



REIMBURSEMENT POLICY STATEMENT GEORGIA MEDICAID

Policy Name		Policy Number	Effective Date
Avastin for use in Ophthalmology Billing Guideline		PY-0734	08/01/2019-12/31/2022
Policy Type			
Medical	Administrative	Pharmacy	REIMBURSEMENT

Reimbursement Policy Statement: Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

Table of Contents

Reimbursement Policy Statement.....	1
A. Subject.....	2
B. Background.....	2
C. Definitions	2
D. Policy	2
E. Conditions of Coverage.....	2
F. Related Policies/Rules.....	2
G. Review/Revision History	3
H. References.....	3



A. Subject

Avastin for use in Ophthalmology Billing Guideline

B. Background

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPSC code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

Avastin is a drug used in the treatment of wet age-related macular degeneration, diabetic eye disease and other problems of the retina. Avastin is injected into the eye and helps to slow down disease related vision loss. The use of Avastin to treat eye disease is considered "off-label", which is allowed by the FDA when doctors are well informed regarding the drug and there are studies that prove it's an effective treatment option. There is no cure for macular degeneration, treatment is aimed at slowing down the progression of the disease and preventing vision loss.

C. Definitions

- Macular Degeneration – a progressive vision impairment resulting from deterioration of the central part of the retina, known as macula.

D. Policy

- I. CareSource does not require a Prior Authorization for the use of Avastin in Ophthalmology, when billed with the following codes:
 - A. J3490 will be reimbursed as follows, when billed with NDC 50242-0061-01 or 50242-0060-01:
 1. For units 1 to 1.25, reimbursement is up to \$70.00 per eye, per calendar month.
 2. For units 2 to 2.50, reimbursement is up to \$140.00 for both eyes, per calendar month.
 - B. J3590 will be reimbursed as follows, when billed with NDC 50242-0061-01 or 50242-0060-01:
 1. For units 1 to 1.25, reimbursement is up to \$70.00 per eye, per calendar month.
 2. For units 2 to 2.50, reimbursement is up to \$140.00 for both eyes, per calendar month.

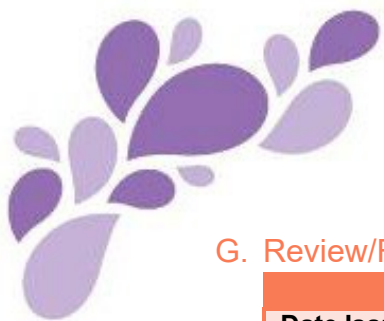
E. Conditions of Coverage

HCPSC J3490, J3590

NDC 50242-0061-01 or 50242-0060-01:

F. Related Policies/Rules

N/A



G. Review/Revision History

DATE		ACTION
Date Issued	06/01/2019	New policy
Date Revised		
Date Effective	08/01/2019	
Date Archived	12/31/2022	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. Boyd, K. (2018, May 22). What Is Avastin? Retrieved October 29, 2018, from <https://www.aao.org/eye-health/drugs/avastin>
2. "Off-Label" and Investigational Use Of Marketed Drugs, Biologics, and Medical Devices - Information Sheet. (2018, July 12). Retrieved October 29, 2018, from <https://www.fda.gov/regulatoryinformation/guidances/ucm126486.htm>

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.

GA-P-0669

DCH Approved: 05/08/2019