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1.0 Description of the Procedure

Scanning laser glaucoma tests (SLGT) allow early detection of glaucoma damage to the nerve fiber layer or optic nerve of the eye before there is visual field loss. The SLGT analyzes the nerve fiber layer in the posterior portion of the eye using a confocal scanning laser ophthalmoscope and/or polarimetry. When appropriately used in the management of glaucoma or glaucoma suspect, therapy can be initiated before there is irreversible loss of vision.

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.

3.1 Specific Requirements

SLGT is covered to diagnose early glaucoma and monitor glaucoma treatment.

The primary diagnosis on the claim must support medical necessity.

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.

4.1 General Criteria

SLGT is not covered when the coverage criteria in **Section 3.0** are not met.

4.2 Specific Criteria

Additionally, SLGT is not covered

- a. to further validate a diagnosis that has been confirmed through earlier detection;
- b. for recipients with “advanced damage”; instead, visual fields should be performed;
- c. when performed in the absence of an indication as denoted by one of the diagnoses listed in Section 8.2; or
- d. when performed as screening.

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

5.1 Specific Criteria

- a. Pre-glaucoma recipients or those with “mild damage” may receive one SLGT per eye per year.
- b. Recipients with “moderate damage” may receive up to two SLGTs per eye per year OR one SLGT per eye and one visual fields per year if medically necessary. When both tests are performed, only one of each test is covered per year.
- c. Complete ophthalmology examination describing the indications supporting medical necessity must be documented in the medical record. The documentation must include evidence of the following:
 1. glaucoma-suspect or mild glaucomatous damage:
 - (a) anomalous appearing optic nerve
 - (b) intraocular pressure > 22 mmHg as measured by applanation
 - (c) symmetric or vertically elongated cup enlargement, neural rim intact, cup to disc ration > 4.0
 - (d) focal optic disk notch
 - (e) optic disk hemorrhage or history of optic disk hemorrhage
 - (f) nasal step or small paracentral or arcuate scotoma
 - (g) mild constriction of visual field isopters

2. moderate glaucomatous damage:
 - (a) enlarged optic cup with neural rim remaining but sloped or pale, cup to disc ratio >0.5, but <0.9
 - (b) definite focal notch with thinning of the neural rim
 - (c) definite glaucomatous visual field defect, e.g., arcuate or paracentral scotoma, nasal step, pencil wedge, or constriction of isopters
- d. The following CPT codes are not separately billable with an SLGT: 92225, 92226, 92250, 76512.

6.0 Providers Eligible to Bill for the Procedure

Ophthalmologists and optometrists who perform this service 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 physician services on the CMS-1500 claim form.

8.2 Diagnosis Codes that Support Medical Necessity

Providers must bill the ICD-9-CM diagnosis code to the highest level of specificity that supports medical necessity. The following diagnoses may support medical necessity:

362.85	364.22	364.53	364.73 thru 364.74
364.77	365.00 thru 365.04	365.10 thru 365.15	365.20 thru 365.24
365.31 thru 365.32	365.41 thru 365.44	365.51 thru 365.52	365.59 thru 365.65
365.81 thru 365.82	365.89	365.9	368.40 thru 368.45
377.00 thru 377.04	377.9	743.20 thru 743.22	

8.3 Procedure Codes

The CPT code covered by the N.C. Medicaid program is 92135. When both eyes are tested, bill 92135, 2 units with no modifiers.

8.4 Reimbursement Rate

Providers must bill their usual and customary charges.

9.0 Policy Implementation/Revision Information

Effective Date: January 1, 1999

Revision Information:

Date	Section Revised	Change
9/1/04	5.0	Added medical necessity criteria and limitations relative to visual fields
9/1/05	Section 2.0	A special provision related to EPSDT was added.
12/1/05	Section 2.2	The web address for DMA's EDPST policy instructions was added to this section.
12/1/06	Sections 2 through 5	A special provision related to EPSDT was added.
5/1/07	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age