# Clinical Policy: Special Ophthalmological Services

Reference Number: WNC.CP.257 Coding Implications
Last Review Date: Revision Log

**See** Important Reminder **at the end of this policy for important regulatory and legal information.**

**Note:** When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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## Description[1]

Special ophthalmological services are special evaluations of the visual system, which go beyond services included under general ophthalmological services. Interpretation and report by the physician is an integral part of special ophthalmological services where indicated.

**Special ophthalmological services include the following procedures**:

### I. Computerized Corneal Topography

**A.** 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.

### II. Sensorimotor Examination

**A.** 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.

### III. Fitting of Therapeutic Contact Lens

**A.** A therapeutic contact lens is also known as a bandage contact lens. Fitting a therapeutic contact lens 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.

### IV. Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)

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

**B.** ***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.

**C.** ***Glaucoma*** is the leading cause of blindness. Glaucoma causes many 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.

**D.** Clinical evidence has shown that long-term use of chloroquine (CQ) or hydroxychloroquine (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.

***E. SCODI techniques are:***

1. **Confocal scanning laser ophthalmoscopy (topography)**
   Confocal scanning laser ophthalmoscopy uses stereoscopic videographic digitized images to make quantitative topographic measurements of the optic nerve head and surrounding retina.
2. **Scanning laser polarimetry**
   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 are the same, which are early detection of glaucoma and more sophisticated analysis for ongoing management. These techniques provide more precise methods of observation of the optic nerve head and surrounding retina to more accurately reveal subtle glaucomatous changes over the course of time than visual fields and disc photos.
3. **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.

## V. Optical Coherence Tomography (OCT)

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

## VI. Ophthalmic Biometry

**A.** 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.

## VII. Fundus Photography

**A.** 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.

**VIII. Electrophysiologic Retinal Testing**

**A.** 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.

**B.** 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.

## Policy/Criteria[1]

**I.** WellCare of North Carolina® shall cover Special Ophthalmological Services when the member 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.

**B.** ***Computerized Corneal Topography***

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

1. WellCare of North Carolina® shall cover Computerized corneal topography when it is determined to be medically necessary, the Member 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. Bullous keratometry;
    f. Post-penetrating keratoplasty surgery;
    g. Post-surgical or post-traumatic irregular astigmatism;
    h. Corneal dystrophies;
    i. Complications of transplanted cornea;

j. Post-traumatic corneal scarring; **OR**
k. Pterygium or corneal ectasia that cause visual impairment.

**C.** ***Sensorimotor examination***

Sensorimotor examination requires 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.

1. WellCare of North Carolina® 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.

**D.** ***Fitting of Therapeutic Contact Lens***

1. WellCare of North Carolina® shall cover Fitting of Therapeutic Contact Lens for the treatment of the following conditions:
   a. Bullous keratopathy;
   b. Dry eye Syndrome;
   c. Corneal ulcers;
   d. Corneal abrasions;
   e. Keratitis;
   f. Corneal edema;
   g. Descemetocele;
   h. Corneal ectasis;
   i. Mooren's ulcer;
   j. Anterior corneal dystrophy; **OR**
   k. Neurotrophic keratoconjunctivitis.
2. The initial fitting of gas permeable contact lens is indicated for the management of keratoconus.

**E.** ***Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)***

1. WellCare of North Carolina® shall cover SCODI to:
   a. Diagnose and monitor glaucoma treatment;
   b. Evaluate disorders of the cornea, iris, and ciliary body;
   c. Evaluate and treat optic nerve, retinal, or macular disease;
   d. Monitor for irreversible retinal toxicity in a member on long-term chloroquine or hydroxychloroquine therapy.

**F.** ***Glaucomatous Damage Stages***

Glaucomatous damage can be mild, moderate, or advanced and is defined by **ONE** of the following criteria for each stage:

1. Criteria for **mild** glaucomatous damage (mild stage glaucoma):
   a. Anomalous appearing optic nerve;
   b. Intraocular pressure greater than 22 mmHg as measured by applanation;

c. Symmetric or vertically elongated cup enlargement, neural rim intact, cup to disc ratio greater than 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; **OR**
g. Mild constriction of visual field isopters.

2. Criteria for **moderate** glaucomatous damage (moderate stage glaucoma):
   a. Enlarged optic cup with neural rim remaining but sloped or pale, cup to disc ratio greater than 0.5, but less than 0.9;
   b. Definite focal notch with thinning of the neural rim; **OR**
   c. Definite glaucomatous visual field defect, e.g., arcuate, or paracentral scotoma, nasal step, pencil wedge, or constriction of isopters.
3. Criteria for **advanced** glaucomatous damage (severe stage glaucoma):
   a. Severe generalized constriction of isopters (i.e., Goldmann 14e greater than 10 degrees of fixation);
   b. Absolute visual field defects within 10 degrees of fixation;
   c. Severe generalized reduction of retinal sensitivity;
   d. Loss of central visual acuity, with temporal island remaining;
   e. Diffuse enlargement of optic nerve cup, with cup to disc ratio greater than 0.8; **OR**
   f. Wipe-out of all or a portion of the neural retinal rim.

**G.** ***Ophthalmic Biometry***

1. WellCare of North Carolina® 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 member undergoing cataract surgery. The provider who is performing the cataract surgery shall perform the OCB.

**H.** ***Fundus Photography***

1. WellCare of North Carolina® shall cover Fundus Photography for examination of the retina to document disease process, plan treatment or follow the progress of diabetic retinopathy in a member with diabetes.

**I.** ***Electrophysiologic Retinal Testing***

1. WellCare of North Carolina® shall cover Electrophysiologic Retinal Testing when it is determined to be medically necessary, **AND** the member 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.

**J.** ***Placement of Amniotic Membrane on the Eye:***

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

**II. Specific Criteria Not Covered by WellCare of North Carolina®.**

**A.** WellCare of North Carolina® shall not cover special ophthalmological services when the criteria in **Policy/Criteria I.** are not met.

**B.** ***Computerized Corneal Topography***

1. WellCare of North Carolina® shall not cover Computerized 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 Criteria **I.E.,**;
   c. On the same date of service as keratoplasty; **OR**
   d. Services performed for screening purposes.

**C.** ***Sensorimotor Examination***

1. WellCare of North Carolina® shall not cover a sensorimotor exam if there is not a complaint and the member'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.

**D.** ***Fitting of Therapeutic Contact Lens***

1. WellCare of North Carolina® shall not cover fitting of therapeutic contact lens (is) on the same date of surface as a cornea procedure.

**E.** ***Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)***

1. WellCare of North Carolina® shall not cover SCODI for the following:
   a. To further validate a diagnosis that has been confirmed through earlier detection;
   b. For a member with advanced glaucomatous damage; instead, visual fields must be performed;
   c. When performed as screening; **OR**
   d. SCODI of the optic nerve and SCODI of the retina are not covered on the same date of service.

**F.** ***Ophthalmic Biometry***

1. WellCare of North Carolina® 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.

**G.** ***Fundus Photography***

1. WellCare of North Carolina® 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.

**Background**[1]

**I. Limitations:**

**A. Separate Procedures**

1. 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.

**B. Contact Lens Fitting for Treatment**

1. Fitting of contact lens for treatment of disease and for management of keratoconus is limited to ***four lenses per 365 days***.

**C. Scanning Computerized Ophthalmic Diagnostic Imaging**

1. **Pre-glaucoma member** or a member with mild damage as described in Criteria I.F.1., may **receive** ***one SCODI per 365 days***.
2. A member with **moderate damage** as described in Criteria I.F.2., 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.

**D. Fundus photography**

1. Fundus photography studies are limited to ***one per 365 days*** for detection and interpretation of diabetic retinopathy in a member with a diagnosis of diabetes mellitus.

**Coding Implications**

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

| CPT®* Codes | Description |
|---|---|
| 65778 | Placement of amniotic membrane on the ocular surface; without sutures |
| 92025 | Computerized corneal topography, unilateral or bilateral, with interpretation and report |
| 92060 | Sensorimotor examination with multiple measurements of ocular deviation (e.g., restrictive, or paretic muscle with diplopia) with interpretation and report (separate procedure) |
| 92071 | Fitting of contact lens for treatment of ocular surface disease |

| CPT®* Codes | Description |
|---|---|
| 92072 | Fitting of contact lens for management of keratoconus, initial fitting |
| 92132 | Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral |
| 92133 | Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve |
| 92134 | Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina |
| 92136 | Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation |
| 92250 | Fundus photography with interpretation and report |
| 92265 | Needle oculoelectromyography, 1 or more extraocular muscles, 1 or both eyes, with interpretation and report |
| 92270 | Electro-oculography with interpretation and report |
| 92273 | Electroretinography (ERG), with interpretation and report; full field (i.e., ffERG, flash ERG, Ganzfeld ERG) |
| 92274 | Electroretinography (ERG), with interpretation and report; multifocal (mfERG) |
| 92283 | Color vision examination, extended, e.g., anomaloscope or equivalent |
| 92284 | Dark adaptation examination with interpretation and report |

| Reviews, Revisions, and Approvals | Reviewed Date | Approval Date |
|---|---|---|
| Original approval date | 05/21 | 06/21 |
| Reviewed CPT codes. | 01/22 | 02/22 |
| Annual Review. CPT codes reviewed. | 11/22 | 11/22 |
| NCHC verbiage removed from NC Guidance Verbiage. | 04/23 | 04/23 |
| Annual Review. CPT codes reviewed | 08/23 | 08/23 |
| Annual Review. Changed Criteria II.B.3 and ICD-10-CM code box to include correct link "State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No: 1T-2 Special Ophthalmological Services. Program Specific Clinical Coverage Policies \| NC Medicaid (ncdhhs.gov)." Removed HCPCS code box. | 02/24 | 02/24 |
| Annual Review. Removed "Medicaid and health choice" verbiage from References. | 02/25 | 02/25 |
| Annual Review. Verbiage added throughout with no effect on criteria. Under Descriptions Added Special Ophthalmological services. Criteria I.A. added 'technical procedure criteria.' Criteria I.B.1.e. changed "Suspected irregular astigmatism based on retinoscopic streak or conventional" to "Bullous keratopathy" as an indication for Computerized corneal topography. Criteria I.C.1.d.Added 'hypotropia.' Criteria I.D.1.b. 'Syndrome' to Dry eye syndromes. Criteria I.E., added SCODI criteria. Criteria I.J. added Placement of an amniotic membrane | | |

| Reviews, Revisions, and Approvals | Reviewed Date | Approval Date |
|---|---|---|
| criteria. Criteria II.A. Added "WellCare of North Carolina® shall not cover special ophthalmological services when the criteria in Policy/Criteria I. are not met." Criteria II.B.1.b. updated to reference Criteria I.E. Criteria II.C. Added: Sensorimotor exam criteria. Criteria II.D. added "WellCare of North Carolina® shall not cover fitting of therapeutic contact lens (is) on the same date of surface as a cornea procedure." Criteria II.E. Under SCODI, removed reference to diagnosis codes and link included in State policy IT-2." Background Deleted "Special Ophthalmological Services" Background I.A. added 'Separate Procedures.' Background I.A. Added "and for management of keratoconus." Background I.C.1-2. Updated to reference Criteria in I.F.1-2. Deleted ICD-10 code table. Added CPT 65778 with an effective date of 7.1.2025. Under NC Guidance/Claims related information, updated state web address. | | |

## References

1. State of North Carolina Medicaid Clinical Coverage Policy No: 1T-2 Special Ophthalmological Services. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published January 1, 2026. Accessed January 1, 2026.

## North Carolina Guidance

*Eligibility Requirements*

a. An eligible beneficiary shall be enrolled in 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.

*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.

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.

**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/

*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.

*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).

*Claims-Related Information*
Provider(s) shall comply with the NC Tracks 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 - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I 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.
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.
   *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 - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/meetingsnotices/medicaid-state-plan-public-notices

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.