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1.0 Description of the Procedure

Blepharoplasty/blepharoptosis eyelid repair is reconstructive plastic surgery of the eyelids. The goal of reconstructive surgery is to restore function to the eye structure.

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.

Blepharoplasty/blepharoptosis eyelid repair is covered when the following medical necessity criteria are met:

- a. Ptosis obstructs vision to less than 30 degrees on the vertical meridian, **OR**
- b. The recipient has exposure keratitis.

Eyelid repair for any other medical reason will be considered on a case-by-case basis.

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.

Blepharoplasty/blepharoptosis eyelid repair is not covered when the medical criteria listed in **Section 3.0** are not met. Blepharoplasty/blepharoptosis eyelid repair performed solely for cosmetic reasons is not covered.

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.

Prior approval is required. The following information must be submitted with the prior approval request:

- a. Medical documentation that the eyelid ptosis obstructs vision. Visual field examination results must be submitted, unless the recipient is a child that is unable to test, **OR**
- b. Medical documentation that the recipient has exposure keratitis of the lower eyelid, **OR**
- c. Medical documentation to substantiate medical necessity when this surgery is contemplated. This must indicate the recipient's complaints, which justify the functional reason for the surgery. This may include interference with vision or visual fields; difficulty reading due to eyelid drooping; looking through eyelashes, and/or seeing upper eyelid skin.

6.0 Providers Eligible to Bill for the Procedure

Physicians enrolled in the N.C. Medicaid program who perform this surgery 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 Medicaid managed care programs.

8.1 Claim Type

Providers bill professional physician services on the CMS-1500 (HCFA-1500) claim form.

8.2 Diagnosis Codes that Support Medical Necessity

ICD-9-CM diagnosis codes that may support medical necessity are these:

370.34	374.30	743.61
	374.31	
	374.32	
	374.33	
	374.34	
	374.87	

8.3 Procedure Codes

CPT codes that are covered by the Medicaid program include the following:

15820	67901
15821	67902
15822	67903
15823	67904
	67906
	67908
	67909
	67911

The CPT procedure codes listed above are subject to the multiple surgery guidelines.

8.4 Reimbursement Rate

Providers must bill their usual and customary charges.

9.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 1986

Revision Information:

Date	Section Updated	Change
12/01/03	Section 3.0	This section was reformatted; there was no change to the content.
12/01/03	Section 4.0	The sentence "Blepharoplasty/belpharoptosis eyelid repair is not covered when the medical criteria listed in Section 3.0 are not met." was added to this section.
12/01/03	Section 5.0	The section was renamed from Policy Guidelines to Requirements for and Limitations on Coverage.
12/01/03	Section 6.0	A sentence was added to the section stating that providers must comply with Medicaid guidelines and obtain referrals where appropriate for Managed Care enrollees.
12/01/03	Section 8.3	The statement in Section 8.4 regarding CPT codes that are subject to multiple surgery guidelines was incorporated into Section 8.3.
12/01/03	Section 8.5	Section 8.5 was renumbered to Section 8.4.
9/1/05	Section 2.0	A special provision related to EPSDT was added.

Date	Section Updated	Change
9/1/05	Section 8.0	The sentence stating that providers must comply with Medicaid guidelines and obtain referral where appropriate for Managed Care enrollees was moved from Section 6.0 to Section 8.0.
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 4	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