



Medicaid Information Bulletin

January 2006



Web address: <http://health.utah.gov/medicaid>

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On-Line (Internet) Address for Medicaid:

<http://health.utah.gov/medicaid>

Please make sure that any Medicaid bookmarks that you have are the new Medicaid Internet address shown above. The old web site has been discontinued.

World Wide Web: <http://health.utah.gov/medicaid>
Medicaid Information

- Salt Lake City area, call 538-6155.
- In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free 1-800-662-9651.
- From other states, call 1-801-538-6155.

(Formerly <http://www.health.state.ut.us/medicaid>)

Requesting a Medicaid publication?

Send a Publication Request Form.

- by FAX: 1-801-536-0476
- by mail to: Division Of Health Care Financing
Box 143106, Salt Lake City UT 84114-3106

06 - 13 Electronic Funds Transfer (EFT) Is Now Available

Electronic Funds Transfer (EFT) is now available for enrolled Medicaid providers. The EFT form is on the Medicaid web site, at <http://health.utah.gov/medicaid/> under Enroll as a Utah Medicaid Provider. If you have any questions contact Provider Enrollment at (801) 538-6155 or toll free (800) 662-9651, press option 3 then 4.

06 - 14 National Provider Identifier

Reminder--Health care providers are required by law to apply for a National Provider Identifier (NPI). To apply online, visit: <https://nppes.cms.hhs.gov> or call 1-800-465-3203 to request a paper application. Visit <http://www.cms.hhs.gov/hipaa/hipaa2> for the latest information regarding the NPI.

The NPI will not be mandated as the sole identifier to be used in standard transactions with most health plans until May 2007 (May 2008 for small health plans). Health care providers should not begin using the NPI exclusively in standard transactions prior to the compliance dates.

Effective January 1, 2006, Medicaid will accept and in fact encourages health care providers to begin submitting an NPI on standard transactions with the Medicaid provider number.

When you receive your NPI number, please fax (801)536-0471 or mail that information along with Provider Name and Medicaid Provider Number to Medicaid Provider Enrollment.

Medicaid will keep you informed of our progress with implementing the NPI.

06 - 15 Interpretive Services

The Division of Health Care Financing offers interpretive services for Medicaid, CHIP and PCN clients to assist in making appointments and during visits for qualified procedures. Clients are entitled to have an interpreter to help them understand procedures, answer questions and assist them with any concerns they may have regarding their medical treatments.

The service is offered for those eligible clients who are not enrolled in a Managed Care Plan (MCP), such as an HMO, MCO, etc., or have a need for carve out services including, dental, pharmacy and chiropractic care. Clients who are members of a MCP must use the interpretive services offered by the MCP, except for the carve out provision described above. Mental health services are not covered by this policy.

Change

Effective September 1, 2005, Medicaid awarded contracts to several new interpretive services vendors. Providers who wish to use Medicaid telephone interpretive services or have a need for on-site interpreting should call one of the vendors listed in the Medicaid Provider Manual. Most of the vendors have 24 hour service, 365 days a year and have toll-free numbers (if necessary) for your convenience. Please see your Medicaid Provider manual for details and instructions for all agencies we have contracted with. To ensure payment of interpretive services by Medicaid you may want to check eligibility of the client prior to contacting the interpreting vendor. You may call our Medicaid Information line at (801) 538- 6155 during regular business hours to verify eligibility, or in an emergency you may try calling the Medicaid Hotline at 1-800- 662-9651. For further information you may contact Diana Webb, (801) 538-6443 or Randa Pickle, (801) 538-6417 at the Utah Department of Health.

Sign Language interpreters are available for eligible Medicaid clients who need assistance. Providers should make arrangements at least 24 hours in advance of appointments by contacting the Medicaid Information line during regular business hours. Providers may contact InterWest Interpreting at (801) 224-7683 or Linguistica International at (801) 908-5744 directly to arrange services.

06 - 16 EDI with UHIN and Utah Medicaid

The Utah Health Information Network (UHIN) is a private, not-for-profit cooperative serving the electronic needs of all payers in Utah. Membership in UHIN grants the member free electronic billing software, training, and unlimited access to all electronic features of UHIN. It allows the biller to track the progress of claim submissions, check claim status, and verify client eligibility. In addition, the biller may pull an electronic remittance advice without the delay of the postal service. All electronic data interchange (EDI) submissions destined for Utah Medicaid must pass through UHIN. For more information on becoming a UHIN member, go to www.uhin.com.

After the provider has received their Trading Partner Number (TPN) from UHIN, they need to fill out a Medicaid Online EDI Enrollment form by going to: www.health.utah.gov/hipaa/enroll.htm and clicking on the "E Form" link. Enter your 12-digit Medicaid contract (provider) number. Verify that it is your provider record by clicking "yes." If the form is blank (except for the provider name and address) you are not enrolled and the form must be filled out. Click on the submit button at the bottom of the form. If it is already filled out, you are enrolled. You may make any necessary changes to your enrollment. Remember to click on the submit button to record any changes.

Five business days after the EDI Enrollment Form (E Form) is successfully submitted the provider can transmit either claims, eligibility, or claim status requests. Since Utah Medicaid has no test system, all claim data is treated as production data. □

06 - 17 Health Common Procedure Coding System - 2006 Revisions

Effective for dates of services on or after January 1, 2006, Medicaid begins accepting the 2006 version of the Health Common Procedure Coding System (HCPCS). HCPCS codes include the 2006 Physicians' Current Procedural Terminology (CPT) codes. You must continue to obtain prior authorization required for procedures on the 2005 list, even though new codes may be added for the same or similar procedures, or codes may be changed on the 2006 list.

For services on and after January 1, 2006, providers must use the 2006 HCPCS codes. 2005 HCPCS codes discontinued in 2006 may only be used for dates of service prior to January 1, 2006. If you have a question concerning billing the 2006 HCPCS codes, please contact Medicaid Information. □

06 - 18 Medicare Part D and Medicaid Prescription Drug Coverage Changes

Beginning January 1, 2006, Medicaid recipients with dual coverage of both Medicaid and Medicare will no longer receive a drug benefit through Medicaid. They will receive the majority of their drugs through the new Medicare Part D. They will be automatically enrolled in Part D by CMS and will receive the low income subsidy. Medicaid will continue, as in the recent past, to cover certain over-the-counter drugs, certain cough and cold preparations, barbiturates, and benzodiazepine drugs. These can be billed through the Medicaid point of sale system using the same limitations and criteria as in the past. Prescription Drug Plans (PDP) will be established that will provide prescription drug benefits to Medicare clients in Utah. Plans will vary as to coverage. These Dual Eligible (DE) individuals will need to select the plan that best suits their needs. Because Medicare Part D will operate under a drug formulary, the dual eligibles clients may need help to select the pharmacy drug plan (PDP) which will best cover their prescription drug needs and they may need help to transition to alternate drugs which are covered under their PDP. These dual eligible clients have more flexibility and can change their PDP at any time, which is different for regular Medicare clients, who are only able to change the PDP once per year at the time of enrollment. Your aid in helping those who have dual coverage to select the best PDP for their drug needs and modifying their drug regimen where necessary to obtain the correct drugs is essential and appreciated. Dual eligibles will have small copays (\$1-\$3), but no deductible, no premium, and no coverage gaps with their new Part D pharmacy coverage. They received a letter in October of 2005 from Medicare which informed them of the PDP to which they have been assigned. In mid-November, they received an official notice from Medicaid telling them of the of the changes in their Medicaid pharmacy coverage which begins on January 1, 2006. □

06 - 19 CPT Codes Non-Covered for Assistant Surgeon

Codes added to the Non-Covered Assistant Surgeon List include:

11005	11008	15040	15110	15111	15115	15116	15130	15131	15135	15136	15300	15301	15320
15321	15420	15421	19296	19297	19298	20982	21085	31620	31636	31637	31638	32019	36598

36818 37184 37185 37186 37187 37188 37718 37722 45391 45392 45990 50382 50384 50387
 50389 52402 52450 58356 66711 □

06 - 20 Coding Updates, Physician Services

This article concerns codes newly added to coverage; Codes removed from prior authorization; codes requiring prior authorization; codes requiring manual review prior to the procedure; codes not covered; post operative days; modifier CR, Catastrophe/Disaster Related; and discontinued CPT codes

Covered Codes: The descriptor has been abbreviated for publication purposes.

- Q0081 Infusion Therapy Visit in Home Health, Not Covered for Chemotherapy. Note: the Code Specifically Excludes Chemotherapy.
- 01965 Anesthesia for Incomplete or Missed Abortion Procedures
- 00529 Anesthesia for Closed Chest Procedures; Mediastinoscopy and Diagnostic Thoracoscopy Utilizing One Lung Ventilation
- 15040 Harvest of Skin for Tissue Cultured Skin Autograft, 100 Sq Cm or less
- 15110 Epidermal Autograft, Trunk, Arms, Legs; First 100 Sq Cm or Less, or One Percent of Body Area ...
- 15111 Epidermal Autograft, Trunk, Arms, Legs; Each Additional 100 Sq Cm, or Each Additional ...
- 15115 Epidermal Autograft, Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits, Genitalia, Hands, Feet . .
- 15116 Epidermal Autograft, Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits, Genitalia, Hands, Feet. . .
- 15130 Dermal Autograft, Trunk, Arms, Legs; First 100 Sq Cm or Less, or One Percent of Body Area . . .
- 15131 Dermal Autograft, Trunk, Arms, Legs; Each Additional 100 Sq Cm, or Each Additional One % . . .
- 15135 Dermal Autograft, Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits, Genitalia, Hands, Feet, and ...
- 15136 Dermal Autograft, Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits, Genitalia, Hands, Feet, and ...
- 15300 Allograft Skin for Temporary Wound Closure, Trunk, Arms, Legs; First 100 Sq Cm or Less, or . . .
- 15301 Allograft Skin for Temporary Wound Closure, Trunk, Arms, Legs; Each Additional 100 Sq Cm . .
- 15320 Allograft Skin for Temporary Wound Closure, Face, Scalp, Eyelids, Mouth, Neck, ears, Orbit . .
- 15321 Allograft Skin for Temporary Wound Closure, Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits,
- 15420 Xenograft Skin (Dermal), for Temporary Wound Closure, Face, Scalp, Eyelids, Mouth, Neck, . . .
- 15421 Xenograft Skin (Dermal), for Temporary Wound Closure, Face, Scalp, Eyelids, Mouth, Neck, . . .
- 21085 Impression and Custom Preparation; Oral Splint Limited to Children Age 20 and Younger with Congenital Anomaly
- 22010 Incision and Drainage, Open, of Deep Abscess (Subfascial), Posterior Spine; Cervical, Thoracic ...
- 22015 Incision and Drainage, Open, of Deep Abscess (Subfascial), Posterior Spine; Lumbar, Sacral. . .
- 32503 Resection of Apical Lung Tumor (Eg, Pancoast Tumor), Including Chest Wall Resection, Rib(s) ...
- 32504 Resection of Apical Lung Tumor (Eg, Pancoast Tumor), Including Chest Wall Resection, Rib(s) ...
- 33507 Repair of Anomalous (Eg, Intramural) Aortic Origin of Coronary Artery by Unroofing or ...
- 33548 Surgical Ventricular Restoration Procedure, Includes Prosthetic Patch, When Performed ...
- 33768 Anastomosis, Cavopulmonary, Second Superior Vena Cava . . .
- 33925 Repair of Pulmonary Artery Arborization Anomalies by Unifocalization; Without . . .
- 33926 Repair of Pulmonary Artery Arborization Anomalies by Unifocalization; with . . .
- 36598 Contrast Injection(s) for Radiologic Evaluation of Existing Central Venous Access Device. . .
- 37184 Primary Percutaneous Transluminal Mechanical Thrombectomy, Noncoronary, Arterial . . .
- 37185 Primary Percutaneous Transluminal Mechanical Thrombectomy, Noncoronary, Arterial . . .
- 37186 Secondary Percutaneous Transluminal Thrombectomy (Eg, Nonprimary Mechanical, Snare . . .
- 37187 Percutaneous Transluminal Mechanical Thrombectomy, Vein(s), Including Intra . . .
- 37188 Percutaneous Transluminal Mechanical Thrombectomy, Vein(s), Including Intra . . .
- 37718 Ligation, Division, and Stripping, Short Saphenous Vein
- 37722 Ligation, Division, and Stripping, Long (Greater) Saphenous Veins from Saphenofemoral Junction
- 44180 Laparoscopy, Surgical, Enterolysis (Freeing of Intestinal Adhesion) (Separate Procedure)
- 44186 Laparoscopy, Surgical; Jejunostomy (Eg, for Decompression or Feeding)
- 44187 Laparoscopy, Surgical; Ileostomy or Jejunostomy, Non-tube
- 44188 Laparoscopy, Surgical, Colostomy or Skin Level Cecostomy
- 44213 Laparoscopy, Surgical, Mobilization (Take-down) of Splenic Flexure Performed in . . .
- 44227 Laparoscopy, Surgical, Closure of Enterostomy, Large or Small Intestine, with Resection . . .
- 45395 Laparoscopy, Surgical; Proctectomy, Complete, Combined Abdominoperineal, with Colostomy
- 45397 Laparoscopy, Surgical; Proctectomy, Combined Abdominoperineal Pull-through . . .
- 45400 Laparoscopy, Surgical; Proctopexy (For Prolapse)
- 45402 Laparoscopy, Surgical; Proctopexy (For Prolapse), with Sigmoid Resection

45990 Anorectal Exam, Surgical, Requiring Anesthesia (General, Spinal, or Epidural), Diagnostic
 46710 Repair of Ileoanal Pouch Fistula/sinus (Eg, Perineal or Vaginal), Pouch . . .
 46712 Repair of Ileoanal Pouch Fistula/sinus (Eg, Perineal or Vaginal), Pouch Advancement . . .
 50250 Ablation, Open, One or More Renal Mass Lesion(s), Cryosurgical, Including Intra . . .
 50382 Removal (Via Snare/capture) and Replacement of Internally Dwelling Ureteral Stent . . .
 50384 Removal (Via Snare/capture) of Internally Dwelling Ureteral Stent via Percutaneous . . .
 50387 Removal and Replacement of Externally Accessible Transnephric Ureteral Stent . . .
 50389 Removal of Nephrostomy Tube, Requiring Fluoroscopic Guidance (Eg, with Concurrent . . .
 77421 Stereoscopic X-ray Guidance for Localization of Target Volume for the Delivery
 80195 Sirolimus
 82271 Blood, Occult, by Peroxidase Activity (Eg, Guaiac), Qualitative; Other Sources
 83631 Lactoferrin, Fecal; Quantitative
 83695 Lipoprotein (A)
 83900 Molecular Diagnostics; Amplification of Patient Nucleic Acid, Multiplex, First Two Nucleic . .
 83908 Molecular Diagnostics; Signal Amplification of Patient Nucleic Acid, Each Nucleic Acid . . .
 83909 Molecular Diagnostics; Separation and Identification by High Resolution Technique . . .
 83914 Mutation Identification by Enzymatic Ligation or Primer Extension, Single Segment, Each . . .
 86200 Cyclic Citrullinated Peptide (Ccp), Antibody
 86355 B Cells, Total Count
 86357 Natural Killer (Nk) Cells, Total Count
 86367 Stem Cells (Ie, Cd34), Total Count
 86480 Tuberculosis Test, Cell Mediated Immunity Measurement of Gamma Interferon Antigen Response
 86923 Compatibility Test Each Unit; Electronic
 86960 Volume Reduction of Blood or Blood Product (Eg, Red Blood Cells or Platelets), Each Unit
 87209 Smear, Primary Source with Interpretation; Complex Special Stain (Eg, Trichrome, Iron . . .
 87807 Respiratory Syncytial Virus (Used with Qw Modifier for Rapid Screen)
 87900 Infectious Agent Drug Susceptibility Phenotype Prediction Using Regularly Updated . . .
 88333 Pathology Consultation During Surgery; Cytologic Examination (Eg, Touch Prep, Squash . . .
 88334 Pathology Consultation During Surgery; Cytologic Examination (Eg, Touch Prep, Squash . . .
 89049 Caffeine Halothane Contracture Test (Chct) for Malignant Hyperthermia . . .
 90680 Rotavirus Vaccine, Pentavalent, 3 Dose Schedule, Live, for Oral Use
 90713 Poliovirus Vaccine, Inactivated, (Ipv), for Subcutaneous or Intramuscular Use.
 90714 Tetanus and Diphtheria Toxoids (Td) Absorbed, Preservative Free, for Use in Individuals 7 Years or Older . . .
 90715 Tetanus, Diphtheria Toxoids and Acellular Pertussis Vaccine (Tdapp) for Use in Individuals 7 Years or Older. . .
 90760 Intravenous Infusion, Hydration; Initial, up to One Hour
 90761 . . . Each Additional Hour up to 8 Hours (Time must Be Greater than 30 Minutes Beyond 1 Hour Increments)
 90765 Intravenous Infusion, for Therapy, Prophylaxis, or Diagnosis (Specify Substance or Drug); Initial, up to One Hour
 90766 . . . Each Additional Hour up to 8 Hours
 90767 . . . Additional Sequential Infusion, up to One Hour
 90772 Therapeutic, Prophylactic or Diagnostic Injection (Specify Substance); Subcutaneous or Intramuscular
 90773 . . . Intra-arterial
 90774 . . . Intravenous Push, Single or Initial Substance/drug
 90775 . . . Each Additional Sequential Intravenous Push of a New Substance/drug
 90868 . . . Concurrent Infusion
 95865 Needle Electromyography; Larynx
 95866 Needle Electromyography; Hemidiaphragm
 95874 Needle Electromyography for Guidance in Conjunction with Chemodenervation . . .
 95991 Refilling and Maintenance of Implantable Pump or Reservoir for Drug Delivery, Spinal or Brain; . . .
 96401 Chemotherapy Administration, Subcutaneous or Intramuscular; Non-hormonal Anti-neoplastic
 96402 . . . Hormonal Antineoplastic
 96409 . . . Intravenous, Push Technique, Single or Initial Substance/drug
 96411 . . . Intravenous, Push Technique, Each Additional Substance/drug
 96413 Chemotherapy Administration, Intravenous Infusion Technique; up to One Hour Single or Initial Substance/drug
 96415 . . . Each Additional Hour, One to 8 Hours
 96420 Chemotherapy Administration, Intra-arterial; Push Technique
 96422 . . . Infusion Technique, up to One Hour
 96423 . . . Infusion Technique, Each Additional Hour up to 8 Hours
 96425 . . . Infusion Technique, Initiation of Prolonged Infusion (More than 8 Hours), Requiring Use of a Portable . . .
 96640 Chemotherapy Administration into Pleural Cavity, Requiring and Including Thoracentesis
 96445 Chemotherapy Administration into Peritoneal Cavity, Requiring and Including Peritoneocentesis
 96450 Chemotherapy Administration, into Cns (I.e. Intrathecal) Requiring and Including Spinal Puncture
 96521 Refilling and Maintenance of Portable Pump (Replaces Code 96520 Which Is Deleted)

96522 Refilling and Maintenance of Implantable Pump or Reservoir for Drug Delivery, Systemic (I.e. Intravenous . . .
 96523 Irrigation of Implanted Venous Access Device for Drug Delivery Systems
 96542 Chemotherapy Injection, Subarachnoid or Intraventricular via Subcutaneous Reservoir, Single or Multiple Agents
 99148 Moderate Sedation Services (Other than Those Services Described by Codes 00100-01999), . . .
 99149 Moderate Sedation Services (Other than Those Services Described by Codes 00100-01999), . . .
 99150 Moderate Sedation Services (Other than Those Services Described by Codes 00100-01999), . . .
 99300 Subsequent Intensive Care, per Day, for the Evaluation and Management of the . . .
 99304 Initial Nursing Facility Care, per Day, for the Evaluation and Management of a Patient . . .
 99305 Initial Nursing Facility Care, per Day, for the Evaluation and Management of a Patient . . .
 99306 Initial Nursing Facility Care, per Day, for the Evaluation and Management of a Patient . . .
 99307 Subsequent Nursing Facility Care, per Day, for the Evaluation and Management of a . . .
 99308 Subsequent Nursing Facility Care, per Day, for the Evaluation and Management of a . . .
 99309 Subsequent Nursing Facility Care, per Day, for the Evaluation and Management of a . . .
 99310 Subsequent Nursing Facility Care, per Day, for the Evaluation and Management of a . . .
 99324 Domiciliary or Rest Home Visit for the Evaluation and Management of a New Patient . . .
 99325 Domiciliary or Rest Home Visit for the Evaluation and Management of a New Patient . . .
 99326 Domiciliary or Rest Home Visit for the Evaluation and Management of a New Patient . . .
 99327 Domiciliary or Rest Home Visit for the Evaluation and Management of a New Patient, . . .
 99328 Domiciliary or Rest Home Visit for the Evaluation and Management of a New Patient, . . .
 99334 Domiciliary or Rest Home Visit for the Evaluation and Management of an Established . . .
 99335 Domiciliary or Rest Home Visit for the Evaluation and Management of an Established . . .
 99336 Domiciliary or Rest Home Visit for the Evaluation and Management of an Established . . .
 99337 Domiciliary or Rest Home Visit for the Evaluation and Management of an Established . . .

Codes removed from Prior Authorization

19357 Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
 Limited to reconstructive surgery related to breast cancer
 19361 Breast reconstruction with latissimus dorsi flap, with or without prosthetic implant
 Limited to reconstructive surgery related to breast cancer
 19364 Breast reconstruction with free flap
 Limited to reconstructive surgery related to breast cancer
 19366 Breast reconstruction with other technique Limited to reconstructive surgery related to breast cancer
 19367 Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, . . .
 Limited to reconstructive surgery related to breast cancer
 19368 . . . with microvascular anastomosis (supercharging)
 Limited to reconstructive surgery related to breast cancer
 19369 Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, . . .
 Limited to reconstructive surgery related to breast cancer
 38206 Blood Derived cell harvest per collection; autologous
 58555 Diagnostic hysteroscopy

Codes Requiring Prior Authorization

01966 Anesthesia for Induced Abortion Procedures (Requires Sterilization Consent & Prior Authorization)
 00840 Intraoperative Lower Abdominal Laparoscopic Procedures
 Prior Approval Required for Any Procedure Related to Sterilization (Code Inadvertently Left off CPT List)
 96116 Neurobehavioral Status Exam (Clinical Assessment of Thinking, Reasoning and Judgment . . .
 Prior Approval: Telephone . Refer to the Pain Management program in the provider manual
 88271 Molecular Cytogenetics; DNA Probe, Each
 88299 Unlisted Cytogenetic Study
 88384 Array-based Evaluation of Multiple Molecular Probes; 11 Through 50 Probes
 88385 Array-based Evaluation of Multiple Molecular Probes; 51 Through 250 Probes
 88386 Array-based Evaluation of Multiple Molecular Probes; 251 Through 500 Probes

Codes Requiring Manual Review

45499 Unlisted Laparoscopy Procedure, Rectum
 51999 Unlisted Laparoscopy Procedure, Bladder
 96549 Unlisted Chemotherapy Procedure

Codes Non-covered

15150	Tissue Cultured Epidermal Autograft, Trunk, Arms, Legs; First 25 Sq Cm or less
15151	Tissue Cultured Epidermal Autograft, Trunk, Arms, Legs; Additional 1 Sq Cm to 75 Sq Cm . . .
15152	Tissue Cultured Epidermal Autograft, Trunk, Arms, Legs; Each Additional 100 Sq Cm, or . . .
15155	Tissue Cultured Epidermal Autograft, Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits, . . .
15156	Tissue Cultured Epidermal Autograft, Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits, . . .
15157	Tissue Cultured Epidermal Autograft, Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits, . . .
15170	Acellular Dermal Replacement, Trunk, Arms, Legs; First 100 Sq Cm or Less, or One Percent
15171	Acellular Dermal Replacement, Trunk, Arms, Legs; Each Additional 100 Sq Cm, or Each . . .
15175	Acellular Dermal Replacement, Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits, Genitalia . . .
15176	Acellular Dermal Replacement, Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits, Genitalia, . . .
15330	Acellular Dermal Allograft, Trunk, Arms, Legs; First 100 Sq Cm or Less, or One Percent of . . .
15331	Acellular Dermal Allograft, Trunk, Arms, Legs; Each Additional 100 Sq Cm, or Each Add . . .
15335	Acellular Dermal Allograft, Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits, Genitalia, . . .
15336	Acellular Dermal Allograft, Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits, Genitalia, . . .
15340	Tissue Cultured Allogeneic Skin Substitute; First 25 Sq Cm or less
15341	Tissue Cultured Allogeneic Skin Substitute; Each Additional 25 Sq Cm
15360	Tissue Cultured Allogeneic Dermal Substitute; Trunk, Arms, Legs; First 100 Sq Cm or Less, or . . .
15361	Tissue Cultured Allogeneic Dermal Substitute; Each Additional 100 Sq Cm, or Each Add . . .
15365	Tissue Cultured Allogeneic Dermal Substitute, Face, Scalp, Eyelids, Mouth, Neck, Ears, . . .
15366	Tissue Cultured Allogeneic Dermal Substitute, Face, Scalp, Eyelids, Mouth, Neck, Ears, . . .
15430	Acellular Xenograft Implant; First 100 Sq Cm or Less, or One Percent of Body Area of Infant . . .
15431	Acellular Xenograft Implant; Each Additional 100 Sq Cm, or Each Additional One Percent . . .
22523	Percutaneous Vertebral Augmentation, Including Cavity Creation (Fracture Reduction . . .
22524	Percutaneous Vertebral Augmentation, Including Cavity Creation (Fracture Reduction . . .
22525	Percutaneous Vertebral Augmentation, Including Cavity Creation (Fracture Reduction . . .
28890	Extracorporeal Shock Wave, High Energy, Performed by a Physician, Requiring Anesthesia . . .
33880	Endovascular Repair of Descending Thoracic Aorta (Eg, Aneurysm, Pseudoaneurysm, . . .
33881	Endovascular Repair of Descending Thoracic Aorta (Eg, Aneurysm, Pseudoaneurysm, . . .
33883	Placement of Proximal Extension Prosthesis for Endovascular Repair of Descending . . .
33884	Placement of Proximal Extension Prosthesis for Endovascular Repair of Descending . . .
33886	Placement of Distal Extension Prosthesis(s) Delayed after Endovascular Repair of Descend . . .
33889	Open Subclavian to Carotid Artery Transposition Performed in Conjunction with . . .
33891	Bypass Graft, with Other than Vein, Transcervical Retropharyngeal Carotid-carotid, . . .
43770	Laparoscopy, Surgical, Gastric Restrictive Procedure; Placement of Adjustable Gastric ...
43771	Laparoscopy, Surgical, Gastric Restrictive Procedure; Revision of Adjustable Gastric . . .
43772	Laparoscopy, Surgical, Gastric Restrictive Procedure; Removal of Adjustable Gastric . . .
43773	Laparoscopy, Surgical, Gastric Restrictive Procedure; Removal and Replacement of . . .
43774	Laparoscopy, Surgical, Gastric Restrictive Procedure; Removal of Adjustable Gastric . . .
43886	Gastric Restrictive Procedure, Open; Revision of Subcutaneous Port Component Only
43887	Gastric Restrictive Procedure, Open; Removal of Subcutaneous Port Component Only
43888	Gastric Restrictive Procedure, Open; Removal and Replacement of Subcutaneous Port . . .
46505	Chemodenervation of Internal Anal Sphincter
50592	Ablation, One or More Renal Tumor(s), Percutaneous, Unilateral, Radiofrequency
57295	Revision (Including Removal) of Prosthetic Vaginal Graft, Vaginal Approach
58110	Endometrial Sampling (Biopsy) Performed in Conjunction with Colposcopy . . .
61630	Balloon Angioplasty, Intracranial (Eg, Atherosclerotic Stenosis), Percutaneous
61635	Transcatheter Placement of Intravascular Stent(s), Intracranial (Eg, Atherosclerotic . . .
61640	Balloon Dilatation of Intracranial Vasospasm, Percutaneous; Initial Vessel
61641	Balloon Dilatation of Intracranial Vasospasm, Percutaneous; Each Additional Vessel . . .
64650	Chemodenervation of Eccrine Glands; Both Axillae
64653	Chemodenervation of Eccrine Glands; Other Area(s) (Eg, Scalp, Face, Neck), per Day
75956	Endovascular Repair of Descending Thoracic Aorta (Eg, Aneurysm, Pseudoaneurysm, . . .
75957	Endovascular Repair of Descending Thoracic Aorta (Eg, Aneurysm, Pseudoaneurysm, . . .
75958	Placement of Proximal Extension Prosthesis for Endovascular Repair of Descending . . .
75959	Placement of Distal Extension Prosthesis(s) (Delayed) after Endovascular Repair of . . .
76376	3d Rendering with Interpretation and Reporting of Computed Tomography, Magnetic . . .
76377	3d Rendering with Interpretation and Reporting of Computed Tomography, Magnetic . . .
77422	High Energy Neutron Radiation Treatment Delivery; Single Treatment Area Using a Single . . .
77423	High Energy Neutron Radiation Treatment Delivery; 1 or More Isocenter(s) with Coplanar . . .
82272	Blood, Occult, by Peroxidase Activity (Eg, Guaiac), Qualitative, Feces, Single Specimen . . .

83037 Hemoglobin; Glycosylated (A1c) by Device Cleared by Fda for Home Use
 83700 Lipoprotein, Blood; Electrophoretic Separation and Quantitation
 83701 Lipoprotein, Blood; High Resolution Fractionation and Quantitation of Lipoproteins Including
 83704 Lipoprotein, Blood; Quantitation of Lipoprotein Particle Numbers and Lipoprotein Particle
 83907 Molecular Diagnostics; Lysis of Cells Prior to Nucleic Acid Extraction (Eg, Stool Specimens)
 90649 Human Papilloma Virus (Hpv) Vaccine, Types 6, 11, 16, 18 (Quadrivalent), 3 Dose Schedule, for Im Use
 90736 Zoster (Shingles) Vaccine, Live, for Subcutaneous Injection
 90779 Unlisted Therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection . . .
 91022 Duodenal Motility (Manometric) Study
 92626 Evaluation of Auditory Rehabilitation Status; First Hour
 92627 Evaluation of Auditory Rehabilitation Status; Each Additional 15 Minutes . . .
 92630 Auditory Rehabilitation; Pre-lingual Hearing Loss
 92633 Auditory Rehabilitation; Post-lingual Hearing Loss
 95251 Ambulatory Continuous Glucose Monitoring of Interstitial Tissue Fluid via . . .
 95873 Electrical Stimulation for Guidance in Conjunction with Chemodenervation . . .
 96116 Neurobehavioral Status Exam (Clinical Assessment of Thinking, Reasoning . . .
 96102 Psychological Testing (Includes Psychodiagnostic Assessment of Emotionality, . . .
 96103 Psychological Testing (Includes Psychodiagnostic Assessment of Emotionality, . . .
 96118 Neuropsychological Testing (Eg, Halstead-reitan Neuropsychological Battery, Wechsler
 96119 Neuropsychological Testing (Eg, Halstead-reitan Neuropsychological Battery, Wechsler . . .
 96120 Neuropsychological Testing (Eg, Wisconsin Card Sorting Test), Administered by a Computer . .
 96416 . . . Initiation of Prolonged Chemotherapy Administration (More than 8 Hours) Requiring Use of a Portable . . .
 96417 . . . Each Additional Sequential Infusion (Different Substance/drug) up to One Hour.
 97760 Orthotic(s) Management and Training (Including Assessment and Fitting When Not . . .
 97761 Prosthetic Training, Upper And/or Lower Extremity(s), Each 15 Minutes
 97762 Checkout for Orthotic/prosthetic Use, Established Patient, Each 15 Minutes
 98960 Education and Training for Patient Self-management by a Qualified, Nonphysician . . .
 98961 Education and Training for Patient Self-management by a Qualified, Nonphysician . . .
 98962 Education and Training for Patient Self-management by a Qualified, Nonphysician . . .
 99051 Service(s) Provided in the Office During Regularly Scheduled Evening, Weekend, or Holiday
 99053 Service(s) Provided Between 10:00 Pm and 8:00 Am at 24-hour Facility, in Addition to Basic Service
 99060 Service(s) Provided on an Emergency Basis, out of the Office, . . .
 99143 Moderate Sedation Services (Other than Those Services Described by Codes 00100-01999) . . .
 99144 Moderate Sedation Services (Other than Those Services Described by Codes 00100-01999) . . .
 99145 Moderate Sedation Services (Other than Those Services Described by Codes 00100-01999) . . .
 99318 Evaluation and Management of a Patient Involving an Annual Nursing Facility Assessment
 99339 Individual Physician Supervision of a Patient (Patient Not Present) in Home, Domiciliary or . . .
 99340 Individual Physician Supervision of a Patient (Patient Not Present) in Home, Domiciliary or . . .

Post Operative-Days

Zero post op days

21085 36598

10 post op days

37184 37185 37186 37187 37188 37718 37722 45990 50382 50384 50387 50389

42 post op days

15040 15110 15111 15115 15116 15130 15131 15135 15136 15300 15301 15320 15321
 15420 15421 22010 22015 32503 32504 33507 33548 33768 33925 33926 44180 44186
 44187 44188 44213 44227 45395 45397 45400 45402 46710 46712 50250

Modifier covered as of August 21, 2005

CR Catastrophe/Disaster Related

Discontinued CPT Codes

In accordance with HCPCS 2006, the following codes will be discontinued effective January 1, 2006. They are removed from the MEDICAL AND SURGICAL PROCEDURES ("CPT Code List") for January 2006.

01964	Anesthesia for abortion procedures
15810	Salabrasion; 20 sq cm or less
44239	Unlisted laparoscopy procedure, rectum
86585	Tine method of tuberculosis skin testing
86587	Stem cells (i.e. CD 34) total count
90799	Unlisted therapeutic, prophylactic or diagnostic injection
90871	. . . multiple seizures, per day (outpatient psychiatric services
90939	Hemodialysis access flow study to determine blood flow in grafts and arteriovenous fistula . . .
92510	Aural rehabilitation following cochlear implant
96100	Psychological testing (includes psychodiagnostic assessment of personality, . . .
96115	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, . . .
96117	Neuropsychological testing battery (eg, Halstead-Reitan, Luria, WAIS-R) with interpretation and report.
97504	Orthotic(s) fitting and training, upper extremity(ies), lower extremity(ies), and/or trunk, each 15 minutes
97703	Checkout for orthotic/prosthetic use, established patient, each 15 minutes
G0252	PET imaging ... for initial diagnosis of breast cancer and/or surgical planning for breast cancer
G0253	PET imaging ... for staging/ restaging of local regional recurrence or distant metastases
G0254	PET imaging for breast cancer, evaluation of response to treatment performed during course of treatment
G0264	Initial nursing assessment of patient directly admitted to observation with diagnosis other than CHF, . . .
G0279	Extracorporeal shock wave therapy, involving elbow epicondylitis
G0280	Extracorporeal shock wave therapy, involving other than elbow

In addition, a reference to codes 90780 - 90784 is removed from the note on codes 90281 through 90396 (immune globulin products) because 90780 - 90784 are discontinued. □

06 - 21 Physician Services

This bulletin discusses IV infusions and Injections coverage; evaluation and management modifiers 25 and 29; influenza and pneumovax vaccinations; therapeutic procedures, prolonged service codes; Incidental edits and a new version of the editing program; Genetic Counseling and Genetic Testing; and prior authorization for advanced imaging.

IV infusions and Injections Coverage Policy Clarification (2006 CPT codes 90760-90779; 96401-96549)

1. When administering multiple infusions, injections, or combinations, only one initial service code should be reported, unless protocol requires that two separate IV sites must be used. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within a group of services, then a subsequent or concurrent code from the appropriate section should be reported.
2. Hydration therapy requires a diagnosis and medical record documentation supporting the therapy for electrolyte imbalance and/or dehydration for reimbursement coverage.
3. Reporting the evaluation and management service with modifier 25, requires review of supportive documentation for significant separately identifiable service beyond the E&M services expected with drug or chemotherapy administration.
4. IV line flush between drugs is considered part of the drug administration service and not reimbursed separately.
5. One payment for a heparin flush is covered at the conclusion of the infusion.
6. Most of the January 2006 CPT Manual hydration, therapeutic, prophylactic and diagnostic injections and infusion codes will be open for at least a one-year study period. Coverage and reimbursement of these codes will be determined after completion of the analysis of use patterns.

Evaluation and Management

Modifier 25

Providers are advised to place the modifier 25 on evaluation and management codes only when procedures performed may include the evaluation and management service. Remember the CPT manual advises the use of the modifier 25 must be limited to times when significant separately identifiable evaluation and management service is provided. A delay in payment is occurring when the modifier 25 is placed on claims which would automatically pay. For example, placing the modifier 25 on preventive evaluation and management codes 99381-99396 means that the claim is suspended for review. Usually codes for vaccines and the administration fee are the only other codes on the claim. The administration fee and E&M service will automatically pay without the modifier for children in the Vaccine for Children Program. In the adult, the vaccine, administration and evaluation and management service should pay unless another procedure is completed which includes the E&M service. There are several procedure codes which will pay the E&M service without the 25 modifier.

Modifier 59

Many claim submissions are containing modifier 50 and modifier 59. When the procedure is a bilateral procedure the modifier

59, should not be added to the procedure on the claim. Adding this modifier when it is not necessary suspends the claim and delays processing for payment. Modifier 59 should not be used to circumvent correct coding initiative edits. The modifier 59 should be used with the procedure is completed at a separate anatomical site. Manual review will determine whether a procedure is distinctly separate from the other procedures performed.

Influenza and Pneumovax vaccinations

Medicaid pays for one influenza vaccination annually. The National Immunization Program at Centers for Disease Control and Prevention states that an additional influenza vaccination is only recommended in children less than nine years of age who are receiving the influenza vaccine for the first time. Patients need to be informed that they should receive only one influenza vaccination each year.

Pneumovax vaccination is a life time vaccination for the majority of patients. Patients should be informed by the prescribing provider that this is a one time vaccination. In rare instances a second vaccination may be provided to some individuals five years from the initial vaccination. Additional doses are not beneficial and are not recommended. Several patients have received multiple pneumovax vaccinations. An information bulletin will be sent out to Medicaid patients, but Medicaid requests the assistance of providers in educating patients about this issue.

Therapeutic procedures

Therapeutic procedures will be added to the following statement in the provider manual, covered service item 12. An evaluation and management (E/M) code and a diagnostic procedure or therapeutic procedure code will generally not be covered separately on the same date of service. This includes service in the Emergency Room, inpatient service and outpatient service.

Prolonged Service Codes

Prolonged service codes require documentation review of **face to face physician** evaluation and management service. Review of records is not covered under the prolonged service code. A time line must be submitted to support face to face evaluation and management services beyond those provided within the procedure code. This would include the history, physical, and counseling time. The neonatal critical care service codes (999293-99296 and 99298-99299) are global code for 24 hours of evaluation and management service; and therefore, ineligible for reimbursement of a prolonged service code.

Incidental edits and a new version of the editing program

The new version of the editing program containing additional Correct Coding Initiative (CCI) edits will be brought on line in January. Incidental edits occur when a procedure is considered an integral component of another procedure.

In the new version of the editing program the venipuncture and IV therapy codes normally completed during critical care service (codes 36400, 36405, 36406, 36430, 90780 and 90781) are included within the time for critical care service 99291 and 99292. The laryngoscopy procedure code (31505, 31515, and 31527) are included within the anesthesia time. Some codes which are considered minor procedures such as straight catheterization and chemical cauterization of granulation tissue include the evaluation and management service as incidental to the procedure. Since the E&M code submitted may pay higher than the procedure, system adjustments have been made. When the E&M pays higher than a procedure, the edited relationship has been reversed to provide payment for the E&M service.

Genetic Counseling and Genetic Testing

The services of masters prepared genetic counselors are not covered in Medicaid. Until there are CPT codes available and provider payment issues are determined through CMS, the services will be non-covered. In Utah there are six genetic tests which are recognized for coverage in the newborn: PKU, Sickle cell (anemia, type c & beta thalassemia), Transverse deficit galactosemia, and congenital hypothyroidism.

Medicaid does not cover testing completed for general population screening where there is no symptomatic evidence or family history of genetic disease, nor is screening covered for investigational or research purposes. Medicaid will only consider addition genetic screening tests for coverage when there is a significant family history of a treatable genetic disorder occurring within a three-generation family group sheet.

If the physician reviews the family history and determines a medically necessary reason to complete cytogenetic testing beyond the standard six tests recognized in Utah, supportive medical record information must be submitted for review of coverage prior to completion of codes 88271, 88384, 88385, 88386, and 88299. The physician is expected to request and review prior medical records to prevent duplication of genetic testing.

Advanced Imaging Prior Authorization

When prior authorization is requested for procedures like MRI, Medicaid requires that the physician provide information that accepted standard imaging tests have been completed within three months of the request. It is also expected that conservative treatment measures have been tried for a 3-month period within six months prior to the request for the test. Conservative measures include anti-inflammatory medications and exercise therapy instruction by the provider and/or

supervised physical or occupational therapy. When conservative measures were tried more than six months prior to the request, the request will be denied. When the physician has a reason anti-inflammatory medication, exercise or physical therapy cannot be prescribed, the information must be submitted with the prior authorization request. □

06 - 22 Anesthesiologist and Radiologist Prior Authorization Denials

Inpatient Effective January 15, 2006, billing for an inpatient's professional radiology service must include an identifier indicating the claim is an inpatient claim. Inpatient claims for professional radiology and anesthesiology services will be paid when the site of service is identified as inpatient. This new policy is to rectify problems under current policy wherein attending physicians have failed to request or obtain approvals for certain procedures requiring prior authorization, i.e., MRIs, sterilizations, etc. This failure to request or obtain prior authorization by the attending physician has resulted in denial of payment to radiologists or anesthesiologists, who likely were unaware that the patient was a Medicaid patient. Identification of the site of service as "inpatient" will allow payment both to the hospital and the affected professionals providing the service.

Outpatient For outpatient services, the current policy remains in effect until February 1, 2006. After that date, failure to request or obtain a prior approval for selected MRI outpatient procedures or sterilizations (as specified in the manual) will result in no payments for any service providers (including hospitals). The only exception to this policy will be for emergency radiological or sterilization procedures meeting Medicaid emergency criteria, as long as the request is received by Medicaid within three business days. □

06 - 23 Sterilization Consent

There are Federal and State legal requirements related to consent to sterilization. Recent provider questions alerted Medicaid that clarification of the instructions on the sterilization consent form (Form 499-A) are needed. The following information will be added to the "Instructions for Sterilization Consent Form" in the physician manual.

- A. Client must be at least 21 years of age at time consent is signed.
- F. The **Consent to Sterilization** must be signed by the individual requesting sterilization. When an interpreter is required to explain the "consent to sterilization" to the individual, the interpreter must sign and date the **interpreters statement section** of the form at the same session as the individual providing consent and the statement of the person obtaining the consent. NOTE: The facility name and address must be completed.
- G. The **Statement of the Person Obtaining the Consent** must be signed and dated by a person suitably knowledgeable and trained to obtain the consent. Under 42 CFR 441.257, the signature of a person obtaining the consent certifies the following:
 - 1) A thorough explanation of the specific sterilization procedure to be performed, a full description of the discomforts and risks of morbidity and mortality that may accompany or follow the procedure, an explanation of the type and possible side effects of anesthesia, and answer any questions the individual may have related to the sterilization procedure.
 - 2) The individual's long term reproductive desires are discussed and they are screened for risk indications for regret. Alternative methods of family planning and birth control, including male sterilization are reviewed.
 - 3) A full description of the benefits or advantages and failure rates of sterilization is reviewed.
 - 4) Safe sexual practices to protect against sexually transmitted disease, including but not limited to HIV infection are discussed.
 - 5) The individual appears mentally capable to understand and voices the understanding that the sterilization procedure is considered irreversible.
 - 6) Advise the individual they are free to withhold or withdraw consent to the procedure at any time prior to the sterilization without jeopardizing their right to future medical care or any federally funded program benefit.
 - 7) Permit the individual to have a witness of his or her choice present when the informed consent is obtained.
 - 8) An interpreter is provided if the individual does not understand the language used on the consent form or the language used by the person obtaining the consent. Suitable arrangements are made to insure that information was communicated effectively to an individual who is blind, deaf, or otherwise handicapped.
 - 9) Provide the individual with a copy of the consent form.
- H. The **Physician Statement** must be completed, dated and signed by the physician performing the sterilization procedure. The physician's signature certifies that they have reviewed and attest the following issues have been addressed:
 - 1) Explain the requirements on the informed consent form with an interpreter present, if required.
 - 2) Review alternative available methods of birth control and that the sterilization procedure is considered irreversible.
 - 3) Advise the individual that no federal benefits may be withdrawn because of a decision not to be sterilized, nor may the decision affect future health care access.
 - 4) To the best of the physician's knowledge the individual appears mentally competent and knowingly and voluntarily

consents to sterilization.

5) In the event emergency abdominal surgery results in the need for a sterilization procedure prior to the 30-day waiting period, the physician describes the circumstances on the consent form.

The following revisions are made to the Sterilization Consent, Form 499-A, in the manual:

1) Under the statement of person obtaining the consent:

The line for the signature of the person obtaining consent – Delete the word physician and replace it with “Signature of the knowledgeable trained person obtaining the consent”.

2) Add a line to fill in the date by box two

3) Change box three to read:

“When the abdominal surgery is completed prior to the thirty-day waiting related to an emergency need for surgery, the physician must describe the circumstances in the paragraph below.”

□

06 - 24 Acknowledgment of Medicaid Criteria on Abortion

Submission of the "Acknowledgment of Medicaid Criteria on Abortion" form to Medicaid Operations is required of physicians performing induced abortion procedures. A copy of this form has been added to the Forms section of the Medicaid Physician Manual and to the list of manuals and forms on the Medicaid website. □

06 - 25 Addendum and Changes to Hospital Coverage

Preauthorization for Inpatient Psychiatric Admission

- a. A telephone call to Medicaid must be made to request authorization for inpatient admission within the first 24 hours of admission for a fee-for-service client. For weekend admissions and holidays, the telephone call to Medicaid must be made the next working day.
- b. Prior authorization for inpatient psychiatric admission will be considered upon physician request with submission of sufficient information to verify the patient's severity of illness and intensity of treatment support the clinical necessity of inpatient admission. The physician must submit documentation which supports the patient requires active treatment beyond that which may be provided as an outpatient, provide a treatment plan with the proposed psychiatric treatment, and describe the anticipated outcome.
- c. Prepaid Mental Health clients must be preauthorized through the contracted mental health care plan as described in the “Diagnostic and Rehabilitative Mental Health Services Provided by DHS Contractors” provider manual.

Emergency Department Reimbursement

The diagnosis primarily responsible for the patients outpatient service is the basis for Medicaid reimbursement of emergency department services. Use the primary reason for the emergency room visit as one of the first five diagnoses listed on the claim. □

06 - 26 Ambulatory Surgery Centers

The Medicare List of Ambulatory Surgery Center codes will be used by Medicaid for Reimbursement using the Medicare grouper system. This system pays the first procedure code in a grouper at 100%. All subsequent procedure payments that are performed in the same operative session will be paid at 50% of the wage related portion of the rate. The wage related portion of the rate will be considered to be 35% of the total rate as per a Medicare cost analysis.

Please note that the Medicaid policy determinations for non-covered codes or codes requiring prior authorization on this Medicare list remain. Medicaid will also cover some podiatry, dental, and lithotripsy codes which frequently require ASC services.

The following codes are open in Utah Medicaid in addition to the codes open in Medicare:

11730	11750	11752	28010	28108	28124	28220
28232	31000	31225	40806	40812	40830	41110
41115	41820	41825	41830	41870	41872	41874

41899 S0400

The effective date for this change will be for all services provided on or after March 1, 2006.

06 - 27 Utah Medicaid Chronic Pain Management Coverage

Effective February 1, 2006, Medicaid will cover comprehensive pain evaluations at an outpatient pain center. The comprehensive pain evaluation will be approved by individual case review based on certain limitations and guidelines. A pain center must provide evaluations by a board-certified pain specialist, a physical therapist, and a mental health professional.

The pain center team will formulate a treatment plan that they will send to the primary care provider (PCP), the review staff, and the Prepaid Mental Health Plan liaison. The mental health liaison will forward the treatment plan to the appropriate mental health provider for long term follow up, if indicated.

Additional visits or services other than the initial evaluation and treatment plan development require separate prior approval.

Comprehensive pain evaluations may be considered for individuals:

1. With chronic pain (which is pain of six months or longer);
2. Who are age 18 or over; and
3. Who have a primary care provider (PCP) for coordination with the pain center.

A comprehensive pain evaluation requires prior authorization by a physician at the plan level or the state level. Staff review information provided by the PCP and other internal data; i.e., pharmacy reports, emergency use, hospital admissions, specialty and ancillary services. If the patient is approved for a pain evaluation, all information is forwarded to the pain center.

Submit the following for authorization to either the identified **medical managed care plan** or the **State designee (Restriction Program or Bureau of Managed Health)**.

- A. Chronic Pain Referral form
- B. History and physical
- C. Other pertinent information (labs, x-rays, scans, consultations, etc.)

The pain center gives final approval. If the pain center concurs this is an appropriate patient, the pain center sends out surveys and other documents to the patient. After the patient returns the surveys, the pain center schedules the first visit.

For more information or to obtain a **Chronic Pain Referral** form, call the **Medicaid Customer Service Line at 1-800-662-9651**. For Medicaid recipients in a managed health care plan, call:

Molina Healthcare at 1-888-483-0760
Healthy U at 1-888-271-5870

06 - 28 Hyperbaric Oxygen Therapy (HBOT)

JCAHO accreditation has been added to the physician and hospital manual. It has always been Medicaid policy that Hyperbaric Oxygen Therapy (HBOT) is covered only for only for hospital based facilities. JCAHO is the official certification organization for hospitals and JCAHO is working with the Undersea and Hyperbaric Medical Society for that body to be the accrediting organization for hyperbaric facilities. Utah Medicaid requires a quality measurement to insure the hyperbaric oxygen therapy unit meet's quality and safety guidelines for patient care. When a hospital purchases a hyperbaric unit and joint commission review will be greater than one year away, the Undersea and Hyperbaric Medical Society may be contacted for a quality and safety review. Because of the potential for a scheduling delay with the Undersea and Hyperbaric Medical Society, Medicaid will allow a period of one year to obtain a quality review of the unit. If an HBO therapy unit does not have a quality review after one year, Medicaid will not be able to provide patient approval for hyperbaric oxygen therapy coverage until the quality review is completed.

06 - 29 Pharmacy Services

This article covers Diphenoxylate preparations; Ventavis; Off Label Use of Drugs; Effective date for October MIB announcements; Benzodiazepines; Physician Identifiers; and Dispense as Written restrictions.

Diphenoxylate preparations

Effective January 1, 2006, a cumulative limit of 180 doses in any 30 day period has been established by the DUR Board for all prescriptions containing diphenoxylate. No concurrent prescriptions of loperamide will be allowed.

Ventavis- Policy change

Ventavis requires two specialized administration devices to monitor and assure appropriate inhalation of the drug. OBRA '90 law specifically allows Medicaid to exclude coverage for drugs in this situation. Medicaid has obtained an opinion from legal advisors that until CMS notifies Utah Medicaid that this interpretation is incorrect, coverage for Ventavis can be disallowed. Accordingly, Ventavis will not be a covered benefit.

There are three other drugs in this class used for pulmonary hypertension (PAH) which remain available with prior authorization: Tracleer®, Flolan®, and Remodulin®.

Off Label Use of Drugs

The Drug Utilization Review (DUR) Board may approve, for a specific case, an unlisted off-labeled use for a given drug if the off labeled use meets ALL of the following criteria:

Use must be diagnosis specific as defined by an ICD-9 code (s).

1. Off-labeled use must be supported by one major multi-site study or three smaller studies published in JAMA, NEJM, Lancet or peer review specialty medical journals such as Journal of Cardiology. Articles must have been published within five years.
2. Off-labeled use must have a defined dosage regimen.
3. Off-labeled use must have a defined duration of treatment.
4. The off-labeled use shows clear and significant clinical or economic advantage over existing approved drug regimens.

Effective date for October MIB announcements

In the October 2005 MIB, cumulative coverage changes were announced without noting the effective date of the change for butalbital containing medications, short acting opiate analgesics, erectile dysfunction drugs, Spirivia®, and skeletal muscle relaxants. The effective date for the skeletal muscle relaxants and the erectile dysfunction drugs change was effective with the MIB publication. A decision was made to delay the effective date of all the other groups until January 1, 2006.

Benzodiazepines: New cumulative limit announced effective January 1, 2006

Beginning January 1, 2006, a graduated reduction in the amount of benzodiazepines that Medicaid will cover will be implemented. Through January 31, 2006, only 300 units maximum will be allowed. Afterward, through February 28, 2006 the limit will be 225 units, then 170 units until March 31, 2006. From April 1, 2006 onward, the limit will be 120 units per any 30 day period. In addition a therapy duplication restriction will be imposed between long acting benzodiazepines (chlordiazepoxide, clorazepate, diazepam, and Xanax XR®), as well as between short acting benzodiazepines (alprazolam, clonazepam, lorazepam, oxazepam) allowing only one of either class to be covered in a 30 day period. A single duplication of therapy between one long acting and one short acting will be allowed.

Benzodiazepine agents of the sedative/hypnotic class (triazolam, flurazepam, quazepam, estazolam, and temazepam) are not affected by this policy and will remain under their current 30 units per 30 days restriction.

Physician Identifiers

Effective April 1, 2006, the Medicaid Point of Sale system will no longer accept the physicians last name as an identifier. Only

a valid DEA, Hcldea, or state medicaid number will be accepted. Deliberate manipulation of physician identifiers to knowingly produce a falsified identifier in order to obtain a paid claim is a violation of established laws, regulations, and policies, and is subject to applicable fines and/or penalties. Monitoring of this activity has shown that this is a problem. Therefore, continued monitoring will occur.

Pharmacies may contact the physician's office to obtain a valid DEA or may contact HCldea to obtain a valid identifier by calling 1-480-477-1000, ext. 118 and requesting the number for the provider, or by visiting the HCldea website at www.hcidea.org.

Dispense as Written restrictions

The Dispense as written (DAW-1) prescription claim qualifier, is only available for use with the Traditional pharmacy program. Brand-name medications may be sought under the Non-traditional program, but only a generic reimbursement is available. This is due to the fact that the federal waiver that was approved for the Non-traditional program only allowed generics to be dispensed. Therefore, when seeking a prior approval for a brand name medication for a Non-traditional client, please be aware that a DAW-1 will not adjudicate the claim for a brand name reimbursement. □

06 - 30 Vision Codes - Correction

The use of the term "Optician" was in error in the October MIB. The following is the corrected original article.

Codes S0620, Routine ophthalmologic exam including refraction; new patient, pays \$39.29, and S0621, Routine ophthalmologic exam including refraction; established patient, pays \$35.50, are now open for optometrists and ophthalmologists. This change allows the vision exam and refraction to be billed under a single code. This will allow for more accurate and correct billing. Opticians may not bill for these services. □

06 - 31 The Turn Around Document (TAD) -- phased out by April 2006

Utah Medicaid is replacing the proprietary TAD with the HIPAA compliant 837 Institutional (837I) electronic transmission by April 2006. All providers currently billing with the TAD are encouraged to begin submitting the electronic 837I.

The Utah Medicaid LTC Companion Guide for the 837I can be found at: www.health.utah.gov/hipaa/guides.htm. (For more details about electronic billing see the "EDI with UHIN and Utah Medicaid" article in this issue of the Medicaid Information Bulletin.) □

06 - 32 Dental Manual Correction

The code D4355, Full mouth debridement, was listed as requiring prior authorization for all ages in the July dental manual revision. The correct policy is D4355 requires prior authorization only for clients aged 17 and younger. Those Traditional and Non-Traditional Medicaid recipients who are age 18 and older do not require prior authorization. The criteria for D4355 requires the recipient to have subgingival calculus present. Full mouth debridement may be done once per year and may be done in conjunction with a prophylaxis in cases requiring subgingival scaling. □

06 - 33 Vision Codes, HCPCS 2006

In accordance with HCPCS 2006, the following codes will be discontinued effective January 1, 2006. They are removed from the Vision Manual for January 2006.

92392 Supply of low vision aids
92395 Supply of permanent prosthesis for aphakia; spectacles □

06 - 34 Medical Supplies

New Opened Codes beginning January 1, 2006

E1025, Lateral thoracic support, non-contoured, for pediatric wheelchair , each, includes hardware.
 E0959, Manual wheelchair accessory, adapter for amputee, each
 E2611, General use wheelchair back cushion, with less than 22 inches, any height.
 L5341, Hemipelvectomy, canadian type, molded socket, endoskeletal system, hip joint, single axis knee, each foot.
 A7000, Canister, disposable, for use with suction pump, each. This is be used for patient owned respiratory suction systems and it limited to two per month.

New Payment Units

Code E0935, Passive Motion Exercise Device, has been paying as a rental on a weekly basis– one unit equaled one week. Beginning on September 1, 2005 the rental is changed to a daily basis–one unit equals one day. This device is allowed for a maximum of 21 days following knee replacement surgery.

Revised units limitations as placed in the Medical Supplies Provider Manual

A4340, Indwelling catheter; specialty type, is limited to 2 per month
 A4351, Intermittent urinary catheter; straight tip, with or without coating, is limited to 10 per month.
 A4352, Intermittent urinary catheter; coude (curved) tip, is limited to 10 per month
 A4353, Intermittent urinary catheter, with insertion supplies is limited to 10 per month
 E0180 P or RR, Pressure pad, alternating with pump, this is purchase or a daily rental item.
 E0277RR, Powered pressure-reducing mattress, this is a daily rental item.

Deleted Codes with Replacements

A5119, skin barrier, wipes or swabs, box of 50, discontinued and replace with
 A5120, skin barrier, wipes or swabs, each.
 B4184, Parenteral nutrition solutions: lipids, 10% with administration set, and
 B4186, Parenteral nutrition solutions: lipids, 20% with administration set, are both replaced with
 B4185, Parenteral nutrition solutions, per 10 grams lipids
 E0953, Pneumatic Tire, each is replace with
 E2211, Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size.
 E0972, Wheelchair accessory, transfer board or device, each, is replaced with
 E0705, Transfer board or device, each.
 E1001, Wheel, single is replaced with
 E2224, Manual wheelchair accessory, propulsion wheel excludes tire, any size, each
 K0064, Zero pressure tube (flat free inserts) any size, each, is replaced with
 E2216, Manual wheelchair accessory, foam filled propulsion tire, any size, each.
 K0068, Pneumatic tire tube, is replaced with
 E2212, Manual wheelchair accessory, tube for pneumatic propulsion tire, any size, each.
 K0104, Cylinder tank carrier, is replaced with
 E2208, Cylinder tank carrier.
 K0630, Sacroiliac orthosis, flexible ... and
 K0631, Sacroiliac orthosis, flexible ... and
 K0632, Sacroiliac orthosis, flexible ... are replaced with
 L0621, Sacroiliac orthosis, flexible ...
 L0622, Sacroiliac orthosis, flexible ...
 L0623, Sacroiliac orthosis, flexible ...
 L0624, Sacroiliac orthosis, ...
 K0637, Lumbar-sacral orthosis, flexible ... and
 K0638, Lumbar-sacral orthosis, flexible ... are replaced with
 L0628, Lumbar-sacral orthosis, flexible ...
 L0629, Lumbar-sacral orthosis, flexible ...

Deleted Codes, no current replacements

A4260, Levonorgestrel contraceptive implant system, including implant and supplies (Norplant)
 A6551, Canister set for negative pressure therapy for electric pumps.
 E0954, Semi-pneumatic tire, each
 E1210, Motorized wheelchair ...
 E1211, Motorized wheelchair ...
 E1212, Motorized wheelchair ...
 E1213, Motorized wheelchair ... □