC refer to NCHC State Plan:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

**H. Reimbursement**

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

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