

Table of Contents

1.0	Description of the Procedure, Product, or Service.....	1
2.0	Eligible Recipients	1
2.1	General Provisions	1
2.2	EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age	1
3.0	When the Procedure, Product, or Service Is Covered.....	2
3.1	General Criteria.....	2
3.2	Specific Criteria	2
4.0	When the Procedure, Product, or Service Is Not Covered.....	3
4.1	General Criteria.....	3
4.2	Specific Criteria	3
5.0	Requirements for and Limitations on Coverage	4
5.1	Prior Approval	4
5.2	Limitations	4
5.3	Evaluation and Management Services	4
6.0	Providers Eligible to Bill for the Procedure, Product, or Service	5
7.0	Additional Requirements	5
7.1	Compliance	5
8.0	Policy Implementation/Revision Information.....	5
	Attachment A: Claims-Related Information	6
A.	Claim Type	6
B.	Diagnosis Codes	6
C.	Procedure Code(s).....	6
D.	Modifiers.....	6
E.	Billing Units.....	6
F.	Place of Service	6
G.	Co-payments	6
H.	Reimbursement	6

1.0 Description of the Procedure, Product, or Service

General ophthalmological services include a medical examination and evaluation with the initiation or continuation of a diagnostic and treatment program. General ophthalmologic services include the following definitions for the two levels of service:

- a. **Intermediate ophthalmological services** are an evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis. This service is used for an acute condition or for a chronic condition which is stable.
- b. **Comprehensive ophthalmological services** are a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but do not need to be performed at one session.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

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 recipients 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 clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/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 recipient'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 recipient's right to a free choice of providers.

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

- a. that is unsafe, ineffective, or experimental/investigational.
- b. 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/or 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 will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid Billing Guide: <http://www.ncdhhs.gov/dma/basicmed/>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

3.0 When the Procedure, Product, or Service Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

3.1 General Criteria

Medicaid covers procedures, products, and services related to this policy when they are 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 recipient'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 recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

Medicaid covers general ophthalmological services for new or established recipients (patients) when the level of service includes several routine optometric/ophthalmologic examination techniques that are integrated with the diagnostic evaluation. Refer to **Subsection 5.2** for services that are included in the diagnostic evaluation.

Intermediate level of service includes all of the following:

- a. medical history and observations;
- b. external ocular and adnexal examination; and
- c. other diagnostic procedures as indicated.

Comprehensive level of service includes all of the following:

- a. medical history and observations;
- b. external and ophthalmoscopic examinations
- c. gross visual fields;
- d. basic sensorimotor examination; and
- e. initiation of diagnostic and treatment programs consisting of:
 1. the prescription of medication;
 2. arranging for special ophthalmological diagnostic or treatment services;
 3. consultations;
 4. laboratory procedures; or
 5. radiological services.

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

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily 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

Medicaid does not cover general ophthalmological services when the criteria in **Subsection 3.2** are not met and for any one of the following:

- a. screening, preventative or refractive error services (routine eye exams);

- b. prescription of lenses;
- c. monitoring contact lenses for refractive error correction; or
- d. follow-up of a condition that does not require diagnosis or treatment.

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

5.1 Prior Approval

Prior approval is not required for General Ophthalmological Services.

5.2 Limitations

- a. General ophthalmological services are integrated services in which medical decision making is not separate from the examining techniques used. The following service components are included as part of general ophthalmologic services and must not be billed separately:
 - 1. slit lamp examination;
 - 2. keratometry;
 - 3. ophthalmoscopy;
 - 4. retinoscopy;
 - 5. tonometry; and
 - 6. motor evaluation.
- b. Intermediate and comprehensive ophthalmological services for established recipients (patients) are each limited to 2 times per year.

5.3 Evaluation and Management Services

Refer to **Attachment A (C)** Procedure Codes.

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

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet Medicaid's qualifications for participation;
- b. be currently enrolled with N.C. Medicaid; 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.

7.0 Additional Requirements

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

7.1 Compliance

Providers shall comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 1974

Revision Information:

Date	Section Revised	Change
11/1/11	Throughout	Initial promulgation of current coverage.
11/1/11	Sections 1.0, 3.0, 4.0, and 5.0	Coverage clarified to include medical ophthalmological exams only

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

A. Claim Type

Professional (CMS-1500/837P transaction)

B. Diagnosis Codes

Providers shall bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

CPT Code	Description
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits
92012	Ophthalmological service: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
92014	Ophthalmological service: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program comprehensive, established patient, 1 or more visits

Evaluation and Management (E/M) visit codes (CPT 99201-99215) must not be billed on the same date of service as CPT codes for general ophthalmological services. Evaluation and management codes may be more appropriate if there are many eye problems, if counseling and coordination of care dominates the visit, or if an underlying medical condition is the primary reason for the visit. The ophthalmology codes are more specific to the services and examination rendered during a visit related to the ocular system. The code choice is dependent on the specific services provided to the recipient. The code that most accurately describes the services performed must be the code reported.

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

General ophthalmological services are comprised of integrated services and are billed with one unit per complete examination even if performed over more than one session.

F. Place of Service

Inpatient, outpatient, office

G. Co-payments

Co-payments are required for General Ophthalmological Services.

H. Reimbursement

Providers shall bill their usual and customary charges.