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1.0 Description of the Procedure

Ocular photodynamic therapy (OPT) is a treatment approved by the Food and Drug Administration for age-related macular degeneration (AMD), the most common cause of blindness in the elderly. OPT includes the infusion of a photosensitive drug with a very specific absorption peak. The drug identifies and adheres to diseased tissue. Infusion is followed by targeted irradiation of the diseased tissue. OPT is only covered in conjunction with the drug Verteporfin.

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

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/medbillcaguide.htm>

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

3.0 When the Procedure 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, see **Section 2.0** of this policy.

OPT is covered for AMD with predominately classic subfoveal choroidal neovascularization (CNV) lesions (where the area of classic CNV occupies greater than 50% of the area of the entire lesion) as determined by a fluorescein angiogram at the most recent visit.

4.0 When the Procedure 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, see **Section 2.0** of this policy.

OPT is not covered when the criteria in **Section 3.0** are not met. Other uses of OPT are not covered.

5.0 Restrictions 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, see **Section 2.0** of this policy.

- a. The recipient must have a diagnosis of choroidal neovascularization, exudative or senile macular degeneration.
- b. Recipients may receive up to five treatments per eye per year with a maximum of ten treatments per eye during a 2-year-period.
- c. Separate reimbursement is not allowed for intravenous infusion services. It is included in payment for 67221.
- d. Providers must maintain documentation including fluorescein angiogram and submit to DMA or its fiscal agent upon request.

6.0 Providers Eligible to Bill for the Procedure

Physicians enrolled in the N.C. Medicaid program who perform this procedure may bill for this service.

7.0 Additional Requirements

There are no additional requirements.

8.0 Billing Guidelines

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

8.1 Claim Type

Providers bill professional services on the CMS-1500 claim form.

8.2 Diagnosis Codes that Support Medical Necessity

The only ICD-9-CM diagnosis that supports medical necessity is 362.52.

8.3 Procedure Codes

The CPT and HCPCS codes that are covered under this policy include the following.

a. For the procedure:

67221—*photodynamic therapy (includes intravenous infusion for destruction of localized lesion of choroid)*

67225—*photodynamic therapy, second eye, at single session*

b. For verteporfin (Visudyne):

J3396—*injection, verteporfin, 0.1 mg*

8.4 Reimbursement Rate

Providers must bill their usual and customary charges.

9.0 Policy Implementation/Revision Information

Effective Date: January 1, 2001

Revision Information:

Date	Section Revised	Change
07/01/04	Section 8.3	The CPT and HCPCS codes covered under the policy were revised.
09/01/05	Section 2.0	A special provision related to EPSDT was added.
12/01/05	Section 2.2	The web address for DMA's EDPST policy instructions was added to this section.
12/01/06	Sections 2 through 5	A special provision related to EPSDT was added.
03/01/07	Section 8.3.1	Revised CPT information to reflect current codes
03/01/07	Section 8.3.2	Revised HCPCS information to reflect current code. (J3395 end-dated 12/31/2004. J3396 effective 01/01/2005.)
05/01/07	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age