

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

## TABLE OF CONTENTS

08 - 23	National Provider Identifier (NPI) . . . . .	2
08 - 24	Statewide Provider Training . . . . .	2
08 - 25	Paper Claims - Old vs. New Format . . . . .	3
08 - 26	Paper Claims Backlog Update . . . . .	3
08 - 27	Multiple-page Paper Claims . . . . .	3
08 - 28	Billing and Reporting Third Party Liability (TPL) . . . . .	3
08 - 29	General Information, Section I, Additions and Clarification . . . . .	4
08 - 30	Gastric Bypass Surgery for Obesity . . . . .	5, 6
08 - 31	Family Nurse Practitioner / Pediatric Nurse Practitioner . . . . .	6-8
08 - 32	Anesthesiology Codes Covered for CRNA . . . . .	8-12
08 - 33	Coding Updates . . . . .	12-14
08 - 34	Medical Supplies . . . . .	14
08 - 35	Dental Code Correction . . . . .	14
08 - 36	Long Term Care Income Update . . . . .	15
08 - 37	Utah Medicaid Criteria for Coverage Decisions . . . . .	15
08 - 38	Pharmacy Coverage Highlights . . . . .	16
08 - 39	NDC Reporting on Physician-Administered Drugs for Outpatient and End Stage Renal Dialysis (ESRD) Claims . . . . .	16, 17
08 - 40	NDC Reporting on Physician-Administered (Including Certified Nurse Midwives and Nurse Practitioners )Drugs for Medicaid Claims . . . . .	18
08 - 41	Tamper-Resistant Prescription Pads Update . . . . .	19
08 - 42	AMP Update . . . . .	19
08 - 43	Preferred Drug List Update . . . . .	19, 20
08 - 44	Updated Immunization Schedule . . . . .	20
08 - 45	Home Health Agency Clarification . . . . .	20

## BULLETINS BY TYPE OF SERVICE

All Providers . . . . .	08-23 through 08-29
Anesthesiologists . . . . .	08-32, 33
Certified Nurse Midwife . . . . .	08-33, 40
Certified Registered Nurse Anesthetists (CRNA) . . . . .	08-32
CHEC Services . . . . .	08-44
Dentists . . . . .	08-35
End Stage Renal Dialysis (ESRD) Center . . . . .	08-39
Enhanced Services for Pregnant Women . . . . .	08-40
Home Health Agency . . . . .	08-45
Hospital (Inpatient) . . . . .	08-30
Hospital (Outpatient) . . . . .	08-39
Long Term Care Provider . . . . .	08-36
Medical Supplier . . . . .	08-34
Nurse Practitioners . . . . .	08-31, 40
Pharmacy . . . . .	08-38, 08-41 through 08-43
Physician Services . . . . .	08-30, 33, 34, and . . . . . 08-37 through 08-44

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.

### 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

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## 08 - 23 National Provider Identifier (NPI)

### Important Message to All Providers

Beginning April 14, 2008, Medicaid intends to reject claims that are submitted with NPI errors. If you are receiving a paper remittance advice, Medicaid is currently providing warning messages related to NPI non-compliant claims. Look for warning codes: **109: NPI missing, 111: NPI invalid format, and 110: NPI not matched**. If you see these messages on your remittance advice, there is a problem with the way your NPI is being submitted on your claims. If you continue to submit claims without correcting this problem, your claims will be rejected on April 14, 2008.

Medicaid will continue to accept both the NPI and Medicaid provider number on claims until April 14, 2008, as long as the NPI is in the primary identification fields. For examples of NPI billing procedures, visit the Medicaid website at <http://health.utah.gov/medicaid>. From the main page, you will find a section specifically for the National Provider Identifier with useful links and training resources. Examples of NPI billing procedures can be found under "Updates for Providers."

### POS Prescriber

Effective April 14, 2008, claims submitted for payment without the prescribing NPI will be denied. The NPI of the prescribing provider must be included on prescription claims.

If you are currently submitting your claims through a clearinghouse or software vendor, contact them to verify that the correct NPI is being submitted in the appropriate location on the claim form. They may be manipulating the NPI prior to filing the claim to Medicaid. It is important for you to confirm that the NPI being submitted on the claim is the same NPI that you reported to Utah Medicaid as belonging to the Medicaid legacy provider number on the claim. Validation of this information is critical to avoid any potential reimbursement issues upon NPI implementation.

Providers should verify that their NPI has been registered by contacting Provider Enrollment at (801) 538-6155 or toll free at 1-800-662-9651. For those providers who have not registered their NPI with Medicaid, please fax it to (801) 536-0471 or mail the information along with your provider name, Medicaid provider number, taxonomy code, and 9-digit zip code to Medicaid Provider Enrollment, PO Box 143106, SLC, UT 84114-3106. For those providers who have not applied for a NPI, this can be done online at <http://nppes.cms.hhs.gov>. If a provider does not know if they are required to have a NPI, or would like to request a paper application, call the NPI enumerator at 1-800-465-3203.

Dissemination of data from the National Plan and Provider Enumeration System (NPPES) began September 2007. More detailed information is available at [www.cms.hhs.gov/nationalprovidentstand/](http://www.cms.hhs.gov/nationalprovidentstand/).

Medicaid staff are currently working with the UHIN National Provider ID Subcommittee to assist in the implementation of NPI. Medicaid will keep you informed of our NPI Contingency Plan.

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## 08 - 24 Statewide Provider Training

Statewide provider training is being scheduled this year from August until October. Please watch for location information, dates, and registration information on the Medicaid website at <http://health.utah.gov/medicaid/>. You will not want to miss the important information planned for our providers this year.

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## 08 - 25 Paper Claims - Old vs. New Format

Effective May 1, 2008, Medicaid will reject and return older versions of the CMS-1500 (professional), UB (institutional), and ADA (dental) paper claim forms. The CMS-1500 12/90 form, the UB-92, and the 1994, 1999, 2000, and 2002 ADA dental forms, along with any other similar forms used before the advent of the CMS-1500 08/05, UB-04, and ADA 2006 forms will not be processed.

Medicaid encourages electronic submission of claims. Providers should contact Utah Health Information Network (UHIN) at 801-466-7705 or online at <http://health.utah.gov/hipaa> and access 'Enrollment'. Refer to the Companion Guides on the Medicaid website at <http://health.utah.gov/medicaid> for instructions on electronic transactions.

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## 08 - 26 Paper Claims Backlog Update

Due to conversion to a new data entry contractor, Medicaid has experienced a delay in processing paper claims received after May 1, 2007. Professional claims received and held in storage since that date, including the old paper claim forms, are now being processed, generally with earliest dates processing first.

Medicaid is in final testing for dental claims. The processing of the dental backlog will begin shortly.

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## 08 - 27 Multiple-page Paper Claims

Effective April 1, 2008, Medicaid will no longer accept multi-page paper professional claims (CMS-1500) or dental claims. If services require more than one claim (6 lines for professional and 18 lines for dental), submit each claim as an individual claim:

- When billing for the Vaccines for Children (VFC) program, bill the appropriate amount of immunizations with the injection code on the same claim.
- When reporting Third Party Liability (TPL), be sure to split the payment appropriately between the claims.
- When submitting medical documentation for any reason, it must be attached to each claim.

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## 08 - 28 Billing and Reporting Third Party Liability (TPL)

Beginning May 1, 2008, Medicaid will require third party liability (TPL) information to be submitted on the claim, whether billing electronically or on paper. It is recommended that you work with your electronic software vendor to add TPL information on your claims. If your software vendor does not allow you to report TPL information, you will need to drop to paper and report the information on the claim.

Medicaid does not key TPL information from an attached Explanation of Benefits (EOB). Only the EOB's submitted for zero payment, or claim denials, will be reviewed. It is necessary to report the TPL amount and patient responsibility for claims to be paid by Medicaid.

For instructions on reporting TPL and other billing information, visit the website at <http://health.utah.gov/medicaid/>.

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## 08 - 29 General Information, Section I, Additions and Clarification

The following chapters in the General Information, Section I, of the provider manual have been modified for April 2008.

### 6 - 6 Billing Medicaid

The provider may bill Medicaid only for services which were medically indicated and necessary for the patient and either personally rendered by him/her or rendered incident to his/her professional service by an employee under immediate personal supervision, except as otherwise expressly permitted by Medicaid regulations. The billed charge may not exceed the usual and customary rate billed to the general public, such as individual patient accounts or third party payer accounts.

As indicated on the *CPT List of Medical and Surgical Procedures*, codes requiring manual review require submission of medical record documentation for staff review. When the exception code (error message on the remittance advice statement), stating documentation required, is reported, the provider should submit the medical record documentation to Medicaid Operations. In cases where the service has been denied after manual review, the remittance advice indicates manually reviewed and denied. This is the point in the process when the provider may consider submitting a request for a hearing.

Unlisted procedures require manual review and often manual pricing. Refer to Section 9 - 1 of this manual.

### 8 - 4 Diagnosis Must Agree with Procedure Code; Use of 'V' Codes

[Effective January 1, 2002, claims must have a diagnosis that fits the procedures completed, or they will be denied] *Deleted*. A diagnosis code in addition to the V code must also be on the claim form. Make sure that the diagnosis and procedure codes agree...Examples A and B.

Supplying the correct diagnosis and procedure for payment is the responsibility of the provider. The differential diagnosis must support the medical necessity of the procedure for reimbursement. Often, more than one diagnosis is required to explain and support a service. When the diagnosis does not support the procedure, a diagnosis to procedure discrepancy will be reported on the remittance advice. Providers should then resubmit a claim with additional or other appropriate diagnoses.

### 9 - 1 Unspecified Services and Procedures

Unspecified services or procedures covered by Medicaid do not require prior authorization. These codes typically are five numbers ending ". . . 99". Do not use unspecified service or procedure codes to provide services which are not a Medicaid benefit. Submit documentation for these codes with the claim for prepayment review. Documentation should include medical records, such as the operative report, patient history, physical examination report, pathology report, and discharge summary, which provide enough information to identify the procedure performed and to support medical necessity of the procedure.

Unlisted procedures require manual review and often manual pricing. During review of medical record information, medical staff will determine payment based on reimbursement for similar procedures. Additional reimbursement may be considered only when care above similar standard procedures is medically necessary. Additional payment will not be considered when procedures are considered investigational or cosmetic.

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**08 - 30 Gastric Bypass Surgery for Obesity - Criteria #22**

Prior authorization for Medicaid payment of obesity surgery is required. Surgery for obesity (i.e. gastric bypass, gastroplasty) will be considered when the patient meets **each of the seven** items below:

1. To meet the weight criteria for morbid obesity the Body Mass Index (BMI) must be equal to or greater than 40 before surgical intervention for a severely obese patient is considered. BMI is calculated by multiplying the person's weight in pounds by 704.5 and then dividing that product by the person's height in inches squared. (See National Institutes of Health website for BMI calculations at <http://nhlbisupport.com/bmi/> )

$$\text{BMI} = 704.5 \times \frac{\text{weight in pounds}}{\text{height in inches} \times \text{height in inches}}$$

2. Must meet both A and B as follows:
  - A. patient must be at least 18 years of age or older, (must be at or over legal age of consent) and,
  - B. without the presence of any one of the following conditions below. These conditions could limit successful clinical outcome or interfere with compliance with the medical management regimen following surgery.
    1. Multi-system failure.
    2. Malignant disease which is not in remission.
    3. Substance abuse or drug addiction.
    4. Psychiatric disorders which will probably interfere with the long-term management of the patient after the operation despite being adequately treated.
    5. Non-compliance with current or past medical therapies.
3. Must meet either A or B as follows:
  - A. One of the following major life threatening complications of obesity:
    1. Alveolar hypoventilation: insufficient ventilation leading to an increase in PaCO<sub>2</sub> > 45 mm Hg
    2. Uncontrolled diabetes: glycated hemoglobin A1C ≥ 8
    3. Uncontrolled hypertension : BP ≥ 150/100 when compliant with medication regimen
  - B. Two of the following conditions:
    1. Hypertension > 140/90
    2. Dyslipidemia refers to an irregularity of the lipid profile, covering a variety of disorders relating to abnormal levels out of accepted laboratory range for total cholesterol, LDL-C, HDL-C, or triglycerides.
    3. Type II diabetes. The body does not produce enough insulin or the cells are resistant to using the insulin the body produces. This excess in blood glucose leads to the various complicating conditions in diabetic patients.
    4. Coronary heart disease
    5. Obstructive sleep apnea documented by sleep study
4. All of the following documentation requirements:
  - A. Complete history and physical examination. Severe obesity often presents co-morbidity. Therefore, evaluations of the cardiovascular, pulmonary, endocrine, and gastrointestinal systems must be completed within the six months prior to surgery. Documentation should include laboratory studies, procedures, and/or imaging studies related to these issues.
  - B. When the client has a history of substance abuse, the medical record must document six months of abstinence from substances of abuse, including but not limited to tobacco, marijuana, and alcohol. Documentation must include at least two negative drug screens within the three months of the request date for prior authorization.
  - C. The medical record must document, with a supervised weight reduction program, a body weight loss of at least 10% within the six months prior to the request for bariatric surgery.
  - D. A smoker must be compliant with smoking cessation for eight weeks prior to surgery which is confirmed and supported by approved laboratory tests (urine and/or serum).
5. There must not be evidence of non-compliance with medical or surgical treatments in the last year including:
  1. Non-compliance with medications or therapy
  2. Failure to keep scheduled appointments
  3. Leaving the hospital against medical advice
  4. Active substance abuse
6. Complete psychiatric evaluation by a board certified or board eligible psychiatrist who is a Medicaid provider. The evaluation must have been done within three months of the request and must include all of the following:
  - A. Psychiatric evaluation must be documented in narrative form which includes all the elements in the Provider Manual, Section 2, under Limitations (N). Psychiatric evaluation requirements can be found at <http://health.utah.gov/medicaid/> in the Physician Manual.

- B. Psychiatric disorders which would probably interfere with the long-term management of the patient after the operation must be adequately treated. MMPI can be included if available.
  - C. Psycho-social assessment that the client has sufficient mental, emotional, and social stability and support to ensure that the client will strictly adhere to long-term follow-up after surgery.
7. Facilities desiring to perform these services for Medicaid recipients must meet all of the following:
- A. Beginning January 1, 2010, bariatric surgical facilities must be Medicare approved. Before January 1, 2010, bariatric surgery will only receive prior approval for bariatric surgery in a Medicare approved facility or a facility currently in the process of becoming Medicare certified. Providers must have the staff and facilities required for Medicare certification.
  - B. The facility must have surgeons experienced in the type of bariatric surgery procedure with a multi-disciplinary team as recommended by the American Society of Metabolic and Bariatric Surgery for surgical follow-up.
  - C. The surgical team shall have a long-term patient follow-up program for the patient including access to the services of a nurse, dietician, psychologist for behavioral modification, exercise physiologist, and a support group. Note: most long-term bariatric programs see the patient at a minimum of every three months for the first year after surgery for laboratory work to evaluate glucose, creatinine, liver function, protein, albumin, iron, vitamin B, folic acid, calcium, and parathyroid hormone. The patient may be seen more often to evaluate weight management efforts and offer support. Some programs follow the patient every two months for the first year, every three months for the second year, and every six months for years three, four, and five. After then, an annual visit is required for life.
8. The patient is informed of the surgical alternatives available. When laparoscopic adjustable gastric banding is the method chosen, the following criteria must be met in addition to items 1-7 above. The individual must meet all of the FDA and manufacturer requirements for the device.
- A. Age requirement of between 18 and 55 years of age
  - B. History of obesity for at least five years
  - C. The physician verifies that the patient does not have any one condition listed as a contraindication to the device:
    - 1. Inflammatory bowel disease
    - 2. Previous bariatric surgery
    - 3. Chronic pancreatitis
    - 4. Severe hiatal hernia
    - 5. Pregnancy or an intention to become pregnant in the next 12 months
    - 6. Autoimmune or connective disease
    - 7. Portal hypertension
    - 8. Congenital anomalies of the GI tract
    - 9. Cirrhosis

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## 08 - 31 Family Nurse Practitioner / Pediatric Nurse Practitioner

The Medicaid policy manual for family and pediatric nurse practitioners will be issued April 2008. Visit the Medicaid website at <http://health.utah.gov/medicaid/tree/index.html> to locate the new manual. If you do not have Internet access, please call Medicaid Information at (801) 538-6155 or 1-800-662-9651 and request a hard copy.

For your convenience, the following CPT codes, which are open to the family and pediatric nurse practitioner provider type, are listed below.

### CPT List of Codes Covered for Family and Pediatric Nurse Practitioners

11975 INSERTION,IMPLANTABLE CONTRACEPTIVE CAPSULES  
 12001 SIMP REPAIR/SUPERFCL WNDS/SCLP,NK,EXTREMIT;2.5 CM<  
 12002 SIMP REPAIR/SUPER WNDS/SCLP,NK,EXTREMIT;2.6-7.5 CM  
 12004 SIMP REPAIR/SUP WNDS/SCLP,NK,EXTREMIT;7.6-12.5 CM  
 12005 SIMP REPAIR/SUP WNDS/SCLP,NK,EXTREMIT;12.6-20.0 CM  
 12006 SIMP REPAIR/SUP WNDS/SCLP,NK,EXTREMIT;20.1-30.0 CM  
 12007 SIMP REPAIR/SUP WNDS/SCLP,NK,EXTREMIT;OVER 30.0 CM  
 12011 SIMP/REPAIR/SUP WNDS/FACE,EAR,LIP,MUC MEM;2.5 CM<  
 12013 SIMP REPAIR/SUP WNDS/FACE,EAR,LIP,MUC MEM;2.6-5 CM  
 12014 SIMP REPAIR/SUP WNDS/FACE,EAR,MUC MEM;5.1-7.5 CM  
 12015 SIMP REPAIR/SUP WNDS/FACE,EAR,MUC MEM;7.6-12.5 CM  
 12016 SIMP REPAIR/SUP WNDS/FACE,EAR,MUC MEM;12.6-20 CM  
 12017 SIMP REPAIR/SUP WNDS/FACE,EAR,MUC MEM;20.1-30.0 CM  
 12018 SIMP/REPAIR/SUP WNDS/FACE,EAR,MUC MEM;OVER 30 CM  
 16000 BURN-INIT TREAT,1ST DEGREE,LOCAL ONLY  
 17110 DESTRUCT OF BEN LESIONS OTHER THAN SKIN TAGS CUTAN  
 36415 COLLECTION OF VENOUS BLOOD BY VENIPUNCTURE

36416 COLLECTION OF CAPILLARY BLOOD SPECIMEN  
 51701 INSERTION OF NON-INDWELLING BLADDER CATHETER (I.E. STRAIGHT CATHETERIZATION)  
 57170 DIAPHRAGM/CERVICAL CAP FITTING WITH INSTRUCTIONS  
 58300 INSERTION OF INTRAUTERINE DEVICE (IUD)  
 81002 URINALYSIS DIPSTICK/TAB REAGENT, NON-AUTO, W/O MICRO  
 81025 URINE PREGNANCY TST BY VISUAL COLOR COMPARISON METHODS  
 82044 URINE MICROALBUMIN  
 83036 HEMOGLOBIN, GLYCOSYLATED (A1C)  
 82270 BLOOD OCCULT, PEROXIDASE, FECES  
 82948 BLOOD GLUCOSE, REAGENT STRIP  
 84478 TRICYLCERIDES  
 84703 GONADOTROPIN, CHORIONIC, QUALITATIVE  
 85018 HEMOBLOBIN (HGB)  
 85014 BLOOD COUNT; HEMATOCRIT (HCT)  
 85651 SEDIMENTATION RATE, ERYTHROCYTE; NONAUTOMATED  
 86580 SKIN TEST; TUBERCULOSIS, INTRADERMAL  
 87210 SMEAR, PRIM SOURCE, W INTERP; WET MOUNT INFECT  
 87804 INFLUENZA  
 87807 RESPIRATORY SYNCYTIAL VIRUS  
 87880 GROUP A STREPTOCOCCUS  
 90471 IMMUNIZATION ADMIN;SINGLE OR COMB VACCINE/TOXOID *Use SL modifier - VFC program*  
 90472 IMMUNIZATION ADMIN;2+SINGLE/COMB VACCINE/TOXOIDS *Use SL modifier - VFC program*  
 90632 HEPATITIS A VACC,ADULT DOSAGE,INTRAMUSCULAR USE  
 90633 HEPATITIS A VACC,PED/ADOLE DOSE-2 DOSE,INTRMUSCLR  
 90634 HEPATITIS A VACC,PED/ADOLE DOSE-3 DOSE,INTRMUSCLR  
 90636 HEPATITIS A/HEPATITIS B VACC,ADULT,INTRAMUSCULAR  
 90645 HEMOPHILUS INFLUENZA B VACC,(4 DOSE),INTRAMUSCULAR  
 90649 HUMAN PAPILOMA VIRUS VACCINE,3 DOSE SCHEDULE,INTR  
 90657 INFLUENZA VIRUS VACC,SPLT VIR,6-35 MO,INTRAMUSCLR  
 90658 INFLUENZA VIRUS VACC,SPLT VIR,3 YRS+,INTRAMUSCLR  
 90669 PNEUMOCOCCAL CONJUG VACC,POLYVALENT,INTRAM,<5 YRS  
 90700 DIPHTHERIA,TETANUS TOXOIDS,(DTAP),INTRAMUSCULAR  
 90701 DIPHTHERIA,TETANUS TOXOIDS,(DTP),INTRAMUSCULAR  
 90702 DIPHTHERIA/TETANUS TOXOIDS ADSORBED PED USE,INTRA  
 90703 TETANUS TOXOID ABSORBED,FOR INTRAMUSCULAR USE  
 90704 MUMPS VIRUS VACCINE,LIVE,FOR SUBCUTANEOUS USE  
 90705 MEASLES VIRUS VACCINE,LIVE,FOR SUBCUTANEOUS USE  
 90706 RUBELLA VIRUS VACCINE,LIVE,FOR SUBCUTANEOUS USE  
 90707 MEASLES,MUMPS,RUBELLA VIRUS VACC,LIVE,SUBCUT/INJEC  
 90708 MEASLES & RUBELLA VIRUS VACCINE,LIVE,SUBCUTANEOUS  
 90710 MEASLES,MUMPS,RUBELLA, & (MMRV),LIVE,SUBCUTANEOUS  
 90712 POLIOVIRUS VACCINE,(ANY TYPE(S))(OPV),LIVE ORAL  
 90713 POLIOVIRUS VACCINE,INACTIVATED,(IPV),SUBCUTANEOUS  
 90714 TETANUS & DIPHTHERIA TOXOIDS PRESERVE FREE <7YRS  
 90715 TETANUS,DIPHTHERIA TOXOIDS PERTUSSIS VAC,>=7 YRS  
 90716 VARICELLA VIRUS VACCINE,LIVE,FOR SUBCUTANEOUS USE  
 90717 YELLOW FEVER VACCINE,LIVE,FOR SUBCUTANEOUS USE  
 90718 TETANUS/DIPHTHERIA ADSORBED 7+ YEARS,INTRAMUSCULAR  
 90719 DIPHTHERIA TOXOID, FOR INTRAMUSCULAR USE  
 90720 DIPHTHERIA,TETANUS,PERTUSSIS VACC,(DTP-HIB),INTRA  
 90721 DIPHTHERIA,TETANUS,PERTUSSIS VACC(DTAP-HIB),INTRA  
 90725 CHOLERA VACCINE FOR INJECTABLE USE  
 90727 PLAGUE VACCINE,FOR INTRAMUSCULAR USE  
 90732 PNEUMOCOCCAL POLYSACCHARIDE VACC,ADULT,SUBCUTAN  
 90733 MENINGOCOCCAL POLYSACCHARIDE VACC(ANY GROUP),SUBCU  
 90734 MENINGOCOCCAL CONJ VACCINE,(TETRAVALENT),INTRAMUSC  
 90735 JAPANESE ENCEPHALITIS VIRUS VACC,SUBCUTANEOUS  
 90744 HEPATITIS B VACCINE;PED PED/ADOLESN T DOSE,INTRAM  
 90746 HEPATITIS B VACCINE,ADULT DOSAGE,INTRAMUSCULAR  
 90748 HEPATITIS B & (HIB) VACCINE,INTRAMUSCULAR  
 90772 THERAPEUTIC OR DIAGNOSTIC INJECTION, SUBQ or IM  
 96150 HEALTH & BEHAV ASSESS, EA 15 MIN FACE-TO-FACE,INIT  
 96151 HEALTH & BEHAVIOR ASSESSMNT,EA 15 MIN;REASSESSMENT  
 96152 HEALTH & BEHAV INTERVENTION,EA 15 MIN,INDIVIDUAL  
 96153 HEALTH & BEHAV INTERVENTION,EA 15 MIN, GROUP  
 96154 HEALTH & BEHAV INTERVENTN,EA 15 MIN,FAMILY W/PATNT  
 96155 HEALTH & BEHAV INTERVENTN,EA 15 MIN,FAMILY W/O PAT  
 99050 SERVICES AFTER HOURS IN ADDITION TO BASIC SERVICES  
 99058 OFFICE SERVICES PROVIDED ON AN EMERGENCY BASIS  
 99080 SPECIAL REPORTS(EG INS,MED DATA)OVER USUAL COMMUN  
 99170 ANOGENITAL EXAM W COLPOSCOPIC MAGNIF CHILD TRAUMA *This code is open only to Nurse Practitioners working with the Criminal Justice system who have completed special training to complete the procedure on children*  
 99201 OFFICE / OUTPAT VISIT NEW 3/3 H:PF E:PF D:SF

99202 OFFICE / OUTPAT VISIT NEW 3/3 H:EP E:EP D:SF  
 99203 OFFICE / OUTPAT VISIT NEW 3/3 H:DT E:DT D:LC  
 99204 OFFICE / OUTPAT VISIT NEW 3/3 H:CM E:CM D:MC  
 99205 OFFICE / OUTPAT VISIT NEW 3/3 H:CM E:CM D:HC  
 99211 OFC,OUTPAT VISIT E/M EST MAY NOT REQUIRE PHYSICIA  
 99212 OFFICE / OUTPAT VISIT ESTAB. 2/3 H:PF E:PF D:SF  
 99213 OFFICE / OUTPAT VISIT ESTAB. 2/3 H:EP E:EP D:LC  
 99214 OFFICE / OUTPAT VISIT ESTAB. 2/3 H:DT E:DT D:MC  
 99215 OFFICE / OUTPAT VISIT ESTAB. 2/3 H:CM E:CM D:HC  
 99381 INIT E&M HEALTHY INDIVID, NEW PT,(AGE UNDER 1 YEAR)  
 99382 INIT E&M HEALTHY INDIVID,EARLY CHILDHOOD(AGE 1-4)  
 99383 INIT E&M HEALTHY INDIVID,LATE CHILDHOOD(AGE 5-11)  
 99384 INIT E&M HEALTHY INDIVIDUAL,ADOLESCENT(AGE 12-17)  
 99385 INITIAL E&M OF HEALTHY INDIVIDUAL 18-39 YEARS  
 99391 PERIODIC REEVAL&MGMT,HEALTHY INDIV AGE UNDER 1YR  
 99392 PERIODIC REEVAL & MGMT HEALTHY INDIVIDUAL(AGE 1-4)  
 99393 PERIODIC REEVAL & MGMT HEALTHLY INDIVID(AGE 5-11)  
 99394 PERIODIC REEVAL & MGMT HEALTHY INDIVID(AGE 12-17)  
 99395 PERIODIC REEVAL & MGMT HEALTHY INDIVID(18-39 YRS)  
 99432 NORM NB CARE(OTHER THAN HOSP/BIRTH RM)PE,CONFERENC  
 H1000 PRENATAL CARE, AT-RISK ASSESSMENT  
 H1001 PRENATAL CARE, AT-RISK ENHANCED; ANTEPARTUM MGMT  
 J0585 BOTULINUM TOXIN TYPE A, PER UNIT  
 J0696 INJECTION, CEFTRIAXONE SODIUM, PER 250 MG  
 J1055 INJ,MEDROXYPROGESTERONE ACETATE,CONTRACEPT 150 MG.  
 J1100 INJECTION,DEXAMETHASONE SODIUM PHOSPHATE, 1 MG  
 J7030 INFUSION, NORMAL SALINE SOLUTION, 1,000 CC  
 J7300 INTRAUTERINE COPPER CONTRACEPTIVE  
 J7302 LEVONORGESTREL-RELEASING IU CONTRACEPTIVE, 52 MG  
 S9446 PATIENT EDUCATION,NOC,NON-MD PROVDR,GROUP,PER SESSION  
***This code is open for pre-postnatal education for females 10-55 years of age--Limited to 8 within 12 months***  
 S9981 MEDICAL RECORDS COPYING FEE, ADMINISTRATIVE  
 T1015 CLINIC VISIT/ENCOUNTER, ALL-INCLUSIVE (used in rural health centers)

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## 08 - 32 Anesthesiology Codes Covered for CRNA

The following CPT codes are covered for a Certified Registered Nurse Anesthetist (CRNA). The base code for the anesthesia is paid once. Therefore, if the CRNA fills in for the initial anesthesiologist, the time for the procedure is paid, but a second base for the code is not paid. A CRNA coverage section has been added to the anesthesiology provider manual.

00100 ANESTHESIA PROCEDURES SALIVARY GLANDS,INCL BIOPSY  
 00102 ANESTHESIA PROCEDURES PLASTIC REPAIR OF CLEFT LIP  
 00103 ANESTHESIA FOR RECONSTRUCTIVE PROCEDURES OF EYELID  
 00104 ANESTHESIA FOR ELECTROCONVULSIVE THERAPY  
 00120 ANESTH EXTERNAL, MIDDLE, INNER EAR INC BIOPSY;NOS  
 00124 ANESTH EXTRNL,MIDDLE,INNER EAR INC BIOPSY;OTOSCOPY  
 00126 ANES XTRNL,MIDDLE,INNER EAR INC BIOPSY;TYMPANOTOMY  
 00140 ANESTH PROCEDURES ON EYE;NOT OTHERWISE CLASSIFIED  
 00142 ANESTHESIA FOR PROCEDURES ON EYE; LENS SURGERY  
 00144 ANESTHESIA PROCEDURES ON EYE; CORNEAL TRANSPLANT  
 00145 ANESTHESIA FOR PROCEDURES ON EYE; VITREORETINAL  
 00147 ANESTHESIA FOR PROCEDURES ON EYE; IRIDECTOMY  
 00148 ANESTHESIA FOR PROCEDURES ON EYE; OPHTHALMOSCOPY  
 00160 ANES NOSE & ACCESSORY SINUSES;NOT OTHERWISE CLASS  
 00162 ANESTH NOSE AND ACCESSORY SINUSES;RADICAL SURGERY  
 00164 ANES NOSE AND ACCESSORY SINUSES;BIOPSY SOFT TISSUE  
 00170 ANES INTRAORAL PROC,INC BIOPSY;NOT OTHERWISE SPECI  
 00172 ANES INTRAORAL PROC,INC BIOPSY;REPAIR CLEFT PALATE  
 00174 ANES INTRAORL,INC BIOPSY;EXCIS RETROPHARYN TUMOR  
 00176 ANESTH INTRAORAL PROC,INC BIOPSY; RADICAL SURGERY  
 00190 ANESTHESIA FOR PROC ON FACIAL BONES OR SKULL;NOS  
 00192 ANESTH PROCEDURES ON FACIAL BONES;RADICAL SURGERY  
 00210 ANESTH INTRACRANIAL PROC;NOT OTHERWISE SPECIFIED  
 00212 ANESTH FOR INTRACRANIAL PROCEDURES; SUBDURAL TAPS  
 00214 ANESTHESIA FOR INTRACRANIAL PROCEDURES;BURR HOLES

00215 ANES INTRACRANIAL PROC;SKULL FRACTURE,EXTRADURAL  
 00216 ANESTH INTRACRANIAL PROCEDURES;VASCULAR PROCEDURES  
 00218 ANES INTRACRANIAL; PROCEDURES IN SITTING POSITION  
 00220 ANES INTRACRANIAL PROC;CEREBROSPINAL FLUID SHUNTING  
 00222 ANES INTRACRANIAL; ELECTROCOAGULATION OF NERVE  
 00300 ANESTH ALL INTEGUMENTARY SYS,MUSC/NERVES HEAD,NOS  
 00320 ANES ALL PROC NECK ORGANS;NOS,AGE 1 YEAR OR OLDER  
 00320 ANES ALL PROC NECK ORGANS;NOS,AGE 1 YR OR OLDER  
 00322 ANES ALL PROC NECK ORGANS;NEEDLE BIOPSY OF THYROID  
 00326 ANESTHESIA LARYNX & TRACHEA IN CHILDREN <1 YEAR  
 00350 ANES MAJOR VESSELS OF NECK;NOT OTHERWISE SPECIFIED  
 00352 ANESTH PROC MAJOR VESSELS OF NECK;SIMPLE LIGATION  
 00400 ANESTHES INTEGUMENTARY SYS EXTREMITIES,TRUNK;NOS  
 00402 ANES CHEST,RECONSTRUCT PROC BREAST,E.G.MAMMOPLASTY  
 00404 ANES CHEST,RECONSTRUCT BREAST,RADICAL/MODIFIED PROC  
 00406 ANES BREAST,RADICAL/MODIFIED,MAMMARY NODE DISSECTN  
 00410 ANES BREAST,RADICAL/MODIFIED,ELEC CONVERSN ARRHYTHMIA  
 00450 ANES CLAVICLE AND SCAPULA;NOT OTHERWISE SPECIFIED  
 00452 ANESTH PROC CLAVICLE AND SCAPULA; RADICAL SURGERY  
 00454 ANES PROC CLAVICLE AND SCAPULA;BIOPSY OF CLAVICAL  
 00470 ANES PARTIAL RIB RESECTION;NOT OTHERWISE SPECIFIED  
 00472 ANES PARTIAL RIB RESECTION;THORACOPLASTY(ANY TYPE)  
 00474 ANES PARTL RIB RESECT;RADICAL,E.G.PECTUS EXCAVATUM  
 00500 ANESTHESIA FOR ALL PROCEDURES ON ESOPHAGUS  
 00520 ANESTHESIA FOR CLOSED CHEST PROCEDURES; NOS  
 00522 ANES CLSD CHEST PROCEDURE;NEEDLE BIOPSY OF PLEURA  
 00524 ANES CLSD CHEST PROCEDURES; PNEUMOCENTESIS  
 00528 ANESTH CLOSED CHEST PROC;MEDIASTIN/DIAG THORACSCPY  
 00530 ANESTHESIA PERMANENT TRANSVENOUS PACEMAKER INSERT  
 00532 ANESTH FOR ACCESS TO CENTRAL VENOUS CIRCULATION  
 00534 ANES TRANSVENEIOUS INSERT/REPLAC CARDIOVERTER/DEFIB  
 00537 ANES CARDIAC ELECTROPHYSIOLOGIC PROC INCL ABLATION  
 00539 ANESTHESIA FOR TRACHEOBRONCHIAL RECONSTRUCTION  
 00540 THORACOTOMY,LUNG,PLEURA,DIAPHRAGM,MEDIASTINUM;NOS  
 00541 ANESTH THORACOTOMY PROC,UTILIZ 1 LUNG VENTILATION  
 00542 THORACOTOMY(LUNGS,PLEURA,DIAPHRAGM);DECORTICATION  
 00546 THORACOTOMY;PULMONARY RESECTION WITH THORACOPLASTY  
 00548 THORACOTOMY;INTRATHORACIC PROC TRACHEA & BRONCHI  
 00550 ANESTHESIA FOR STERNAL DEBRIDEMENT  
 00560 HEART,PERICARDIUM,GREAT VESSELS,W/O PUMP OXYGENATR  
 00561 ANESTH PROC ON HEART SURG W/PUMP OXYGEN < AGE 1  
 00562 HEART,PERICARDIUM,GREAT VESSELS,W PUMP OXYGENATOR  
 00563 ANES PROC HEART;W PUMP OXY HYPOTHERMIC CIR ARREST  
 00566 ANES DIRECT CORONARY ART SYPASS W/O PUMP OXYGENTR  
 00580 ANESTHESIA FOR HEART OR HEART/LUNG TRANSPLANT  
 00600 ANES CERVICAL SPINE, CORD;NOT OTHERWISE SPECIFIED  
 00604 ANESTHESIA CERVICAL SPINE & CORD;SITTING POSITION  
 00620 ANES THORACIC SPINE, CORD;NOT OTHERWISE SPECIFIED  
 00622 THORACIC SPINE & CORD;THORACOLUMBAR SYMPATHECTOMY  
 00630 ANESTH PROC LUMBAR REGION;NOT OTHERWISE SPECIFIED  
 00632 ANESTH PROC LUMBAR REGION; LUMBAR SYMPATHECTOMY  
 00634 ANESTH PROC LUMBAR REGION; CHEMONUCLEOLYSIS  
 00635 ANES PROC LUMBAR REG;DIAG/THERAP LUMBAR PUNCTURE  
 00670 ANESTHESIA FOR EXTENSIVE SPINE & SPINAL CORD PROC  
 00700 UPPER ANTERIOR ABDOMINAL WALL;NOT OTHERWISE SPECIF  
 00702 UPPER ANTERIOR ABDOMINAL WALL;PERCUT LIVER BIOPSY  
 00730 ANES PROCEDURES ON UPPER POSTERIOR ABDOMINAL WALL  
 00740 ANES UPPER GASTROINTESTINAL ENDOSCOPIC PROCEDURES  
 00750 ANESTH FOR HERNIA REPAIRS IN UPPER ABDOMEN, NOS  
 00752 ANES HERNIA REPAIR UPPER ABDOMEN;LUMBAR & VENTRAL  
 00754 ANESTH HERNIA REPAIRS UPPER ABDOMEN; OMPHALOCELE  
 00756 HERNIA REPAIRS;TRANSABOMINAL DIAPHRAGMATIC HERNIA  
 00770 ANES FOR ALL PROC ON MAJOR ABDOMINAL BLOOD VESSELS  
 00790 INTRAPERITONEAL UPPER ABDOMEN;INC LAPAROSCOPY;NOS  
 00792 INTRAPERITONEAL,INC LAPAROSCOPY;PARTL HEPATECTOMY  
 00794 INTRAPERITONEAL;PANCREATECTOMY,PARTL/TOTL(WHIPPLE)  
 00796 ANES INTRAPERITONEAL;LIVER TRANSPLANT (RECIPIENT)  
 00800 ANESTH PROC ON LOWER ANTERIOR ABDOMINAL WALL; NOS  
 00810 ANESTHESIA FOR INTESTINAL ENDOSCOPIC PROCEDURES

00820 ANESTH PROCEDURE ON LOWER POSTERIOR ABDOMINL WALL  
 00830 ANESTH FOR HERNIA REPAIRS IN LOWER ABDOMEN; NOS  
 00832 HERNIA REPAIRS LOWER ABDOMEN; VENTRAL & INCISIONAL  
 00834 ANESTH HERNIA REPAIRS IN LOWER ABDOMEN NOS, <1 YR  
 00836 ANESTH HERNIA REPAIRS IN LOWER ABDOMEN NOS, INFANT  
 00840 INTRAPERITONEAL LOWER ABDOMEN, INC LAPAROSCOPY; NOS  
 00842 ANESTH INTRAPERITONEAL LOWER ABDOMEN; AMNIOCENTESIS  
 00844 ANESTH INTRAPERITONEAL; ABDOMINOPERINEAL RESECTION  
 00846 INTRAPERITONEAL LOWR ABDOMEN; RADICAL HYSTERECTOMY  
 00848 INTRAPERITONEAL LOWER ABDOMEN; PELVIC EXENTERATION  
 00851 INTRAPERITONEAL LOWR ABDOMEN; TUBAL LIGATN/TRANSECT  
 00860 EXTRAPERITONEAL LOW ABDOMEN, INC URINARY TRACT; NOS  
 00862 RENAL, INC UPPER 1/3 OF URETER / DONOR NEPHRECTOMY  
 00863 EXTRAPERITONEAL; RADICAL PROSTATECTOMY  
 00864 EXTRAPERITONEAL; TOTAL CYSTECTOMY  
 00865 ANES EXTRAPERITONEAL LOWER ABDOMEN; PROSTATECTOMY  
 00866 ANES EXTRAPERITONEAL LOWER ABDOMEN; ADRENALECTOMY  
 00868 ANES EXTRAPERITONEAL; RENAL TRANSPLANT (RECIPIENT)  
 00870 ANES EXTRAPERITONEAL LOWER ABDOMEN; CYSTOLITHOTOMY  
 00872 LITHOTRIPSY, EXTRACORPOREAL SHOCK WAVE; WATER BATH  
 00873 LITHOTRIPSY, XTRACORPORL SHOCK WAVE; W/O WATER BATH  
 00880 ANESTH PROC ON MAJOR LOWER ABDOMINAL VESSELS; NOS  
 00882 LOWR ABDOMINAL VESSELS, INFERIOR VENA CAVA LIGATION  
 00902 ANESTHESIA FOR; ANORECTAL PROCEDURE  
 00904 PERINEAL (INC BIOPSY MALE GENITAL); RADICAL PERINEAL  
 00906 PERINEAL (INC BIOPSY MALE GENITAL SYSTM); VULVECTOMY  
 00908 PERINEAL (INC BIOPSY MALE GENITAL); PROSTATECTOMY  
 00910 ANES TRANSURETHRAL PROC (INC URETHROCYSTOSCOPY); NOS  
 00912 ANES; TRANSURETHRAL RESECTION OF BLADDER TUMOR(S)  
 00914 ANES; TRANSURETHRAL RESECTION OF PROSTATE  
 00916 ANES; POST-TRANSURETHRAL RESECTION BLEEDING  
 00918 ANES TRANSUR PROC; W FRAG, & OR REMOV URETERAL CALCU  
 00920 ANESTHESIA FOR PROCECURES ON MALE GENITALIA; NOS  
 00921 ANESTHESIA MALE GENITALIA; VASECTOMY, UNILAT/BILAT  
 00922 ANES PROC MALE EXTERNAL GENITALIA; SEMINAL VESICLES  
 00924 MALE XTNRL GENITALIA; UNDESCENDED TESTIS, UNI/BI LAT  
 00926 MALE XTRNL GENITALIA; RADICAL ORCHIECTOMY, INGUINAL  
 00928 MALE XTRNL GENITALIA; RADICAL ORCHIECTOMY, ABDOMINAL  
 00930 MALE XTRNL GENITALIA; ORCHIOPEXY, UNILATRL & BILATRL  
 00932 MALE XTRNL GENITALIA; COMPLETE AMPUTATION OF PENIS  
 00934 AMPUTATN PENIS W BILATRL INGUINAL LYMPHADENECTOMY  
 00936 AMPU PENIS W BILAT INGUINL & ILIAC LYMPHADENECTOMY  
 00940 VAGINAL (BIOPSY LABIA, VAGINA, CERVX, ENDOMETRIUM) NOS  
 00942 ANES VAG PROC; COLPOTOMY, VAGINECTOMY, COLPOR, URETHRA  
 00944 ANESTHESIA VAGINAL PROC; VAGINAL HYSTERECTOMY  
 00948 ANESTHESIA VAGINAL PROCEDURE; CERVICAL CERCLAGE  
 00950 ANESTHESIA FOR VAGINAL PROCEDURES; CULDOSCOPY  
 00952 ANESTHESIA FOR VAGINAL PROCEDURES; HYSTEROSCOPY  
 01112 ANES BONE MARROW ASPIRATION &/OR BIOPSY ANTER/POST  
 01120 ANESTHESIA FOR PROCEDURES ON BONY PELVIS  
 01130 ANESTHESIA FOR BODY CAST APPLICATION OR REVISION  
 01140 ANES INTERPELVIABDOMINAL (HIND QUARTER) AMPUTATION  
 01150 TUMOR OF PELVIS, EXCEPT HIND QUARTER AMPUTATION  
 01160 CLOSED PROC SYMPHYSIS PUBIS OR SACROILIAC JOINT  
 01170 OPEN PROC INV SYMPHYSIS PUBIS OR SACROILIAC JOINT  
 01180 ANESTH FOR OBTURATOR NEURECTOMY; EXTRAPELVIC  
 01190 ANESTH FOR OBTURATOR NEURECTOMY; INTRAPELVIC  
 01200 ANESTH FOR ALL CLOSED PROC INVOLVING HIP JOINT  
 01202 ANESTH FOR ARTHROSCOPIC PROCEDURES OF HIP JOINT  
 01210 OPEN PROC INV HIP JOINT; NOT OTHERWISE SPECIFIED  
 01212 ANES OPEN PROC INV HIP JOINT; HIP DISARTICULATION  
 01214 ANES OPEN PROC INV HIP JOINT; TOTAL HIP ARTHROPLSTY  
 01215 ANES OPEN PROC HIP JOINT; REVIS TOTAL HIP ARTHRO  
 01216 ANES HIP JOINT; REVISION OF TOTAL HIP ARTHROPLASTY  
 01220 ANES FOR ALL CLOSED PROC INV UPPER 2/3 OF FEMUR  
 01230 ANES FOR OPEN PROC INV UPPER 2/3 OF FEMUR; NOS  
 01232 ANES OPEN PROC INV UPPER 2/3 OF FEMUR; AMPUTATION  
 01234 OPEN PROC INV UPPER 2/3 OF FEMUR; RADICAL RESECTION  
 01250 NERVES, MUSCLES, TENDONS, FASCIA, & BURSAE UPPER LEG  
 01260 PROC INV VEINS OF UPPER LEG, INCLUDING EXPLORATION

01270 PROC ARTERIES OF UPPER LEG, INC BYPASS GRAFT, NOS  
 01272 ARTERIES UPPER LEG, INC BYPASS GRAFT, FEMORAL LIGATN  
 01274 UPPER LEG, BYPASS GRAFT; FEMORAL ARTERY EMBOLECTOMY  
 01320 NRVS, MUSCLES, TENDNS, FASCIA, BURSAE KNEE &/OR POPLITL  
 01340 FOR ALL CLOSED PROCEDURES ON LOWER 1/3 OF FEMUR  
 01360 FOR ALL OPEN PROCEDURES ON LOWER 1/3 OF FEMUR  
 01380 ANESTHESIA FOR ALL CLOSED PROCEDURES ON KNEE JOINT  
 01382 ANESTHESIA FOR DIAGNOST ARTHROSCOPIC PROC KNEE JNT  
 01390 CLOSED PRCDRS UPPER ENDS TIBIA, FIBULA, &/OR PATELLA  
 01392 OPEN PRCDRS UPPER ENDS TIBIA, FIBULA &/OR PATELLA  
 01400 ANESTHESIA OPEN OR SURG ARTHRO PROC KNEE JOINT; NOS  
 01402 ANES, OPEN PROC KNEE JOINT; TOTAL KNEE ARTHROPLASTY  
 01404 OPEN PROCEDURES KNEE JOINT; DISARTICULATN AT KNEE  
 01420 ALL CAST APPLICATION, REMOVAL OR REPAIR KNEE JOINT  
 01430 VEINS OF KNEE, POPLITEAL AREA; NOT OTHERWISE SPECFD  
 01432 VEINS KNEE & POPLITEAL AREA; ARTERIOVENOUS FISTULA  
 01440 PROCEDURES ARTERIES OF KNEE & POPLITEAL AREA; NOS  
 01442 POPLITEAL THROMBOENDARTERECTOMY, W/WO PATCH GRAFT  
 01444 POPLITEAL EXCSN & GRAFT/REPAIR OCCLUSION/ANEURYSM  
 01462 ANES FOR ALL CLOSED PROCEDURES, LOW LEG, ANKLE, FOOT  
 01464 ANESTHESIA FOR ARTHROSCOPIC PROC ANKLE &/OR FOOT  
 01470 ANES, PROC NERVES, MUSCLES, TENDONS, FASCIA; NOS  
 01472 ANES, LOW LEG; REPR RUPT ACHILLE TENDON, W W/O GRAFT  
 01474 ANES LOW LEG; GASTROCNEMIUS RECESSON (STRAYER PROC)  
 01480 ANES, OPEN PROCEDURES BONES LOW LEG, ANKLE, FOOT; NOS  
 01482 ANES, OPEN PROC BONE LOW LEG, ANK, FOOT; RADICL RESEC  
 01484 ANES, BONES LOW LEG; OSTEOTOMY/PLASTY TIBIA, FIBULA  
 01486 ANES, OPEN PROC BONE LOW LEG; TOTAL ANKLE REPLACMNT  
 01490 ANES, LOWER LEG CAST APPLICATION, REMOVAL OR REPAIR  
 01500 ANES, PROC ARTERIES LOW LEG, INCL BYPASS GRAFT; NOS  
 01502 ANES, PROC ARTERIES LOW LEG; EMBOLECTOMY, DIRECT/CATH  
 01520 ANESTHESIA FOR PROCEDURES ON VEINS, LOWER LEG; NOS  
 01522 ANES, VEINS LOW LEG; VENOUS THROMBECTOMY, DIRECT/CATH  
 01610 ANES, PROC NERVE, MUSC, TENDON, FASICA, BURSAE SHOULDER  
 01620 ANES, HUMER HEAD, NECK, STERNOCLAV, ACROMIO, SHOULD JT  
 01622 ANES DIAGNOSTIC ARTHROSCOPIC PROC SHOULDER JOINT  
 01630 ANES, HUMER HEAD, NECK, STERNO, ACROMIO, SHOULDR JT; NOS  
 01632 ANES, HEAD, NECK, STERNO, ACROMIO, SHOULD JT; RAD RESECT  
 01634 ANES, STERNO, ACROMIO JT; SHOULDER DISARTICULATION  
 01636 ANES; INTERTHORACOSCAPULAR (FOREQUARTER) AMPUTATION  
 01638 ANES, STERN, ACROM, SHOULD JT; TOTAL SHOULDR REPLACMT  
 01650 ANES, PROCEDURE ON ARTERIES OF SHOULDER, AXILLA; NOS  
 01652 ANES, ARTER SHOULD, AXILL; AXILLRY-BRACHIAL ANEURYSM  
 01654 ANES, PROC ARTERIES SHOULDER, AXILLA; BYPASS GRAFT  
 01656 ANES, PROC ARTERIES; AXILLARY-FEMORAL BYPASS GRAFT  
 01670 ANES, FOR PROCEDURES ON VEINS OF SHOULDER, AXILLA  
 01680 ANES, SHOULDER CAST APPLICATION, REMOVAL/REPAIR NOS  
 01682 ANES, CAST APPLICATN, REMOVAL/REPAIR; SHOULDER SPICA  
 01710 NRVS, MSLS, TNDNS, FASCIA, BURSAE UPPER ARM/ELBOW; NOS  
 01712 UPPER ARM & ELBOW; TENOTOMY, ELBOW TO SHOULDER, OPEN  
 01714 UPPER ARM & ELBOW; TENOPLASTY, ELBOW TO SHOULDER  
 01716 UPPER ARM; TENODESIS, RUPTURE LONG TENDON OF BICEPS  
 01730 ANES FOR ALL CLOSED PROCEDURES ON HUMERUS & ELBOW  
 01732 ANES FOR DIAGNOSTIC ARTHROSCOPIC PROC ELBOW JOINT  
 01740 ANES FOR OPEN OR SURG ARTHROSCOPIC PROC ELBOW; NOS  
 01742 OPEN PROCEDURES HUMERUS & ELBOW; OSTEOTOMY HUMERUS  
 01744 HUMERUS & ELBOW; REPAIR NONUNION/MALUNION HUMERUS  
 01756 OPEN PROCEDURES HUMERUS & ELBOW; RADICAL PROCEDURES  
 01758 HUMERUS & ELBOW; EXCISION OF CYST/TUMOR OF HUMERUS  
 01760 PROCEDURES HUMERUS & ELBOW; TOTAL ELBOW REPLACMNT  
 01770 PROCEDURES ON ARTERIES OF UPPER ARM & ELBOW; NOS  
 01772 PROCEDURES ARTERIES UPPER ARM & ELBOW; EMBOLECTOMY  
 01780 PROCEDURES ON VEINS OF UPPER ARM & ELBOW; NOS  
 01782 VEINS OF UPPER ARM & ELBOW; PHLEBORRHAPHY  
 01810 NRVS, MUSCLE, TNDN, FASCIA, BURSAE FOREARM, WRIST, HAND  
 01820 CLOSED PROC RADIUS, ULNA, WRIST OR HAND BONES; NOS  
 01829 ANESTHESIA FOR DX ARTHROSCOPIC PROCEDURES ON WRIST  
 01830 ANES OPEN PROC RADIUS, ULNA, WRIST/HAND JOINTS; NOS  
 01832 RADIUS, ULNA, WRIST, HAND BONES; TOTL WRIST REPLACMNT

01840 ANES PROCED ON ARTERIES OF FOREARM,WRIST,HAND;NOS  
 01842 ANES ON ARTERIES FOREARM,WRIST,HAND; EMOLECTOMY  
 01844 VASCULAR SHUNT OR SHUNT REVISN,ANY(E.G. DIALYSIS)  
 01850 ANES PROC ON VEINS OF FOREARM,WRIST AND HAND; NOS  
 01852 ANES VEINS OF FOREARM,WRIST AND HAND;PHLEBORRHAPHY  
 01860 FOREARM,WRIST,HAND CAST APPLICATION,REMOVL/REPAIR  
 01916 ANESTHESIA FOR DIAGNOSTIC ARTERIOGRAPHY/VENOGRAPHY  
 01920 ANES CARD.CATH.CORONARY ANGIOGRAPHY,VENTRICULOGR  
 01922 ANES FOR NON-INVASIVE IMAGING / RADIATION THERAPY  
 01925 THER INTERVEN RADIOLOGIC ARTERIAL;CAROTID/CORONARY  
 01926 THER INTERVEN RADIOLOGC PROC ARTERIAL;HRT/CRAN  
 01931 THER INTERVEN RADIOLOGC PROC VENOUS/LYMPHATIC;TIPS  
 01932 THER INTERVEN RAD PROC VENOUS/LYMPHATIC;THORACIC  
 01933 THER INTERVEN RAD VENOUS/LYMPHATIC;INTRACRANIAL  
 01951 ANES,2ND & 3RD DEGREE BURN EXCSN; <4% BODY AREA  
 01952 ANES,2ND & 3RD DEGREE BURN EXCSN; 4% TO 9% BODY AR  
 01960 ANESTHESIA FOR; VAGINAL DELIVERY ONLY  
 01961 ANESTHESIA FOR CESAREAN DELIVERY ONLY  
 01962 ANESTHESIA FOR URGENT HYSTERECTOMY FOLLOWING DELIV  
 01963 CESAREAN HYSTERECTOMY W/O LABOR ANALGSIA/ANES CARE  
 01965 ANES FOR INCOMPLETE OR MISSED ABORTION PROCEDURES  
 01967 NEURAXIAL LABOR ANALGSIA/ANES PLANNED VAGINAL DELV  
 01968 ANES CESAREAN DLVRY FOLLOW NEURAXIAL ANALGSIS/ANES  
 01968 ANES CESAREAN DLVRY FOLLOW NEURAXIAL ANALGSIA/ANES  
 01969 ANES CESAREAN HYSTEREC FOLLOW NEURAXIAL ANALG/ANES  
 01991 ANESTH NERVE BLOCKS & INJECTIONS;OTHER THAN PRONE  
 01992 ANESTH NERVE BLOCKS & INJECTIONS;PRONE POSITION  
 01996 DAILY HOSP MNGMNT EPIDURAL/SUBARACHNOD DRUG ADMIN  
 31500 INTUBATION, ENDOTRACHEAL, EMERGENCY PROCEDURE  
 36248 SELECT CATH PLACEMT,ART SYS;2ND,3RD ORD/LOW EXTRM  
 41899 UNLISTED PROC,DENTOALVEOLAR STRUCTURES  
 62273 INJECTION, EPIDURAL, OF BLOOD OR CLOT PATCH  
 62311 INJECTION,SNGL EPIDURAL/SUBARACHNOD;LUMBAR,SACRAL  
 92950 CARDIOPULMONARY RESUSCITATION  
 99148 MODERATE SEDATION SRVCS BY DIFF PHYS,<5 YRS,30 MIN  
 99149 MODERATE SEDATION SRVCS BY DIFF PHYS,5 YRS+,30 MIN  
 99150 MODERATE SEDATION SRVCS BY DIFF PHYS,EA ADD 15 MIN  
 99440 NB RESUSCITATION:PRESSURE VENILAT,CHEST COMPRESS

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## 08 - 33 Coding Updates

### Correction to the January 2008 MIB

29905 Arthroscopy, subtalar joint, surgical, with synovectomy was inadvertently left off the list of 42 post operative days.

### Issue Clarification

76819 Fetal biophysical profile with non-stress testing is the correct CPT code to use.  
 76818 Fetal biophysical profile without non-stress testing, submitted with CPT code 59025 (fetal non-stress test), is denied.

Global pregnancy is not to be unbundled. Some group practices have expressed an opinion that they should be able to unbundle the global pregnancy fee so that each physician in the group practice receives payment for a visit during the pregnancy. This is incorrect billing which may be subject to post payment review. As described in the manual, additional evaluation and management codes are not paid when the patient sees another physician in the group practice or the emergency room for the same or similar issues on the same date of service. The physician or group practice is to bill the evaluation and management code for the level of service provided on the date of service.

### Physician Home Visit Clarification

99349 Physician home visits are covered for patients eligible for hospice in the hospice program. Patients eligible for hospice are not eligible to receive services through Medicaid. Medicaid will consider coverage of a physician home visit when the patient has a condition which makes travel (i.e. 50 miles) very difficult and they live in a rural area where access to medical care is limited. All services will continue to require prior authorization.

Usage of CPT Code 99477 - Newborn Transitional Care

99477 Newborn transitional care. The code 99477 is billed for the INITIAL DAY only for admission of a neonate who requires intensive observation, but NOT intensive therapy. The additional services required for intensive therapy are outlined in the CPT Introductory text for Inpatient Neonatal and Pediatric Critical Care and Intensive Services (CPT 2008, Prof Ed, p.20), "To report initial services [99477] ..." and then, "When a neonate or infant is not critically ill, but requires intensive observation, frequent interventions and other intensive care services, the Continuing Intensive Care Services codes (99298, 99299, 99300) should be used ... 5000 grams or less. When the present body weight... exceeds 5000 grams, the Subsequent Hospital Care Services Codes (99231-99233) should be used."

The American Academy of Pediatrics Committee on Coding and Nomenclature indicates that the code 99477 fills a gap between the usual E/M codes for initial pediatric ward admission and full-fledged intensive care (i.e. 99295-6) for which aggressive interventional support is required. The code is not physician specialty-specific; therefore, family practitioners and pediatricians may also report this service with the adequate clinical documentation of the intensive observation required.

CPT changes 2008: An Insider's View, p.30-32, "The code 99477, initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or less, who requires intensive observation, frequent interventions, and other intensive care services. For the specific initiation of neonate care, the following codes should be reported:

Report code 99431 for inpatient care of the normal newborn.  
 Report code 99295 for the care of the critically ill neonate.  
 Report code 99221-99223 for inpatient hospital care of the neonate not requiring intensive observation, frequent interventions, and other intensive care services.

The patient's newly born status imparts an inherent instability when sick due to the presence of incompletely developed organs at birth that demonstrate dysfunction and require careful evaluation, continual monitoring, and frequent adjustments of therapy during even mild degrees of illness. Typically, these requirements lead to the management of such newborns in neonatal intensive care or special care nurseries where nursing expertise and monitoring equipment appropriate to meet their needs are available 24 hours a day.

The hospital admission codes (99221-99223) were designed for the older child and adult. These codes do not work well in defining the level of illness of the neonate and do not match the type of team supervision and frequent evaluations typical of the care provided in these intensive care units. In addition, meeting documentation guidelines is difficult for these patients who have limited or no past medical history, social history, or review of symptoms. The types of physical examinations typical of the older patient are also quite different. Many items listed in the comprehensive exam would not be appropriate for the newborn.

The following is an example of the services rendered under code 99477:

A 2250-g infant is born at 36 to 37 weeks of gestation by the vaginal route to a mother with unknown Group B Streptococcal disease status. At six hours of life, the baby develops the sudden appearance of tachypnea, grunting, thermal instability, mold tachycardia, and cyanosis responsive to supplemental oxygen. The physician is summoned to the nursery, examines the patient, and admits the infant to the neonatal intensive care unit. The physician undertakes a complete physical examination of the infant. After completion of the examination, a blood culture, complete blood count, chest X ray, and blood glucose are ordered. A spinal tap is obtained, an umbilical venous catheter is placed, and a flat plate of the abdomen is ordered to check the catheter position. The baby is placed on nasal cannula oxygen and a blood gas is obtained through a radial arterial sample. The physician speaks with the parents, the obstetrician, and the pediatrician.

Prior Authorization Required

The following services are under the contracted mental health program. In the few rural health sites where contracted mental health is not available, prior authorization may be requested through Medicaid.

- 00104 Anesthesia for electroconvulsive therapy  
Prior authorization required through contracted mental health program
- 90870 Electroconvulsive therapy (includes necessary monitoring)  
Prior authorization required through contracted mental health program

Covered Codes

- 43644 Laparoscopy, surgical, gastric restrictive procedure with gastric bypass and Roux-en-Y gastroenterostomy  
Prior authorization: Written . . . . . Criteria #22
- 43770 Laparoscopy, surgical, gastric resective procedure, placement of adjustable gastric band  
Prior authorization: Written . . . . . Criteria #22
- 43772 Removal of adjustable gastric band component only
- 43846 Gastric restrictive procedure with gastric bypass for morbid obesity; with short limb (150cm or less) Roux-en-Y gastroenterostomy laparoscopy, surgical, gastric resective procedure, placement of adjustable gastric band  
Prior authorization: Written . . . . . Criteria #22

Addition to Certified Nurse Midwife Manual  
Code S3620-BL

Newborn screening (36) tests sponsored through the state laboratory are covered under the hospital DRG. Sometimes the infant is born outside of the hospital. The code S3620 submitted with the BL modifier is to be used by certified nurse midwives or clinics to bill for the state laboratory newborn screening kit when the procedure is completed through them instead of the hospital. The state laboratory newborn screening kit code includes the initial lab tests and a followup test about two weeks from birth. The venipuncture code may be billed in addition to code S3620-BL.

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## 08 - 34 Medical Supplies

Opened Codes

- A6530 Gradient compression stocking, below knee, 18-30 mmhg, each...2 pair every 6 months
- A6533 Gradient compression stocking, thigh length, 18-30 mmhg, each...2 pair every 6 months

New Codes Open Effective January 1, 2008

- E0328 Hospital bed, pediatric, manual, 360 degree side enclosure, top of headboard, footboard, and side rails up to 24 inches above the spring mattress, included mattress, age 0-20, EPSDT, rental per month.
- E0329 Hospital bed, pediatric, electric or semi electric, 360 degree side enclosure, top of headboard, footboard, and side rails up to 24 inches above the spring mattress, included mattress, age 0-20, EPSDT, rental per month.
- E2227 Manual wheelchair accessory, gear reduction drive wheel, each
- E2312 Power wheelchair accessory, hand or chin control interface, mini-proportional, remote joystick, proportional, including fixed mounting hardware.

Discontinued Code Effective January 1, 2008

- B4086 Gastrostomy/jejunostomy tube, any material, any type, (standard or low profile), each, 3 per month

Replacement Codes for B4086 Effective January 1, 2008

- B4087 Gastrostomy/ jejunostomy tube, standard, any material, any type, each, 3 per month
- B4088 Gastrostomy/ jejunostomy tube, low profile, any material, any type, each, 3 per month

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## 08 - 35 Dental Code Correction

- D3330 Endodontic therapy - molars, excluding final restoration / all/ root canal therapy

There was a misprint identified in the Dental Manual. Policy should read, "covered benefit excluding third molars. Second and third molars are also excluded for **non-pregnant** women and adults age 21 and older. X-rays billed as part of a root canal procedure will be rebundled as part of the global root canal fee."

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## 08 - 36 Long Term Care Income Update

The Long Term Care provider manual has been updated for April 1, 2008. Section 4-7, Family Income, has been modified specifically. Please note page 23, item C. Reporting Changes in Family Income, now states:

The facility, the client, or the client's representative is responsible to report to the Medicaid eligibility worker all changes that may affect the client's contribution to the cost of care within 10 days of the date of the change. This includes, but is not limited to, the amount of income received, medical premiums paid, length of stay, and marital status.

### 1. Income Changes

If a change in income results in an increase in the client's contribution to the cost of care, do not collect the increase. Notify Medicaid eligibility immediately and they will determine what the increased contribution to the cost of care will be and when you should begin to collect it. The change will usually be effective for the next month.

If the client receives a one-time lump sum payment, do not collect it. Also, do not send it to the Office of Recovery Services (ORS). Collect only the usual amount of family income and contact the Medicaid eligibility worker.

If you have questions concerning the collection of family income as explained in this subsection, please contact the Medicaid eligibility worker.

To access the updated manual online, go to <http://health.utah.gov/medicaid/tree/index.html>.



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## 08 - 37 Utah Medicaid Criteria for Coverage Decisions

The purpose of the Utah Medicaid policy is to provide criteria for determining benefit and coverage for specific medical technologies, including procedures, equipment, and services. Utah Medicaid refers to recognized, evidence-based medicine reference tools and/or medical literature for the development of coverage and reimbursement policy and criteria. To the extent there are any conflicts between Utah Medicaid policy, criteria, and applicable evidence-based medicine criteria, the Utah Medicaid policy prevails or Utah Medicaid will use its best judgment in coverage and reimbursement decisions. For specific Utah Medicaid coverage and benefits, refer to the Utah Medicaid Provider Manuals.

Utah Medicaid uses many nationally and internationally recognized peer reviewed, evidence-based medicine criteria to guide utilization management decisions. Utah Medicaid contracts for and uses recognized evidence-based medicine tools (i.e. McKesson Care Enhanced Review Manager Enterprise® and Milliman CareWebQI Guidelines and Criteria®) for review of services, payment reviews, policy research, and development.

Utah Medicaid policy is guided by state and federal regulations and maintains access to evidence-based medical literature that is valid, unbiased, scientifically strong, clinically relevant, safe and efficacious, updated regularly, and peer reviewed. When Utah Medicaid does not have established criteria, Utah Medicaid will refer to (contracted) evidence-based reference tools, or other medical literature for decisions, or use its best judgment. Policy development includes review of the information in the tools or analysis of peer reviewed literature.

Utah Medicaid criteria are available in Section II of the Utah Medicaid Provider Manual. Copies of specific, contracted, evidence-based medicine reference tools are available upon request. Utah Medicaid managed care organizations are required to follow Utah Medicaid policy and criteria in the administration of the Utah Medicaid managed care programs.



## 08 - 38 Pharmacy Coverage Highlights

The following drugs will need to meet these new prior authorization requirements, effective April 1, 2008:

### Vyvanse

- Therapy to be initiated between the FDA-approved ages of 6-12.
- Documented diagnosis of ADHD.
- Vyvanse must be more cost-effective than the patient's current ADHD therapy.
- Vyvanse must follow an unsuccessful trial of a dextroamphetamine.
- Prior approval is for 12 months.
- Renewal of PA requires a telephone call from the physician's office.

### Selzentry

- Minimum age: 16 years old.
- Documentation of a co-receptor tropism assay test indicating CCR5-tropic HIV-1 infection.
- Documentation of optimized background therapy for the treatment of HIV-1 infection.
- Prior approval is for 12 months.
- Renewal of PA requires a telephone call from the physician's office.

Reminder: Medicaid pays for 150 units/month for Methadone, regardless of strength. The FDA has recently restricted the sale of Methadone 40mg tablets to substance abuse providers. Despite this new restriction, Medicaid will not "grandfather" patients who have been taking high doses of Methadone to allow large quantities of available strength tablets. Patients will need to be managed within currently allowed Medicaid quantity limits.

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## 08 - 39 NDC Reporting on Physician-Administered Drugs for Outpatient and End Stage Renal Dialysis (ESRD) Claims

The following policy is in effect for Medicaid and Non-Traditional Medicaid.

The Deficit Reduction Act of 2005 (DRA) includes new provisions regarding state collection of data for the purpose of collecting Medicaid drug rebates from drug manufacturers for physician-administered drugs. Section 6002 of the DRA adds section 1927 (a)(7) to the Social Security Act to require states to collect rebates on physician-administered drugs. In order for Federal Financial Participation (FFP) to be available for these drugs, the state must provide collection and submission of utilization data in order to secure rebates. Since there are often several NDCs linked to a single Healthcare Common Procedure Coding System (HCPCS) code, the Centers for Medicare and Medicaid Services (CMS) deems that the use of NDC numbers is critical to correctly identify the drug and manufacturer in order to invoice and collect the rebates.

Effective July 1, 2008, ESRD centers and outpatient hospital departments (excluding emergency rooms) billing physician-administered drugs with Revenue Code 0251, 0252, 0257-0259, 0634, or 0635 must report the NDC of the product. This policy relates to drugs identified by all HCPCS codes beginning with "J" and some "A, Q, K or S" that are associated with drugs (Codes available at <http://health.utah.gov/medicaid/stplan/bcrp.htm>). Medicaid requires reporting the appropriate Revenue Code, HCPCS, and NDC relating to the physician-administered drug. **Note: Vaccine billing is not affected by this policy.**

The Utah Medicaid Hospital Provider Manual - Revenue Code List has been updated. See the list at <http://health.utah.gov/medicaid/tree/index.html>.

### National Drug Code (NDC)

The NDC must be entered with 11 digits in a 5-4-2 digit format. The first five digits of the NDC are the manufacturer's labeler code, the middle four digits are the product code, and the last two digits are the package size. If you are given a NDC that is less than 11 digits, add the missing digits as follows:

For a 4-4-2 digit number, add a 0 to the beginning.  
 For a 5-3-2 digit number, add a 0 as the sixth digit.  
 For a 5-4-1 digit number, add a 0 as the tenth digit.

Measurements

NDC units are based upon the numeric quantity administered to the patient and the unit of measurement. The actual metric decimal quantity administered and the unit of measurement is required for billing. If reporting a fraction, use a decimal point. Unit of measurement codes are:

- F2 = International Unit
- GR = Gram
- ML = Milliliter
- UN = Unit (Each)

Compounds

When billing compounds, only one NDC can be used per procedure code. For this situation, providers must use the procedure code and procedure code units and corresponding NDC and NDC units of each ingredient within the compound. Each line submitted for the compound is subject to the claims processing edits.

Multiple NDCs

At times it may be necessary for providers to report multiple NDCs for a single procedure code. For codes that involve multiple NDCs (other than compounds, see above), providers must bill the procedure and the corresponding procedure code units, NDC qualifier, NDC, NDC unit qualifier, and NDC units. The claim line must be billed with the charge for the amount of the drug dispensed for the procedure code identified on the line. Enter the NDC information of the next drug on the following line. Do not report the procedure code on this line as it relates to the procedure code of the line previous to this NDC.

When billing the Institutional (UB-04) format electronically, the information needs to be reported in the following X12 fields. NDC information will not be pulled from any other data element. For multiple NDCs, repeat this loop as necessary. Contact your software vendor for specific information.

- 2410 LIN03 = NDC number proceeded with N4 (LIN02 = N4).
- 2410 CTP05-1 = Units qualifier (GR, ML, ME, UN).
- 2410 CTP04 = Number of units (place the number of units immediately after the units qualifier).
- 2410 CTP03 = Cost or unit price.

To view the companion guide, see <http://health.utah.gov/hipaa/guides.htm> .  
 To view the paper claim form instructions, see [http://standards.uhin.com/standards\\_index.htm](http://standards.uhin.com/standards_index.htm) . #57 Institutional Claim Form (UB04).

340B Programs

If the drug was purchased through the 340B program, include the modifier UD after the HCPCS code.

Outpatient Reimbursement

Effective July 1, 2008, Medicaid will reimburse from the HCPCS code rather than the percentage of billed charge.

A crosswalk which shows the NDC codes that correspond to each HCPCS code is available on the Centers for Medicare and Medicaid Services (CMS) website: <http://www.cms.hhs.gov/apps/ama/license.asp?file=/McrPartBDrugAvgSalesPrice>

Provider Manual pages listed below have been updated on the Medicaid website:

<b>Manual Type</b>	<b>Section</b>	<b>Subsection</b>	<b>New</b>
All Providers	Section 1	Subsection 11	Add 11-15
Hospital	Attachments		Revenue Code List
Hospital	Section 2	Subsection 2	Item 3
Hospital/ESRD	Section 4	Subsection 5	Item 1

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## 08 - 40 NDC Reporting on Physician-Administered (Including Certified Nurse Midwives and Nurse Practitioners) Drugs for Medicaid Claims

The following policy is in effect for Medicaid, Non-Traditional Medicaid, and the Primary Care Network.

Effective May 1, 2008, Medicaid will no longer accept the NDC in the note or comment section electronically. Contact your software vendor to ensure you can submit electronically the HIPAA compliant transactions relating to NDCs.

Effective May 1, 2008, all HCPCS codes beginning with "J" and some "A, Q, K or S" codes that are associated with drugs (Codes available at <http://health.utah.gov/medicaid/stplan/bcrp.htm>) require reporting the NDC. Claims that do not include the NDC code will be denied for payment. There will no longer be any modifications in place to accept this data other than the appropriate billing format. **Note: Vaccine billing is not affected by this policy.**

### Compounds

When billing compounds, only one NDC can be used per procedure code. For this situation, providers must use the procedure code and procedure code units and corresponding NDC and NDC units of each ingredient within the compound. Each line submitted for the compound is subject to the claims processing edits.

### Multiple NDCs

At times it may be necessary for providers to report multiple NDCs for a single procedure code. For codes that involve multiple NDCs (other than compounds, see above), providers must bill the procedure and the corresponding procedure code units, NDC qualifier, NDC, NDC unit qualifier, and NDC units. The claim line must be billed with the charge for the amount of the drug dispensed for the procedure code identified on the line. Enter the NDC information of the next drug on the following line. Do not report the procedure code on this line as it relates to the procedure code of the line previous to this NDC.

When billing the professional format (CMS-1500) electronically, the information needs to be reported in the following X12 fields. Contact your software vendor for specific information.

2410 LIN03 = NDC number proceeded with N4 (LIN02 = N4).  
 2410 CTP05-1 = Units qualifier (GR, ML, ME, UN).  
 2410 CTP04 = Number of units (place the number of units immediately after the units qualifier).  
 2410 CTP03 = Cost or unit price.

To view the companion guide, see <http://health.utah.gov/hipaa/guides.htm> .

To view the paper claim form instructions, see [http://standards.uhin.com/standards\\_index.htm](http://standards.uhin.com/standards_index.htm) . #56 Professional Claim Form (CMS1500).

### 340B Programs

If the drug was purchased through the 340B program, include the modifier UD after the HCPCS code.

A crosswalk which shows the NDC codes that correspond to each HCPCS code is available on the Centers for Medicare and Medicaid Services (CMS) website: <http://www.cms.hhs.gov/apps/ama/license.asp?file=/McrPartBDrugAvgSalesPrice>

Provider Manual pages listed below have been updated on the Medicaid website:

<b>Manual Type</b>	<b>Section</b>	<b>Subsection</b>	<b>New</b>
All Providers	Section 1	Subsection 11	Add 11-15
Physician	Section 2	Subsection 2	Item 20
Certified Nurse Midwife	Section 2	Subsection 1	Item 1-3
Enhanced Services for Pregnant Women	Section 2	Subsection 4	

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## 08 - 41 Tamper-Resistant Prescription Pads Update

In May, 2007, Congress passed a bill that required that effective October 1, 2007, written prescriptions for drugs under the Medicaid program must be on tamper-resistant prescription pads. The effective date of this bill has now been changed to April 1, 2008.

Effective April 1, 2008, all new written Medicaid prescriptions (except those for residents of nursing facilities, intermediate care facilities for the mentally retarded (ICF/MR), or other specified institutional and clinical settings) must be written on tamper-resistant prescription pads. The following requirements are mandated:

1. Applies only to written prescriptions. Prescriptions that are electronic (those that are faxed, taken over the phone, or transmitted through other electronic means) are not covered under this law.
2. Applies only to new prescriptions filled on or after April 1, 2008. Does not apply to refills of prescriptions initially filled to April 1, 2008, until law requires a new prescription.
3. Compliance with all federal and state laws regarding the types of documentation and how prescriptions are filled must be maintained.

If a pharmacy fills a prescription that does not comply with the requirements above, funds paid by Medicaid will be recovered. Prescribers will have to ensure that pads used to write Medicaid prescriptions meet the following requirements in order to be considered "tamper-resistant". If not, the patient will likely be sent back to get another prescription written on a compliant prescription form.

Effective April 1, 2008, the prescription form must contain at least one of the following three characteristics:

1. One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;
2. One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber;
3. One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

Effective October 1, 2008, to be considered tamper-resistant, a prescription pad must contain all three of the above characteristics.

If you do not know how to find a vendor for tamper-resistant prescription pads, you may call 1-877-750-4047 ext. 0 or 1-877-290-4262 and ask for Utah's tamper-resistant pad information.

Successful implementation of the above requirements will require support of both prescribers and pharmacies. We recognize that the time frame is difficult to meet, but the requirement is a federal law, and we do not have the authority to change it. Please contact the Medicaid Pharmacy team at (801) 538-6293 or (801) 538-6495 if you have any questions.

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## 08 - 42 AMP Update

Due to pending legal action that resulted in a temporary injunction, the implementation of the AMP-based reimbursement methodology and new AMP-based Federal Upper Limits, as outlined in the Deficit Reduction Act, has been put on hold. No further information is available at this time. Medicaid will continue to publish information as it becomes available.

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## 08 - 43 Preferred Drug List Update

During the 2007 legislative session, the Utah State Legislature passed Senate Bill 42 allowing Medicaid to adopt a preferred drug list (PDL). Medicaid began to phase in a preferred drug list beginning October 1, 2007. In order to meet this goal, Medicaid has taken the following steps:

- The first official P&T Committee meeting was held on August 7, 2007. These meetings are open to the public and generally are held at 7:00 AM on the third Friday in the Cannon Health Building at 288 N. 1460 W. in Salt Lake City, Utah.

- Persons who wish to address the P&T Committee may contact Duane Parke at (801) 538-6841 at least 7 calendar days prior to the meeting. Comments from visitors, while welcome, may be limited due to time constraints.
- The P&T Committee consists of an academic pharmacist, a hospital pharmacist, a chain store pharmacist, an independent pharmacist, a governmental pharmacist, a pediatrician, a family practice physician, a psychiatrist, and an internist.
- The Drug Information Service at the University of Utah summarizes and updates clinical efficacy and safety information from the Oregon Evidence-Based Practice Center or the Drug Information Service. These materials will be posted in advance on the Pharmacy Services Website at <http://health.utah.gov/medicaid/pharmacy>.
- The P&T Committee will advise Medicaid in choosing preferred agent(s) for each selected class of drugs based on clinical efficacy and safety.
- Division staff then examine confidential cost information and make a recommendation on which drugs in a class should be preferred.
- Prescribers may document medical necessity in a patient's chart and hand write "Medically Necessary - Dispense As Written" on prescriptions for non-preferred drugs. Please note: the override does not affect mandatory generic dispensing laws. If a generic version of a drug is available, the brand name will continue to require prior authorization.

To date, the Division has finalized a Preferred Drug List in the following drug classes:

- Statins
- Proton Pump Inhibitors
- Diabetic Testing Strips and Supplies
- Oral Antidiabetics
- Long-Acting Opioid Narcotics
- Antihypertensives: ARBs, ACEs, Calcium Channel Blockers, and Beta-Blockers

Reminder: The Preferred Drug List is NDC-specific. The list of covered NDC's can be downloaded from the Medicaid Pharmacy Website at <http://health.utah.gov/medicaid/pharmacy>.

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## 08 - 44 Updated Immunization Schedule

### Changes to the Recommended Immunization Schedule for Children Aged Birth to 18 Years (CHEC Well Child)

Providers should be aware that the Advisory Committee on Immunization Practices (ACIP) has released an updated immunization schedule for children aged birth to 18 years. This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines as of December 1, 2007. These changes will be incorporated in the Child Health Evaluation and Care (CHEC) Medicaid Provider Manual, effective April 1, 2008.

All immunizations should be kept current to prevent childhood diseases and maintain optimal health. Immunizations are part of an EPSDT (CHEC) well-child exam and are covered under the CHEC program.

For more information or questions call the Utah Department of Health Medicaid Information Line at 1-800-662-9651 or the Immunization Program at (801) 538-9450.

The schedule is also available online at <http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm#printable>.

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## 08 - 45 Home Health Agency Clarification

The Home Health Agency Manual has been updated for April 1, 2008. Chapter 5, Prior Authorization, under item B on page 23, has been modified to read:

Medicaid will review the [Prior Authorization] request and documentation. All required documentation must be submitted at the time of the request, or the request will be denied for insufficient documentation. If the provider chooses to resubmit with the required documentation, the approval will begin with date of receipt. Approval may be given for up to sixty days, unless the Plan of Care indicates a shorter time is required for home health care. For complete information about the Prior Approval process, please refer to Section I of this manual, Chapter 9, Prior Authorization Process. Section I is available on the Internet at <http://health.utah.gov/medicaid/pdfs/SECTION1.pdf>.

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