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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.

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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:

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.

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.

Fitting of Therapeutic Contact Lens ~~for Treatment of Disease~~

A therapeutic contact lens is also known as a bandage contact lens. ~~The primary purpose of~~ F~~f~~itting ~~of~~ a therapeutic contact lens ~~for treatment of disease~~ is part of the rehabilitative process or treatment plan used to promote healing of a diseased or injured eye, rather than vision correction., A therapeutic contact lens is fitted to 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~~.

Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)

Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) is used to evaluate retinal disorders, glaucoma and anterior segment disorders.

Retinal disorders are the most common cause of severe and permanent vision loss. SCODI can be used to measure the effectiveness of therapy and to evaluate the need for ongoing therapy in a beneficiary with retinal disease.

Glaucoma is the leading cause of blindness. 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.

Clinical evidence has shown that long-term use of chloroquine (CQ) or hydroxychlorine (HCQ) can lead to irreversible retinal toxicity. Prior to starting CQ or HCQ, SCODI may be indicated to provide a baseline and repeated annually for follow-up. SCODI techniques are:

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~~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 objectives ~~is~~ are the same, which are early detection of glaucoma and more sophisticated analysis for ongoing management. ~~to~~ These techniques provide more precise methods of observation of the optic nerve head and surrounding retina ~~and more~~ to 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.

Optical Coherence Tomography (OCT)

Optical Coherence Tomography (OCT) are noninvasive imaging tests that use light waves to take cross-section pictures of the retina.

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.

Fundus Photography

Retinal eye screening via fundus photography provides early detection of retinopathy in a beneficiary with diabetes. 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.

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.

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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.

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
   1. 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.

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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/

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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 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 Special Ophthalmological Services when the beneficiary meets the following specific criteria:

a. 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 Medicaid Additional Criteria Covered

None Apply.

3.2.3 Computerized Corneal Topography

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

Medicaid 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~~;bullous keratopathy;
f. post-penetrating keratoplasty surgery;
g. post-surgical or post-traumatic irregular astigmatism;
h. corneal dystrophies;

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i. complications of transplanted cornea;
j. post-traumatic corneal scarring; **or**
k. pterygium or corneal ectasia that cause visual impairment.

3.2.4 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 a beneficiary who is able to respond. Examples of sensory function testing include Worth 4 dot, Maddox rod, and Bagolini lenses.

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

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

3.2.5 Fitting of Therapeutic Contact Lens

a. Medicaid shall cover the fitting of therapeutic contact lens for the treatment ~~of disease for any~~ of the following conditions:
   1. bullous keratopathy;
   2. dry eye~~s~~ syndrome;
   3. corneal ulcers;
   4. corneal abrasions;
   5. keratitis;
   6. corneal edema;
   7. descemetocele;
   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.

3.2.6 Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)

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

a. Medicaid shall cover SCODI to:
   1. Diagnose and monitor glaucoma treatment;
   2. Evaluate disorders of the cornea, iris and ciliary body;
   3. Evaluate and treat optic nerve, retinal, or macular disease;
   4. Monitor for irreversible retinal toxicity in a beneficiary on long-term chloroquine or hydroxycloriquine therapy.

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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.

3.2.7 Ophthalmic Biometry

Medicaid 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.

3.2.8 Fundus Photography

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

3.2.9 Electrophysiologic Retinal Testing

Medicaid 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.

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3.2.10 Placement of Amniotic Membrane on the Eye

Medicaid shall cover placement of an amniotic membrane on the ocular surface without sutures to treat damaged or diseased corneal tissue.

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 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

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

4.2.2 Computerized Corneal Topography

Medicaid shall not cover computerize~~-t~~ed 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 Sensorimotor Examination

Medicaid shall not cover a sensorimotor exam if there is not a complaint and the beneficiary's condition is properly controlled. A repeat exam shall not be covered for any of the following:

a. when there is no change in the treatment plan;
b. no new symptoms are present; or
c. the previous result was reliable.

4.2.4 Fitting of Therapeutic Contact Lens

Medicaid shall not cover fitting of therapeutic contact lens on the same date of surface as a cornea procedure.

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4.2.5 Scanning Computerized Ophthalmic Diagnostic Imaging

Medicaid shall not cover SCODI for the following:

a. to further validate a diagnosis that has been confirmed through earlier detection;
b. for a beneficiary ~~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.

4.2.6 Ophthalmic biometry

Medicaid 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.

4.2.7 Fundus Photography

Medicaid 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.

~~**4.2.8 Placement of Amniotic Membrane on the Eye**~~

~~Medicaid shall not cover placement of an amniotic membrane by an optometrist or other healthcare provider. Placement of an amniotic membrane is only covered when performed by an ophthalmologist or physician.~~

4.2.9 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 a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

Medicaid 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.

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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 beneficiary ~~beneficiaries~~ or ~~those~~ a beneficiary with mild damage as described in **Subsection 3.2.5.a** may receive one SCODI per 365 days.

b. ~~Beneficiaries~~ A Beneficiary 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 a beneficiary ~~beneficiaries~~ with a diagnosis of diabetes mellitus.

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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 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).

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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
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

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Date	Section Revised	Change
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 descemetocele
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.
01/15/2020	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."
01/15/2020	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".
8/15/2023	All Sections and Attachments	Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 8/15/2023 with an effective date of 4/1/2023.
01/15/2024	Attachment A(B)	Annual update to ICD-10 codes
	Section 1.0	Further defined Fitting of Therapeutic Contact Lenses and Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)
	Section 1.0	Defined Optical Coherence Tomography (OCT)
	Section 3.2.3	Added bullous keratopathy as an indication for Computerized corneal topography
	Section 3.2.4	Added hypotropia as an indication for a sensorimotor exam

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Date	Section Revised	Change
	Section 3.2.6	Added SCODI is to be covered to Diagnose and monitor glaucoma treatment; Evaluate disorders of the cornea, iris and ciliary body; Evaluate and treat optic nerve, retinal or macular disease; Monitor for irreversible retinal toxicity in a beneficiary on long-term chloroquine and/or hydroxychloroquine therapy
	Section 3.2.10	Added coverage for Placement of an amniotic membrane on the ocular surface without sutures is used to treat damaged or diseased corneal tissue.
	Section 4.2.3	Added: Medicaid shall not cover a sensorimotor exam if there is not a complaint and the beneficiary's condition is properly controlled. A repeat exam shall not be covered for any of the following: when there is no change in the treatment plan; no new symptoms are present; or the previous result was reliable.
	Section 4.2.4	Added: Medicaid shall not cover fitting of therapeutic contact lens on the same date of surface as a cornea procedure.
	Section 4.2.8	Removed: Medicaid shall not cover placement of an amniotic membrane by an optometrist or other healthcare provider. Placement of an amniotic membrane is only covered when performed by an ophthalmologist or physician.
	Attachment A.B	Deleted tables: ICD-10 diagnosis codes to support medical necessity for SCODI procedures and ICD-10 diagnosis codes to support medical necessity for fundus photography procedures.
	Attachment A.C.	Added 65778 to CPT Code(s) table

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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.

~~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~~
~~H36.8~~	~~H40.1591~~	~~H40.52x1~~
~~H36.81~~	~~H40.1592~~	~~H40.52x2~~

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~~H36.811~~	~~H40.1593~~	~~H40.52x3~~
~~H36.812~~	~~H40.1594~~	~~H40.52x4~~
~~H36.813~~	~~H40.20x0~~	~~H40.53x0~~
~~H36.819~~	~~H40.20x1~~	~~H40.53x1~~
~~H36.82~~	~~H40.20x2~~	~~H40.53x2~~
~~H36.821~~	~~H40.20x3~~	~~H40.53x3~~
~~H36.822~~	~~H40.20x4~~	~~H40.53x4~~
~~H36.823~~	~~H40.211~~	~~H40.60x0~~
~~H36.829~~	~~H40.212~~	~~H40.60x1~~
~~H36.89~~	~~H40.213~~	~~H40.60x2~~
~~H40.001~~	~~H40.219~~	~~H40.60x3~~
~~H40.002~~	~~H40.2210~~	~~H40.60x4~~
~~H40.003~~	~~H40.2211~~	~~H40.61x0~~
~~H40.009~~	~~H40.2212~~	~~H40.61x1~~
~~H40.011~~	~~H40.2213~~	~~H40.61x2~~
~~H40.012~~	~~H40.2214~~	~~H40.61x3~~
~~H40.013~~	~~H40.2220~~	~~H40.61x4~~
~~H40.019~~	~~H40.2221~~	~~H40.62x0~~
~~H40.031~~	~~H40.2222~~	~~H40.62x1~~
~~H40.032~~	~~H40.2223~~	~~H40.62x2~~
~~H40.033~~	~~H40.2224~~	~~H40.62x3~~
~~H40.039~~	~~H40.2230~~	~~H40.62x4~~
~~H40.041~~	~~H40.2231~~	~~H40.63x0~~
~~H40.042~~	~~H40.2232~~	~~H40.63x1~~
~~H40.043~~	~~H40.2233~~	~~H40.63x2~~
~~H40.049~~	~~H40.2234~~	~~H40.63x3~~
~~H40.051~~	~~H40.2290~~	~~H40.63x4~~
~~H40.052~~	~~H40.2291~~	~~H40.811~~
~~H40.053~~	~~H40.2292~~	~~H40.812~~
~~H40.059~~	~~H40.2293~~	~~H40.813~~
~~H40.10x0~~	~~H40.2294~~	~~H40.819~~
~~H40.10x1~~	~~H40.231~~	~~H40.821~~
~~H40.10x2~~	~~H40.232~~	~~H40.822~~
~~H40.10x3~~	~~H40.233~~	~~H40.823~~
~~H40.10x4~~	~~H40.239~~	~~H40.829~~
~~H40.1110~~	~~H40.241~~	~~H40.831~~
~~H40.1111~~	~~H40.242~~	~~H40.832~~
~~H40.1112~~	~~H40.243~~	~~H40.833~~
~~H40.1113~~	~~H40.249~~	~~H40.839~~
~~H40.1114~~	~~H40.30x0~~	~~H40.89~~
~~H40.1120~~	~~H40.30x1~~	~~H40.9~~
~~H40.1121~~	~~H40.30x2~~	~~H42~~
~~H40.1122~~	~~H40.30x3~~	~~H47.10~~
~~H40.1123~~	~~H40.30x4~~	~~H47.11~~
~~H40.1124~~	~~H40.31x0~~	~~H47.12~~
~~H40.1130~~	~~H40.31x1~~	~~H47.143~~
~~H40.1131~~	~~H40.31x2~~	~~H47.149~~
~~H40.1132~~	~~H40.31x3~~	~~H47.9~~
~~H40.1133~~	~~H40.31x4~~	~~H53.40~~

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~~H40.1134~~ ~~H40.1210~~ ~~H40.1211~~ ~~H40.1212~~ ~~H40.1213~~ ~~H40.1214~~ ~~H40.1220~~ ~~H40.1221~~ ~~H40.1222~~ ~~H40.1223~~ ~~H40.1224~~ ~~H40.1230~~ ~~H40.1231~~ ~~H40.1232~~ ~~H40.1233~~ ~~H40.1234~~ ~~H40.1290~~ ~~H40.1291~~ ~~H40.1292~~ ~~H40.1293~~ ~~H40.1294~~ ~~H40.1310~~ ~~H40.1311~~ ~~H40.1312~~ ~~H40.1313~~ ~~H40.1314~~ ~~H40.1320~~ ~~H40.1321~~ ~~H40.1322~~ ~~H40.1323~~ ~~H40.1324~~ ~~H40.1330~~ ~~H40.1331~~ ~~H40.1332~~ ~~H40.1333~~ ~~H40.1334~~ ~~H40.1390~~ ~~H40.1391~~ ~~H40.1392~~ ~~H40.1393~~	~~H40.32x0~~ ~~H40.32x1~~ ~~H40.32x2~~ ~~H40.32x3~~ ~~H40.32x4~~ ~~H40.33x1~~ ~~H40.33x2~~ ~~H40.33x3~~ ~~H40.33x4~~ ~~H40.40x0~~ ~~H40.40x1~~ ~~H40.40x2~~ ~~H40.40x3~~ ~~H40.40x4~~ ~~H40.41x0~~ ~~H40.41x1~~ ~~H40.41x2~~ ~~H40.41x3~~	~~H53.411~~ ~~H53.412~~ ~~H53.413~~ ~~H53.419~~ ~~H53.421~~ ~~H53.422~~ ~~H53.423~~ ~~H53.429~~ ~~H53.431~~ ~~H53.432~~ ~~H53.433~~ ~~H53.439~~ ~~H53.451~~ ~~H53.452~~ ~~H53.453~~ ~~H53.459~~ ~~H53.481~~ ~~H53.482~~ ~~H53.483~~ ~~H53.489~~ ~~Q15.0~~

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

ICD-10-CM Code(s)		
Service Provided Fundus Photography		
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

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~~E10.3551~~ ~~E10.3552~~ ~~E10.3553~~ ~~E10.359~~ ~~E10.3591~~ ~~E10.3592~~ ~~E10.3593~~ ~~E10.36~~ ~~E10.37X1~~ ~~E10.37X2~~ ~~E10.37X3~~ ~~E10.39~~ ~~E10.40~~ ~~E10.41~~ ~~E10.42~~ ~~E10.43~~ ~~E10.44~~ ~~E10.49~~ ~~E10.51~~ ~~E10.52~~ ~~E10.59~~ ~~E10.610~~ ~~E10.618~~ ~~E10.620~~ ~~E10.621~~ ~~E10.622~~ ~~E10.628~~ ~~E10.630~~ ~~E10.638~~ ~~E10.641~~ ~~E10.649~~ ~~E10.65~~ ~~E10.69~~ ~~E10.8~~ ~~E10.9~~ ~~E11.00~~ ~~E11.01~~ ~~E111~~ ~~E1110~~ ~~E1111~~ ~~E11.21~~ ~~E11.22~~ ~~E11.29~~	~~E11.3592~~ ~~E11.3593~~ ~~E11.36~~ ~~E11.37X1~~ ~~E11.37X2~~ ~~E11.37X3~~ ~~E11.39~~ ~~E11.40~~ ~~E11.41~~ ~~E11.42~~ ~~E11.43~~ ~~E11.44~~ ~~E11.49~~ ~~E11.51~~ ~~E11.52~~ ~~E11.59~~ ~~E11.610~~ ~~E11.618~~ ~~E11.620~~ ~~E11.621~~ ~~E11.622~~ ~~E11.628~~ ~~E11.630~~ ~~E11.638~~ ~~E11.641~~ ~~E11.649~~ ~~E11.65~~ ~~E11.69~~ ~~E11.8~~ ~~E11.9~~ ~~E13.00~~ ~~E13.01~~ ~~E13.10~~ ~~E13.11~~ ~~E13.21~~ ~~E13.22~~ ~~E13.29~~ ~~E13.311~~ ~~E13.319~~ ~~E13.321~~	~~E13.37X1~~ ~~E13.37X2~~ ~~E13.37X3~~ ~~E13.39~~ ~~E13.40~~ ~~E13.41~~ ~~E13.42~~ ~~E13.43~~ ~~E13.44~~ ~~E13.49~~ ~~E13.51~~ ~~E13.52~~ ~~E13.59~~ ~~E13.610~~ ~~E13.618~~ ~~E13.620~~ ~~E13.621~~ ~~E13.622~~ ~~E13.628~~ ~~E13.630~~ ~~E13.638~~ ~~E13.641~~ ~~E13.649~~ ~~E13.65~~ ~~E13.69~~ ~~E13.8~~ ~~E13.9~~ ~~O24.410~~ ~~O24.414~~ ~~O24.415~~ ~~O24.419~~ ~~O24.420~~ ~~O24.424~~ ~~O24.425~~ ~~O24.429~~ ~~O24.430~~ ~~O24.434~~ ~~O24.435~~ ~~O24.439~~ ~~O24.83~~ ~~O24.911~~ ~~O24.912~~ ~~O24.913~~ ~~O24.919~~ ~~O24.93~~ ~~O99.810~~ ~~O99.814~~ ~~O99.815~~

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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)	
65778 92025 92060 92071 92072 92132 92133 92134	92136 92250 92265 92270 92273 92274 92283 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 of 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/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/