

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

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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

08 - 48 Statewide Provider Training

Utah Medicaid providers are invited to attend the 2008 Medicaid Statewide Provider Training Seminar. We have added three new locations to better serve you. The seminar will include important information regarding new Medicaid ID cards, paper claims, taxonomy codes, billing issues, and other new items. The seminar will last approximately 2-2 ½ hours. We encourage any suggestions for additional training topics.

Please submit your RSVP or training topic suggestions to :

E-mail: medicaidops@utah.gov

Phone: (801) 538-6485, 1-800-662-9651, option 5, or (801) 538-6155, option 5.

When leaving information, please state your group name, how many will be in attendance, and a contact name and telephone number.

Seminar Schedule 2008

City	Date	Address	Time
Tooele	8/05	Tooele Health Department 151 North Main, Tooele	9:30 AM
Ogden	8/07	Ogden Regional Medical Center 5475 South 500 East, Ogden Cedar Room	9:30 AM or 1:30 PM
Monticello	8/12	San Juan Hospital 364 West 100 North, Monticello	9:30 AM
Price	8/13	South Eastern Health Dept 28 South 100 East, Price	9:30 AM
Logan	8/19	Environmental Health Bldg (new) 85 East 1800 North, Logan	9:30 AM
Layton	8/20	Davis Hospital 1600 West Antelope Dr, Layton Classrooms 1 & 2	9:30 AM
Nephi	8/26	Central Valley Medical Center (new) 48 West 1500 North, Nephi	9:00 AM
Fillmore	8/26	Fillmore Hospital 674 South HWY 99, Fillmore	1:30 PM
FQHC	8/27	860 East 4500 South # 206 SLC/ Video Conference	1:00 PM
Salt Lake	9/03	State Library 250 North 1950 West, SLC	9:30 AM or 1:30 PM
Salt Lake	9/04	South County DWS 5735 South Redwood Rd, SLC	9:30 AM or 1:30 PM
American Fork	9/09	American Fork Hospital (new) 170 North 1100 East, American Fork Classroom 1 (West entrance)	9:30 AM
Provo	9/10	North West Plaza Clark Auditorium 1134 North 500 West, Provo	9:30 AM

Richfield	9/16	Sevier County EMS Building 50 West 925 North, Richfield	9:00 AM
Panguitch	9/16	Garfield Memorial Hospital (new) 200 North 400 East, Panguitch Conference room, Admin bldg	1:30 PM
Cedar City	9/17	Iron County School District 2077 West Royal Hunte Dr, Cedar City	9:30 AM
St George	9/18	Dept of Workforce Services 162 North 400 East, St George	10:00 AM or 1:30 PM
Heber	9/23	Heber Health Department (new) 55 South 500 East, Heber Room 100	9:30 AM
Roosevelt	9/24	Northeastern Medical Center 210 West 300 North, Roosevelt	9:30 AM

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08 - 49 National Provider Identifier (NPI)

Utah Medicaid Achieves NPI Compliance

The Division of Health Care Financing for the state of Utah, has transitioned from Medicaid Provider ID numbers to the new federally required National Provider Identifier (NPI) on April 14, 2008, marking the end of the Utah Medicaid Contingency Plan. This change was mandated under the Health Insurance Portability and Accountability Act of 1996, known as HIPAA.

Medicaid will continue to include NPI billing tips and reminders in the Medicaid Information Bulletin as we notice trends in claims processing.

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 "What's New; Paper Claim Forms - examples."

To verify that your NPI has been registered, contact 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/ .

It was a long and winding road to compliance and we would like to thank all providers who registered their NPI and contributed to the successful transition.

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08 - 50 Utah Medicaid Identification Card

The identification card for Utah Medicaid recipients is changing. The Department of Workforce Services is implementing a new eligibility system called, "Electronic Resource and Eligibility Product" (eREP). The eREP product is Utah's new eligibility determination system that is scheduled to begin to replace the current eligibility system in October 2008.

As a result of the implementation of this new system, Medicaid has created a new medical identification card. This new card has been designed to better meet the needs of the clients as well as the providers. Because the eREP system will be brought up over a period of four months, it is possible that providers will see both the new and the older versions of the Medicaid cards for quite some time. Either card type is valid for only the period identified on the card that is presented at the time of service.

The first phase of implementation will include Emery, Summit, Wasatch and Utah counties. Clients residing in these counties will be the first to receive the new version of the Medicaid card. For information about the implementation schedule, visit the DWS website at <http://jobs.utah.gov/jobseeker/dwsdefault.asp>.

The transition to the eREP system will have a significant impact on the way Utah Medicaid providers and their office personnel interpret the Medicaid card. In order to introduce the new card now, there is an example included in this article. The example presented here is a fictional client family and is an extreme case, allowing for a more thorough explanation of the changes. These changes will be a discussion topic for the statewide provider seminars scheduled to begin in late summer.

Some characteristics of the card will not change. There are, however, many significant differences. The new design is intended to more closely conform to the size of medical cards already being used in the healthcare community. The Medicaid card will continue to be printed on 8X11 size paper and the background color for the body of the card remains the same: Traditional and Emergency Only - purple, Non Traditional - blue, Primary Care Network - yellow, and QMB Only - peach.

The client may choose to detach the body of the card from the top address area on the sheet of paper. If they do, the card may then be folded in quarters. This will allow them to present an actual card-sized insurance card at the provider's office. Each quadrant of the card may contain information essential to the provider. The back of the card will be used for spend-down cases with incurred medical bills. Copying the card for your records is still recommended. The card may be unfolded for copying and all relevant information will be on a single copy. Spend-down clients with incurred medical bills will have additional information for providers printed on the back of the card.

The top, right quadrant is the "front" of the card. The Medicaid program is printed in the banner line. Families may have multiple cards for members enrolled in different program types, or if there is more information than the single card can display. The card covers only the date span specified on this quadrant of the card. The health plan or primary care physician's name will appear in this section. If the client is restricted and/or has third party liability, there is a field for yes or no on each option. There are important messages for the client and provider printed here, with phone numbers listed as well.

The top, left quadrant may contain special instructions. Spend-down clients have a message for providers. Required co-pays will be described for the provider, by client according to the co-pay code.

The lower, left quadrant has specific client identifying information such as client name, ID number, (F) for FULL benefits, and gender which are listed under the first heading. Date of birth and age are under the second heading. Co-pay indicator code (described above) for each individual client, health plan and mental health plan phone numbers, physician and pharmacy name for restricted clients can also be found.

The lower, right quadrant will have additional information about restrictions (if any) for the client. The card will list all providers authorized by restriction program staff, including hospital prescribers and urgent care facility. The TPL/Medicare information section displays details about the primary insurance.

See following page for an example of the new card as it will appear when detached from the address section.

- Medicaid Program
- Eligibility Date Span
- Health Plan or Primary Care Provider
- Restricted or TPL
- Important Messages and Phone Numbers

- Special Instructions for Providers about Spend down Clients
- Co-Pay Explanations

Special Instructions:
This client is responsible to pay the medical/pharmacy bills listed on back of this card.

Co-Pay Codes

- A Co-pay/Co-ins for non-emergency use of ER, Pharmacy, Outpatient Hospital and Physician Services & Inpatient Hospital
- O Co-pay required for non-emergency use of ER, Outpatient Hospital and Physician services & Pharmacy
- D Co-pay required for non-emergency use of ER, Outpatient hospital and Physician services, Pharmacy & Inpatient Hospital

Name/ID	DOB/Age	Co-Pay	Provider	Restrictions	TPL/Medicare Information
Josephine Mississippi 123456789 (F) Female	09/09/1973 34	A	Select Access 800-662-9651 Davis Mental Health 801-555-1212 Dr. James Kirkpatrick Albertson's Pharmacy	Hospital: Utah Valley Reg Med Ctr Prescriber: Robert Finneganouttigan, James Enterprise Kirkpatrick, Angelique Goodhue. Urgent Care: Sugarhouse Intacare.	Regence Blue Cross Blue Shield P O Box 30272, Salt Lake City, UT 84130 Policy Holder: David Haller Bessonrether ID#: 454536574 Group# 45217891
Joseph Mississippi 123456779 (F) Male	09/09/1973 34	O	Select Access 800-662-9651 Davis Mental Health 801-555-1212 Dr. James Kirkpatrick Albertson's Pharmacy	Hospital: Utah Valley Reg Med Ctr Prescriber: Robert Finneganouttigan, James Enterprise Kirkpatrick, Angelique Goodhue. Urgent Care: Sugarhouse Intacare.	Regence Blue Cross Blue Shield P O Box 30272, Salt Lake City, UT 84130 Policy Holder: David Haller Bessonrether ID#: 454536574 Group# 45217891
Joe Mississippi 123456709 (F) Female	09/09/1973 34	D	Select Access 800-662-9651 Davis Mental Health 801-555-1212 Dr. James Kirkpatrick Albertson's Pharmacy	Hospital: Utah Valley Reg Med Ctr Prescriber: Robert Finneganouttigan, James Enterprise Kirkpatrick, Angelique Goodhue. Urgent Care: Sugarhouse Intacare.	Regence Blue Cross Blue Shield P O Box 30272, Salt Lake City, UT 84130 Policy Holder: David Haller Bessonrether ID#: 454536574 Group# 45217891

- Client Name, ID Number with or without (F) for FULL benefits
- Date of Birth and Age for each Client
- Co-Pay type (explained in upper left quadrant)
- Name and Phone Number for Health Plan, Restriction Pharmacy

- Restriction Hospital, Prescribers, Urgent Care
- Third Party Liability or Medicare Billing information
 - Address, Policy Holder, ID Numbers

08 - 51 Chronic Pain Program Modifications

To better help clients and health plans access chronic pain consultations, the Department has made the following changes to the Utah Medicaid Chronic Pain Program:

1. Lifted the age restriction effective immediately in order to include children.
2. Removed the prior authorization requirement effective immediately.
3. Changed process to fax referrals directly to approved Utah Medicaid pain providers.
4. Removed the requirement that all recipients who are provided a pain consultation are automatically enrolled in the Restriction Program.

The program will continue to require a multi-disciplinary consult that includes a psychiatric evaluation and medical evaluation.

The program will continue to require the Utah Medicaid Chronic Pain Referral Form. It can be downloaded from <http://health.utah.gov/medicaid/provhtml/forms.htm>. The Chronic Pain Referral Form must be completed by the referring provider and faxed directly from the referring provider to the pain specialist.

The program will continue to emphasize that there must be a primary care provider (PCP) involved who will prescribe.

Any willing Medicaid board certified pain specialist, physical therapist, or psychiatrist/psychologist who wants to participate in the Chronic Pain Program can contact Darlene Benson at darlenebenson@utah.gov or call (801) 538-6149. Health Clinics of Utah is now accepting new pain patients. Health plans, patients, providers, or staff may contact the following to refer patients or schedule appointments:

Attn: Joe Mason / Dr. Robert Finnegan
Health Clinics of Utah
3195 South Main
Suite 200
Salt Lake City, UT 84115
Phone: (801) 468-0354
Fax: (801) 468-0353

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08 - 52 Global Pregnancy Billing

When the same physician or group practice sees the patient throughout the pregnancy, the global delivery code is to be billed. If payment has been made through Baby your Baby, fee for service, or another managed care organization for antepartum care, the payments are to be returned when the global delivery fee is paid by the managed care group at the time of delivery.

Physicians who provide the antepartum and postpartum care, but have another provider complete a c-section, may bill the c-section delivery with an 80 modifier if they participated as the assistant surgeon. The 62 modifier or 52 modifier are not covered modifiers with the delivery code. The antepartum and postpartum care code may be billed separately in this circumstance.

The above paragraph has been added to the following manuals for July 1, 2008: Physician Manual, page 17, Maternity Care (32), and Certified Nurse Midwife Manual, page 2, section 1-1.

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08 - 53 Coding Changes and Updates

ICD.9 Changes

The *Authorized Diagnoses for Emergency Department Reimbursement* list has been revised. Code 574.4 was removed and code 574.6, calculus of bile duct with acute cholecystitis, was added July 1, 2008.

Code 643.1, severe vomiting in pregnancy, has been changed to include the range 643.10-643.13 effective July 1, 2008.

Non Covered CPT Code

71555 Magnetic resonance angiography, chest, with, without contrast, is non covered effective July 1, 2008.

Prior Authorization

Prior authorization requirements have changed to written approval for knee arthroscopy in the range of codes 29870 through 29888, effective July 1, 2008.

Incidental Edits and Obtaining Urine Specimen

The Physician Manual, page 10, item 12 of covered services, has been updated for July 1, 2008. Under the incidental edits topic, it now reads, "straight catheterization or other method used with the sole purpose of obtaining a urine specimen."

Clarification on After Hours Codes

After hours codes 99050 and 99058 are covered only for established patients when the service is provided outside of the provider's normal office hours. For example, when a provider whose normal hours of operation are from 11 am to 9 pm, examines a patient at 8 pm, after hours services are not a covered Medicaid service.

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08 - 54 Outpatient and Inpatient Hospital Revenue Codes

Effective July 1, 2008, Medicaid is following the national standard to require CPT codes to be listed with the revenue code. This standard will apply with the exception of the following revenue codes: 0360, 0361, 0450-0452, 0458-0460, 0469, and 0730, wherein CPT codes will not be required.

Reimbursement will remain at 77% of billed charges.

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08 - 55 Medical and Surgical Criteria Updates

Several criteria, which appear in the *Criteria for Medical and Surgical Procedures* list, have been updated for July 1, 2008. The updated attachment can be found on the Medicaid website at <http://health.utah.gov/medicaid/tree/index.html>.

Below are policy updates for criteria #4 Knee Arthroscopy, criteria #6 Surgical Treatment of Reflux Esophagitis and Hiatal Hernia/Open or Laparoscopic, criteria #22 Gastric Bypass Surgery, criteria #39 Pregnancy Ultrasound, criteria #40B MRI, criteria #41 Fiberoptic Endoscopic Evaluation of Swallowing (FEESST), criteria #42 Varicose Vein Surgery, criteria #43 Sleep Study in Adults, and criteria #46 Craniectomy or Craniotomy Decompression.

Criteria #4 Knee Arthroscopy

Clinical examination and plain x-ray films are still the gold standard for evaluation and management of the knee.

Documentation requirements, must include documentation for **items 1-3**.

1. Requires x-ray as a first study which must have been completed within 6 months of the request. An x-ray has ruled out fractures, osteochondritis dissecans, osteochondral defect, or degenerative arthritis which may affect treatment in a soft tissue injury. A CT scan may be considered in lieu of an x-ray if it was already completed as the first study. For criteria related to MRI of knee see Criteria 40 B.
2. Submit documentation of physical examination with differential diagnose(s) which has been completed within six months of the request. The physical examination has ruled out patellofemoral syndrome, bursitis and tendonitis. Note: If the cause of knee pain is not obvious physical examination should rule out flat feet, fallen arches, and the hip as a source of knee pain, especially in children.

3. Eight weeks of conservative treatment has been tried, including: **(all)** rest, ice, compression, elevation in first 24 to 72 hours.
 - a. Non-steroidal anti-inflammatory drugs (NSAID's). NOTE: Waived if medically unable to take NSAID's or in cases of infection like osteomyelitis.
 - b. Initial physical therapy assessment required.
 - i. Sessions of physical therapy and recommended ROM strengthening exercises for home as determined appropriate by the physical therapist. NOTE: Based on the program eligibility of the the patient, there may be limitations on the number of visits the patient may be able to access per year. Note: physical therapy may be waived when infection like osteomyelitis.
 - ii. Immobilization and activity modification. Note: Crutches or bracing may be recommended for specific types of injury. (i.e. grade III grade MCL injury first 4-6 weeks).
 - iii. Activity modification to avoid excessive pressure on knees (i.e. no squatting, no competitive sports activities).

Coverage Indications select at least **one** of the following sections:

1. Removal of intra articular loose body or loose body associated with Osteochondritis dissecans, must document **(All)**. Note: Loose bodies that are stable or attached to the synovial membrane, recess or bursa can be treated conservatively (item 3 above). Note: Autologous cartilage transplant and cultured cartilage grafting is not a covered service.
 - a. Symptoms **(all)**
 - (1) Joint pain associated with swelling or effusion.
 - (2) Locking. Note: True locking is defined as more than a momentary locking of the joint with the knee in a fixed position, as compared with the sensation of momentary catching with extension of the knee.
 - (3) Giving way. Note: Knee buckles so that you are unable to bear weight and usually occurs while going up and down stairs or standing. Often people report falling within the last three months. This is an indication of muscle weakness. Reports of giving way involving knee rotation (i.e. while pivoting, turning corners) is more consistent with internal derangement.
 - b. Findings **(all)**
 - (1) Pain with passive ROM
 - (2) Limited ROM (i.e. extension or flexion)
 - (3) Clicking
 - c. X-ray confirms loose body.
2. Debridement, drainage, and lavage aspirate for local effusion or systemic sepsis **(one or more)**.
 - a. Has indication of osteomyelitis within last three months **(one or more)**.
 - (1) ESR>30mm/hr
 - (2) Temp>100.4
 - (3) WBC >10,000cu/mm
 - (4) Blood culture positive
 - (5) C reactive protein >10mg/L
 - b. Septic joint – Patient has fever, pain, joint tenderness, effusion or swelling and/or erythema or warmth over joint. Joint has been aspirated and based on culture and sensitivity antibiotic treatment has been started. Multiple aspirations can be done, but Arthroscopy and Lavage are indicated when: **(one)**
 - (1) Fluid becomes to purulent to aspirate.
 - (2) Signs of local sepsis do not abate and the synovial fluid analysis does not return to normal within two days.
 - (3) Septic joint occurs with rheumatoid arthritis and other joint disease.
3. Synovectomy
 - a. Minor Symptoms **(all)**
 - (1) Knee pain or giving way
 - (2) Tenderness over suspected plica
 - b. Major Symptoms **(all)**
 - (1) Knee pain
 - (2) Limited ROM. Note: "Not easily defined–varies from patient to patient" (Interqual)
 - (3) Joint effusion/swelling
 - (4) Synovial thickening
 - (5) Minimal of no degenerative changes in bone/cartilage by x-ray
 - (6) Symptoms unimproved after disease specific treatment \geq 12 weeks. Note: conservative treatment such as cortisone injections for rheumatoid arthritis should be tried. The specific therapy depends on the disease process.
 - c. Indications: **(one)**
 - (1) Rheumatoid arthritis
 - (2) Localized pigmented villonodular synovitis

- (3) Hemophilic joint disease
 - (4) Other chronic inflammatory conditions
4. Lateral retinacular release for patellar pathology for any **one** of the following. Note: Lateral retinacular release procedures should not be used to treat anterior pain alone.
- a. Findings (**All**)
 - (1) Patellar or peripatellar pain continues after eight weeks of conservative therapy
 - (2) Physical examination documents
 - (a) Retropatellar crepitus
 - (b) Signs and symptoms of impingement syndrome
 - (c) Abnormal patellar tracking (**one**)
 - i. Lateral subluxation >1cm
 - ii. Q angle >20 degrees
 - iii. Patellar tilt excessive/abnormal
 - (3) Imaging (**Both**)
 - (a) Minimal or no changes patellofemoral articular surface by x-ray
 - (b) Other findings by x-ray. Note: MRI may be considered when documentation supports the x-ray and CT is not conclusive.
 - i. Lateral patellar subluxation
 - ii. Patellar tilt excessive abnormal
 - b. Indications (**one**)
 - (1) Lateral subluxation
 - (2) Lateral dislocation
 - (3) Lateral tracking abnormalities
 - (4) Procedure required with other patellar realignment procedures.
5. Internal derangement of the knee (**a and b**)
- a. Symptoms with (**1 and 2**) and at least one out of symptoms **3-6**.
 - (1) Significant pain associated with sensitivity to palpation along the medial or lateral joint not responding to conservative treatment after **eight weeks**
 - (2) X-ray indicates widening of the joint compartment
 - (3) Locking of joint or loss of movement
 - (4) Instability by physical exam
 - (5) Muscle atrophy
 - (6) Effusion
 - b. Includes meniscal, cartilaginous or ligamentous (ACL and PCL) injury (**one from 1-5**)
 - (1) Meniscal tear repair (a, b, **and c**; **or a and d**)
 - (a) Positive McMurray's test, Apply test, Steinman test (**one**)
 - (b) Unstable after completion of conservative treatment (item 3)
 - (c) Site of tear has vascular supply for favorable outcome
 - (d) True knee locking. Note: If a torn fragment has been trapped in the joint, locking usually occurs at 20-45 degrees of extension. There is a click or a snap after the joint unlocks
 - (2) ACL (a, b, **or c**; **and d**)
 - (a) History of sports or other serious injury
 - (b) Audible pop
 - (c) A sensation that the knee may buckle (due to instability)
 - (d) ACL testing confirms: Lachmans test (high negative value), Anterior drawer test, pivot shift test (high positive value) (**one**)
 - (3) PCL (a **and b**)
 - (a) Most PCL tears grade I and II heal with medical conservative treatment (item 3). Note: The PCL is difficult to view arthroscopically, the anterior 2/3 is poorly seen because of fat and synovium. Injury can result from hyperextension or hyperextension with external rotation with activity like skiing (see section f.i.(1) Grade III tear below).
 - (b) Posterior drawer test, Posterior sag test, PCL sulcus test (**one**)
 - (4) LCL (a **or b**; **and c**)
 - (a) Associated with more severe injuries, usually hyperextension and external rotation.
 - (b) Individual feels a pop.
 - (c) LCL varus stress test of joint confirms.
 - (5) MCL (a **or b**; **and c**)
 - (a) MCL tear is rarely isolated and is usually associated with ACL or meniscal tears
 - (b) Individual reports feeling a pop after a direct lateral blow to the knee. Note: Most tears are treated non surgically with conservative medical management
 - (c) MCL valgus stress test of joint. Note: Test is positive starting at grade II tear.

6. Multiple ligament injury with suspected ligament instability as **indicated by one a- e**:
 - a. Mechanical laxity or excess in ROM in the joint due to loss of integrity of the ligaments and other soft tissues which contribute to joint stability (**one**).
 - (1) Diagnosis of grade III PCL tears and MRI evidence of additional injuries in the posterolateral complex. NOTE: Increased external rotation of the tibia and increased lateral opening on varus stress should alert the clinician to involvement of the posterolateral complex. In grade III posterior subluxation is greater than 10mm.
 - (2) In injuries to the medial collateral ligament (MCL) when it reaches grade II or when there is addition concern of associated injury of medial meniscus, capsule, and ACL.
 - (3) ACL and LCL tear with evidence of instability.
 - (4) PCL and ACL tear with evidence of instability.
 - b. Recurrent ligament injury after surgery when the diagnostic certainty regarding the degree and type of pathology is low.
 - c. Segond (avulsion of fibular head) and Tibial plateau fractures are associated with multiple ligament tears.
 - d. Suspected tear of extensor mechanisms (i.e. quadriceps, patellar tendons). Note: unable to straight leg raise, palpable joint gap, change in patella height. This is extensor mechanism requiring orthopedic intervention.
 - e. When clinical evaluation indicates injury, the patient requires urgent surgical intervention for a bucket tear or an indication of neurological or vascular damage. Note: conservative measures are not indicated.
7. Chondroplasty (**All**). Note: Osteoarthritis must be ruled out as the sole source of pain.
 - a. History of giving way or current knee pain
 - b. Findings at knee
 - (1) Limited ROM
 - (2) Joint effusion and swelling
 - (3) Crepitus
 - c. X-ray normal or mild osteoarthritic changes
 - d. Requires documentation of a 6-month trial of conservative treatment as outlined in item 3.
8. Joint exploration (**one**). Note: conservative treatment may be waived when emergent surgery is necessary.
 - a. Post penetrating injury
 - b. Imaging confirmed lesion or mass
 - c. Bakers cyst (all)
 - (1) Pain in posteromedial knee increased with activity
 - (2) Popliteal mass but knee exam otherwise normal
 - (3) Bakers cyst >3cm by ultrasound
 - (4) Continued symptoms after eight weeks of conservative therapy-item 3 (**All**)
 - (a) Aspiration and local corticosteroid injection

Criteria #6 Surgical Treatment of Reflux Esophagitis and Hiatal Hernia/Open or Laparoscopic

Type I hernias are small and may or may not be accompanied by gastroesophageal reflux disease (GERD). These are treated with medical management. Complications are rare and are mostly related to reflux. Many patients with type II hernias are asymptomatic or have only vague intermittent symptoms. Type II, III, IV paraesophageal hernias account for 5% of all hernias. Paraesophageal hernias are associated with abnormal laxity of structures normally preventing displacement of the stomach (i.e. the gastrosplenic and gastrocolic ligaments). The natural tendency of a type II hernia is progressive enlargement. Type III hernias are type I and II hernias with a sliding element. Type IV hernia is associated with a large defect in the esophageal membrane allowing other organs such as the colon spleen, pancreas or small intestine to enter the hernia sac.

Documentation requirements, must include documentation for **items 1&2**:

1. Failed 4-month trial of conservative medical therapy:
 - a. A proton pump inhibitor and over the counter antacid (**all**)
 - i. Double dose PPI therapy if not responsive after three days
 - ii. Compliant with medications, but persistent reflux regurgitation symptoms
 - iii. Inability to tolerate medications
 - b. Dietary lifestyle management. Note in medical record document attempts at dietary management including avoidance of smoking, weight loss efforts, avoidance of certain foods thought to relax the valve and make reflux more likely (i.e. coffee, chocolate, onions, high-sugar foods, and high-fat foods), no snacking prior to bed time and sleep with head elevated.
2. Diagnosed type II or greater paraesophageal hernia documented by **a and b**: Note: The Berstein test and esophageal pH monitoring are not useful.

- a. Endoscopic findings of **(one)**
 - i. Severe esophagitis in patients with symptoms of reflux
 - ii. Benign stricture
 - iii. Barretts metaplasia. Note: Barretts columnar lined epithelium without severe dysplasia or carcinoma.
- b. Esophageal manometry. Note: Test may provide alternative diagnosis such as scleroderma or achalasia for which anti-reflux surgery may be contraindicated. Manometric evidence of lower esophageal sphincter pressure less than 10mm Hg has been associated with improved surgical results because it provides assurance of gastric motility.

Coverage Indications, must document **one (a-f)**:

- a. Incarcerated hernia by barium swallow. Note: This condition is a rare emergency. Patient presents with severe chest pain or upper abdominal pain, dysphagia, and a mediastinal mass on CxR.
- b. Paraesophageal hiatal hernia Type II or greater confirmed by UGI or Endoscopy. Note: Occurs in less than 5% of patients. Pain may be the most common symptom; symptoms of reflux may not be present.
- c. GERD with sliding hiatal hernia, documented by **all** of the following:
 - i. Pain by history (**both**)
 - (1) Chest/upper abdomen. Note: Other sources of chest and upper abdominal pain (i.e. angina, biliary colic) should be ruled out.
 - (2) Postprandial and nocturnal.
 - ii. Sliding hiatal hernia diagnosis confirmed (diagnosed above) and tests positive for esophagitis (**one**)
 - (1) Endoscopy
 - (2) GI series
- d. Recurrent esophageal stricture, documented by **all** of the following:
 - i. Dysphagia by history
 - ii. Stricture confirmed by barium swallow or endoscopy
 - iii. Dilation at least twice > 4 months
 - iv. Proton pump inhibitor ≥ 4 months
 - v. No aspirin or NSAIDs > 4 months
- e. Re-operation for recurrence of severe reflux despite maximum medical management.
- f. Surgery may be indicated for pediatric patients with persistent GERD who have had maximum conservative medical management. Note: Recurrent pulmonary symptoms in association with GERD (i.e. aspiration, pneumonia) have been advocated as an indication for surgery for pediatric patients. Consensus has not been achieved in the role of surgery for patients with asthma that is thought to be related to GERD. Many cases of GERD resolve without surgery. Improvement in respiratory function has not been documented after medical or surgical therapy. Research indicates that children on maximal pharmaceutical therapy for 5 years or more have not experienced adverse effects. For surgical consideration the patient must meet **all** of the following:
 - i. Regurgitation prominent GERD with oral pharyngeal symptoms or a condition that tends to be complicated with regurgitation. Note: Conditions include: history of esophageal atresia repair, laryngeal malacia, neurological impairment (i.e. cerebral palsy), chronic lung disease (i.e. cystic fibrosis—patients do not have acid neutralizing substance in saliva or mucous membranes) or patient undergoing chemotherapy.
 - ii. Need for chronic medical therapy and side effects from therapy
 - iii. Endoscopic diagnosed (**one**):
 - (1) Esophagitis confirmed by biopsy
 - (2) Hiatal hernia

Criteria #22 Gastric Bypass Surgery

The word "GERD" has been added to the Gastric Bypass Surgery Criteria #22. Number 8.C.4. now reads, "The physician verifies that the patient does not have any one condition listed as a contraindication to the device: Severe hiatal hernia or GERD."

Criteria #39 Pregnancy Ultrasound

The following statement was addressed in the January 2008 MIB and inadvertently left out of the criteria in the manual:

"Ten ultrasounds will be allowed in 12 months to cover two pregnancies in one year." The manual has been updated for July 1, 2008, to reflect this policy.

Criteria#40 B MRI**Cardiac MRI**

The 64-slice MDCT provides data similar to cardiac angiography and is becoming a replacement for angiography in many centers. Some studies indicate the multi-slice CT surpasses the cardiac MRI in accuracy, reliability, and quality. For consideration of a cardiac MRI, other cardiac imaging studies (i.e. angiography, TTE, and TEE) must have been completed in the last 2 months.

Coverage

For coverage consideration, all the following documentation must be submitted: (ALL):

1. An assessment of cardiac arrhythmia is provided.
2. Describe whether the cardiac issue(s) under consideration are anatomical and/or functional.
3. Provide reports of all the completed cardiac evaluation tests. NOTE: There must be a medically necessary reason the MRI is required in addition cardiac evaluation test.
4. Describe whether the patient has an allergy to dye or renal insufficiency which prevents the use of contrast (MDCT, MRA). Note: the patient has been screened for any contraindications such as a pacemaker, implanted defibrillator, Swan-Gantz catheter, recent coronary stenting (<6 weeks), and other conventional contraindications.

Indications are one of more of the following (select all that apply)

1. Congenital heart disease to define structural relationships outside of the cardiac chambers.
2. Endocarditis only when TTE and TEE are technically limited and there is suspicion of: **(one)**
 - a. Perivalvular involvement
 - b. Aortic root involvement
 - c. Fistula.
3. Pericardial disease **(all)** must be documented). Note: MRI can specify findings of constrictive pericarditis include adherence of the pericardium to the underlying epimyocardium, transudative and hemorrhagic effusions, loculated effusions and pericardial neoplasms.
 - a. Echocardiogram (TEE) not diagnostic for constrictive pericarditis
 - b. Invasive hemodynamic measurements do not differentiate constrictive pericarditis from restrictive heart disease
 - c. Evaluation for pericardial surgery
4. Myocardial viability assessment **(all)** must be documented.
 - a. Cardiomyopathy with significantly reduced left ventricular ejection fraction
 - b. In conclusive finding of myocardial viability on nuclear perfusion imaging or stress echocardiogram
NOTE: TTE non-diagnostic for constrictive pericarditis
 - c. Determine if patient has viable myocardium for revascularization
5. Cardiac mass **(all)**. Note: MRI is considered the gold standard for comprehensive imaging of tumor and cardiac masses.
 - a. Mass suspected on TTE
 - b. TEE **(one)**
 - i. Not diagnostic
 - ii. Not feasible because of respiratory compromise or esophageal obstruction
6. Right ventricular dysplasia with arrhythmogenic focus **(all)** must be documented.
 - a. Low CAD risk (Patient less than 35, no history chest pain, no family history CAD, normal Q waves, no diabetes mellitus or other known risk factors for heart disease.
 - b. Presyncope/syncope > 2 episodes in history
 - c. Physical examination identifies no more than a grade one murmur
 - d. ECG is non diagnostic
 - e. Findings **(one)**
 - i. Mild right ventricular enlargement by TTE
 - ii. Regional right ventricular dysfunction by TEE
 - iii. Ventricular tachycardia sustained >30 seconds by ambulatory ECG monitoring

MRI Knee

Clinical examination and plain x-ray films are still the gold standard for evaluation and management of the knee. MRI should not be used as a routine screening tool in all knee injuries. It should be used only when the diagnosis remains in doubt. It does not replace clinical evaluation and management, and multiple view x-rays as primary diagnostic tools.

Documentation requirements (All 1-3):

1. Requires x-ray as a first study which must have been completed within 6 months of the request. An x-ray has ruled out fractures, osteochondritis dissecans, osteochondral defect, or degenerative arthritis which may affect treatment in a soft tissue injury. A CT scan may be considered in lieu of an x-ray if it was already completed as the first study.
2. Submit documentation of physical examination with differential diagnose(s) which has been completed within 6 months of the request. The physical examination has ruled out patellofemoral syndrome, bursitis and tendonitis. Note: If the cause of knee pain is not obvious physical examination should rule out flat feet, fallen arches, and the hip as a source of knee pain, especially in children.

3. Eight weeks of conservative treatment has been tried at a site of probable ligament tear, including: rest, ice, compression, elevation in first 24 to 72 hours.
 - a. Non-steroidal anti-inflammatory drugs (NSAID's). (NOTE: Waived if medically unable to take NSAID's)
 - b. Initial Physical Therapy Assessment required. Sessions of physical therapy and recommended ROM strengthening exercises for home as determined appropriate by the physical therapist. NOTE: Based on the program eligibility of the the patient, there may be limitations on the number of visits the patient may be able to access per year. Note: The PT may also recommend crutches or bracing (i.e. grade III grade MCL injury first 4-6 weeks).

Coverage Indications select at least **one** of the following sections:

1. Detection, staging, and post-treatment of knee tumor, occult soft tissue mass, or cysts (**All**)
 - a. Abnormal findings (one)
 - (1) On x-ray or bone scan
 - (2) Palpable intra-articular or periarticular mass and x-ray negative
 - (3) X-ray indicates mass eroding through bone cortex
 - b. One of the following: (one)
 - (1) Known diagnosis of cancer elsewhere. Note: Cancer or tumor s/s may include night pain, persistent severe pain, atypical symptoms without injury history, weight loss. Infection may be a factor if fever, severe pain, swelling, redness, heat, or history drug abuse.
 - (2) Unexplained localized pain and/or other symptoms not explained by plain x-ray.
 - c. Ultrasound results and documentation indicate the diagnosis remains unclear
 - d. NSAID's have been tried for 8 weeks
 - e. Describe how the MRI will affect the differential diagnosis and/or treatment plan.
2. Osteomyelitis (**All**)
 - a. X-ray is not diagnostic of osteomyelitis
 - b. Bone scan results have not demonstrated well-localized increased uptake
 - c. Has indication of osteomyelitis within last three months (**one or more**)
 - (1) ESR>30mm/hr
 - (2) Temp>100.4
 - (3) WBC >10,000cu/mm
 - (4) Blood culture positive
 - (5) C reactive protein >10mg/L
 - d. Describe how the MRI will affect the differential diagnosis and/or treatment plan
3. Persistent knee pain secondary to injury when **all** of the following are met within last six months:
 - a. The knee remains unresponsive to 8 weeks of conservative treatment with persistent pain/swelling and/or instability. NOTE: Isolated injuries of ACL, PCI, MCL, and LCL should receive initial conservative therapy, most do not require surgical intervention.
 - b. There are clinical indications and a description of how the MRI will likely change or improve the planned treatment (Describe). NOTE: Brooks completed a study of 238 patients and found that there was no evidence that the MRI would identify the number of negative arthroscopies. A negative arthroscopy was identified in 4% of patients studied.
4. Internal derangement (**All**)
 - a. Widening of the joint compartment on x-ray.
 - b. Includes meniscal, cartilaginous, or ligamentous (ACL and PCL) injury. NOTE: A trial of conservative care is still recommended prior to diagnostic testing. A good clinical examination and MRI are comparable in sensitivity, specificity, positive and negative likelihood ratios.
 - c. Knee pain associated with sensitivity to palpation along medial or lateral joint.
5. Multiple ligament injury with suspected ligament instability as **indicated by one a-d; and e:**
 - a. Mechanical laxity or excess in ROM in the joint due to loss of integrity of the ligaments and other soft tissues which contribute to joint stability (**one**).
 - (1) Diagnosis of grade III PCL tears and MRI requested to identify additional injuries in the posterolateral complex. NOTE: Increased external rotation of the tibia and increased lateral opening on varus stress should alert the clinician to involvement of the posterolateral complex.
 - (2) In injuries to the medial collateral ligament (MCL) an MRI may be warranted when there is additional concern of associated injury of medial meniscus, capsule, **and** ACL.
 - b. Recurrent ligament injury after surgery when the diagnostic certainty regarding the degree and type of pathology is low.
 - c. Segond (avulsion of fibular head) and Tibial plateau fractures are associated with multiple ligament tears
 - d. Suspected tear of extensor mechanisms (i.e. quadriceps, patellar tendons). Note: unable to straight leg raise, palpable joint gap, change in patella height. This is extensor mechanism requiring orthopedic intervention.
 - e. Describe how the MRI will affect the differential diagnosis or treatment plan.
6. Child or adolescent with normal x-ray, joint effusion and no evidence of inflammatory arthritis when stress fracture suspected. (**All**) NOTE: occult fracture or congenital anomalies may be present especially in children 3 or younger.

- a. Localized pain and history of overuse or excessive activity.
- b. Symptoms persist despite rest.
- c. Normal findings on x-ray completed at least 2 weeks apart.
- d. Bone scan negative, contraindicated or nonspecific due to possibility of infectious or inflammatory process.
- e. Describe how the MRI will affect differential diagnosis, management or treatment.

Non-covered

1. For meniscal or ACL tears when they are the only tears identified. Research studies comparing MRI and clinical judgement in evaluating meniscal tears and ACL tears indicate these ligament injuries are accurately diagnosed through physical examination and clinical judgement.
2. When used to diagnose or evaluate rheumatoid arthritis or degenerative joint disease.
3. When the clinical examination diagnoses torn meniscus, loose body, or osteochondritis dissecans **and** arthroscopy **or** ligament reconstruction is planned.
4. When there is persistent true locking of the knee which indicates a torn meniscus or loose body requiring surgical intervention. NOTE: True locking is defined as more than a momentary locking of the joint with the knee in a fixed position, as compared with the sensation of momentary catching with extension of the knee.
5. When clinical evaluation indicates injury, the patient requires urgent surgical intervention (i.e. bucket tear, indication of neurological or vascular damage) and the MRI will not impact the need for surgery.
6. Before physical examination and routine conventional radiographs or as substitute for clinical judgement.
7. When there is radiographic evidence of degenerative joint disease, inflammatory arthritis, stress fracture, osteonecrosis, or reflex sympathetic dystrophy because imaging will not alter the treatment plan.

Criteria #41 Fiberoptic Endoscopic Evaluation of Swallowing (FEESST)

Fiber optic endoscopic evaluation of swallowing with sensory testing (FEESST) is an alternative to modified barium swallow evaluation for patient at risk of aspiration. NOTE: Video fluoroscopy has long been viewed as the "gold standard" for evaluation of a swallowing disorder for the comprehensive information it provides. However, it is not very efficient and accessible in certain clinical and practical situations. Fiber optic endoscopic evaluation of swallowing (FEES) has been shown to be safe and effective for assisting in swallowing evaluation, and in therapy as a visual display to help patients learn various swallowing maneuvers. A specially equipped flexible endoscope is passed into the oropharynx. The specialty equipment includes a sensory stimulator, a television monitor, a video printer, and a videocassette recorder. (Codes 92610, 92612, 92613)

Indications and Coverage: (All)

1. Must have **one** of the conditions in which patients may benefit from the procedure:
 - a. Stroke or other central nervous system disorders which affect swallowing and speech.
 - b. Patients without an obvious CNS disorder with difficulty in swallowing, a clinical history of aspiration, or a history of aspiration pneumonia.
 - c. Presence of oral motor disorders with symptoms such as drooling of food or liquids placed in the mouth or oral food retention.
 - d. Lack of coordination, sensation loss, (postural difficulties) or other neuromotor disturbances affecting the ability to close the buccal cavity, bite, chew, suck, shape or squeeze a food bolus into the upper esophagus while protecting the airway.
 - e. To visualize the larynx directly for signs of trauma or neurologic damage and assess laryngeal competence post-surgery where the laryngeal nerve was vulnerable.
2. The diagnosis or clinical suspicion of aspiration currently must be present for the procedure to be considered medically necessary.
3. Medical record documentation must support the medical necessity and describe why the FEESST procedure provides more information and benefit than barium swallow evaluation studies.
4. The results of FEESST testing will impact the clinical decisions **(both)**:
 - a. Affect the daily dietary management of the impaired patient.
 - b. Impact on the evaluation and management of therapy programs.

Limitations and Non Coverage

1. These services are limited to physicians. Incident to services cannot be billed.
2. FEESST is not recommended when pathology such as an esophageal lesion is suspected.
3. The procedure is not covered for routine screening or when preformed in the absence of a specific sign or symptom supporting medical necessity.
4. Services for diagnoses not listed as covered in this policy, or for excessive frequency.
5. The clinical effectiveness and applicability of the addition of sensory testing to the FEES procedure have not been determined. Therefore, CPT codes 92614 through 92617 are non covered services.

Criteria #42 Varicose Vein Surgery

In the past, varicose vein surgery has been accomplished by vein ligation and stripping and/or sclerotherapy. Since this procedure may be accomplished outside of medical necessity, for cosmetic reasons, it has become important to specify coverage indications for the procedure. NOTE: Refer to the CPT Medical-Surgical List for non-covered procedure codes.

Non Coverage

If any **one** of the following are the procedure requested, stop review, the procedure is not covered:

1. Ultrasound guided sclerotherapy. Note: Duplex scanning or an ultrasound procedure performed for the purpose of guidance during the injection of sclerosing solution for the treatment of varicose veins is not considered medically necessary.
2. Laser ablation and radio frequency ablation. Note: Laser ablation and radio frequency ablation of the saphenous vein are not covered as alternatives to vein ligation and stripping. Medicaid covers the least costly alternative method, and these procedures are additive to traditional ligation and stripping procedures.
3. The injection of sclerosing solution. Note: The injection of sclerosing solution into telangiectasis, such as spider veins, hemangiomas, and angiomas is a non-covered services. Treatment for these superficial veins in most commonly provided for cosmetic purposes. Therefore, sclerotherapy or laser treatment of superficial telangiectasis, is not a covered service.

Coverage indications include **all** of the following:

1. History and physical documentation must support **(one)**
 - a. Substantial pain and edema which impair mobility and impact ADL
 - b. Significant superficial thrombophlebitis,
 - c. Dependent edema
 - d. Complications such as venous stasis with ulceration or dermatitis.
2. Abnormal duplex scan within six-months of the request
3. A six-month trial of supportive therapy including **(a-d required)**:
 - a. Walking
 - b. Avoidance of prolonged standing
 - c. Support or compression hose therapy
 - d. Leg elevation
 - e. Weight reduction if appropriate (optional)
4. Sclerotherapy **(all)**
 - a. Must be used in conjunction with surgical stripping and ligation.
 - b. The varicosities must be symptomatic with pain, burning, etc.
 - c. There must not be any sapheno femoral insufficiency or disease which occludes deep veins.
 - d. The veins are bulging above the surface of the skin and are at least 5 millimeters in size.
5. The ICD-9 code supports medical necessity **(one)**:
 - a. 454.0 Varicose veins of lower extremities with ulcer
 - b. 454.1 Varicose veins of lower extremities with inflammation
 - c. 454.2 Varicose veins of lower extremities with ulcer and inflammation

Criteria #43 Sleep Study in Adult

When apnea is identified during a hospitalization every attempt should be made to perform polysomnography prior to patient discharge from the hospital. When a sleep study is approved for an outpatient evaluation, the approval includes the expectation for a CPAP trial which will be approved under code 95811. Prior to considering that a patient should be referred for polysomnography or to a sleep specialist, the referring physician must submit the following information to the Utilization Review nurse. Documentation of all items in section 1 must be addressed and applicable items must be submitted as follows before consideration of section 2:

1. Documentation
 - a. The patient should receive a thorough history, physical examination, and medical evaluation through their primary care physician, internist, or pulmonologist. In addition to the H&P the evaluation should include:
 - i. TSH laboratory study is done to rule out hypothyroidism.
 - ii. Sleep questionnaire. Note: Questionnaire may include: weight loss efforts and their date; nocturnal reasons for insomnia such as pain, reflux, angina, dyspnea, or headache; the medications used to relieve nasal obstruction, insomnia, depression and pain including OTC, and herbal supplements because a sleep disorder may be caused by some antidepressants, stimulants, bronchodilators, xanthines, decongestants, diuretics, histamine antagonists, antihypertensives, steroids, caffeine, and nicotine; and sleep enhancement methods relaxation exercise, music, or a dull book.

- iii. A sleep log covering 7-14 days, documenting the conservative measures recommended and/or attempted. NOTE: log may include: change in sleep position using rocker recliner, lumbosacral roll, pillows, not eating hot spicy food or meal 3 hours prior to bedtime, not exercising 4 hours before bedtime, avoid caffeine 5 hours before bedtime, and avoiding alcohol 5 hours before bedtime.
 - iv. A cardiovascular work up in a patient with symptoms suggestive of heart problems. (If applicable)
 - b. When initial conservative measures have failed and anatomy of neck, throat, or chin indicates an ENT reason for obstructive sleep apnea, an otorhinolaryngologist should be consulted. Dental appliance if appropriate fitted and tried. NOTE: If an ENT problem is suspected and the nature of the anatomic deformity is not obvious to the otorhinolaryngologist, a sleep study should be completed in an attempt to identify the nature of the collapse or narrowing during sleep. Research indicates that anyone surgical procedure may not correct the problem. A sleep study with a CPAP trial should be completed prior to any of the following surgeries to see if the obstruction will resolve without surgery.
 - c. If consideration for sleep study enrollment is based only on daytime sleepiness, lack of restful sleep, inability to sleep, narcolepsy, or pseudo narcolepsy, a psychiatric evaluation should be completed.
 - i. Review should determine if there are sedative side effects in current medications.
 - ii. The patient should be evaluated for depression or a stress anxiety disorder.
 - iii. Psychiatric evaluation should assess whether the patient's compliance history and attitude suggest they would be compliant with the sleep disorder treatment plan and use of CPAP.
2. Basic criteria for sleep study in Suspected Apnea after evaluating for causes listed in section "1" and a trial of conservative treatment.
 - a. **One** of the following conditions must be present:
 - i. **Witnessed apnea** or choking spells during sleep
 - ii. **Morning headaches** which resolve one to two hours after awakening in morning
 - iii. **Excessive/persistent** daytime sleepiness confirmed by Epworth scale. Note: Pharmacology & psychiatric screening has ruled out manageable causes.
 - b. When a request for polysomnography is based on a night time pulse oximetry study, the results must meet **one** of the following:
 - i. The oxygen saturation must fall at least 4% or greater below the baseline level **and** the mean O² level based on a full nights sleep must be 90% or less **with** an oxygen saturation less than 85% a minimum of twenty times during the night time pulse oximetry study. NOTE: The baseline level is the level taken during waking hours before the sleep study is initiated. For example a chronic obstructive pulmonary disease (COPD) patient with a baseline of 86% is not eligible of a sleep study when the mean O² during sleep study is 84%.
 - ii. If the patient's baseline oxygen saturation level is 74 or greater, the patient may also be considered a suitable candidate for a sleep study if they have **one** episode of apnea where the O² saturation is 70% or less.
 - c. When a request is based on the fact that the person carries excessive weight about the neck and chin, the person must have a BMI \geq 29 **and** hypertension, as well as nocturnal oxygen desaturation.
 - d. When ENT evaluation concludes surgery is necessary (i.e. tracheotomy, uvulopalatoplasty with or w/o tonsillectomy, laser midline glossectomy and lingualplasty, or inferior sagittal osteotomy & genioglossal advancement with hyoid motomy/suspension), a trial of CPAP is required to determine whether surgery is the best course of action.
3. CPAP is covered under the following conditions:
 - a. Polysomnography requires at least six hours of attended sleep through sleep stages with the physiological and pathophysiological parameters reviewed and interpreted by the physician. Documentation to support obstructive sleep apnea during six hours of recorded sleep requires at least 30 episodes of apnea each lasting a minimum of 10 seconds. The diagnosis of sleep apnea requires the calculation of the Apnea-Hyponea Index (AHI). The AHI is the average number of apnea and hyponea episodes per hour and must be based on a **minimum of two** hours of sleep recorded by polysomnography using actual hours of sleep. The need for CPAP must be documented by **I or ii**:
 - i. An AHI \geq 15 is documented during a minimum of 2 hours of diagnostic polysomnography.
 - ii. There are AHI > 5 and < 14 events per hour **and** documented symptoms of one:
 - (1) Daytime sleepiness with Epworth scale >10
 - (2) Hypertension, blood pressure >140/90
 - (3) Ischemic heart disease
 - (4) History of stroke
 - b. For patients with severe and unambiguous obstructive sleep apnea, initial diagnostic polysomnography must meet AHI requirements as outlined above. CPAP titration during polysomnography on the same night may be an alternative to a full night of diagnostic polysomnography as long as the CPAP titration is carried out for at least 3 hours. This titration during polysomnography must provide documented evidence that the CPAP eliminates or nearly eliminates respiratory events during REM and NREM sleep.

Criteria #46 Craniectomy or Craniotomy Decompression

The benefit of decompression depends on the patient's age, clinical signs and symptoms on admission, and the existence of major extracranial injuries. The procedure is usually considered when medical conservative interventions prove unsuccessful. The procedure is usually considered within the first 48 hours after the accident while monitoring the ICP and cerebral tissue oxygenation p(ti)O₂. Most studies indicate the best outcomes occur with this procedure when the Glasgow score is between 6 to 8.

1. Patients with primary fatal brain stem damage should not under go decompression surgery, as indicated by:
 - a. An initial and persisting GS score of 3 despite conservative therapy.
 - b. With bilateral fixed/dilated pupils or other signs of herniation. NOTE: Signs of herniation include, progressive loss of consciousness, coma, irregular breathing, respiratory arrest, irregular pulse, cardiac arrest, loss of brainstem reflexes (blink, gag, pupillary reaction to light). **If the points in one are met, stop. The service is not covered. If not met, review item two–adult or three–pediatric.**
2. Adult craniotomy should be performed when despite medical treatment there is:
 - a. Sustained increase in intracranial pressure(ICP) >20mm Hg, but ICP has not exceed 40mm Hg.
 - b. Initial GSC score is 4 or has reached 4 on the 1st post traumatic day.
 - c. Pupils are dilating, not fixed and dilated.
3. In children decompression craniectomy should be preferably considered within the first 6 hours but up to 48 hours of a traumatic brain injury when all of the following are true. NOTE: A UK study recommends cranial decompression be considered when the ICP reaches 25 mm Hg in children and the cerebral perfusion pressure reaches 50 mm Hg.
 - a. No episodes of ICP >40mm Hg
 - b. GCS > 3 at some point subsequent to injury
 - c. Diffuse cerebral swelling on CT scan
 - d. Evolving cerebral herniation syndrome. Note: Clinical signs and symptoms of acute increased intracranial pressure include, headache, vomiting, vision distortion, diminished sensorium, pupillary dysfunction, hypertension, bradycardia, flexor/extensor posturing.

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08 - 56 Biliary Stents in Peripheral Arteries

Medicaid has become aware that stents are being used in the treatment of peripheral artery disease which were not designed for this purpose. There are a number of stents available that are designed for placement across stenotic arterial lesions. These stents have undergone clinical testing and are FDA approved for this purpose. There are, however, stents that have not been approved for this use which are being used for relieving narrowing of peripheral arteries. These stents are being used off label and are designed to be used to open biliary tract stenosis.

Medicaid has determined that this off label use of biliary stents has not been documented to be medically efficacious and is not reimbursable by Utah Medicaid. There is no available evidence that this practice is either safe or effective. This practice is considered investigational and therefore not reimbursable.

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08 - 57 Preferred Drug List Update

The Utah Medicaid Preferred Drug List continues to expand on a monthly basis. 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, Beta-Blockers, Aldosterone Antagonists
- Asthma Inhalers and Leukotriene Receptor Antagonists

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

Prescribers may document medical necessity in a patient's chart and hand write "Medically Necessary - Dispense As Written" on the 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.

P&T committee meetings are held on the third Friday of every month to discuss new drug classes for PDL consideration. The meetings are open to the public. Public comment that responds to the materials presented by the Drug Information Service at the University of Utah is most helpful. The foundation documents used for most reviews are prepared by the Oregon Evidence-Based Practice Center or the Drug Information Service and are posted in advance on the P&T committee website.

Manufacturers are requested to submit any additional materials they would like reviewed as part of the process to:

Drug Information Service
 Attn: Linda Tyler, PharmD
 University of Utah Hospitals & Clinics
 421 Wakara Way, Suite 204
 Salt Lake City, UT 84108

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08 - 58 Pharmacy Coverage Highlights

The following drugs require prior authorization July 1, 2008.

Xyzal

- Documentation stating when and how OTC loratadine and cetirizine preparations have failed.
- Non-sedating antihistamines are limited to 30 doses / 30 days.
- Initial PA is granted for 1 year. Renewal of PA requires a telephone call from the physician's office or pharmacy.

Letairis

- Minimum age requirement: 18 years old.
- Documented diagnosis of Pulmonary Arterial Hypertension (WHO Group I) with WHO class II or class III symptoms.
- Copy of prescription from physician.
- Females cannot be capable of becoming pregnant.
- Medicaid will approve doses up to 10 mg / day.
- Initial authorization is granted for 1 year. Renewal of PA requires a telephone call from the physician's office or pharmacy.

Prior authorization requirements for prescription non-sedating antihistamines now require a trial and failure of both an OTC loratadine formulation and Zyrtec OTC. Zyrtec OTC formulations do not require a prior authorization.

The following drugs for overactive bladder / urinary incontinence no longer require prior authorization:

- Detrol LA
- Oxybutynin ER
- Sanctura / Sanctura XR
- Enablex
- Vesicare
- Oxytrol Patch (covered in Traditional Medicaid only)

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08 - 59 Tamper-Resistant Prescription Pads Update

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

Currently, 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.

Currently, 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.

Successful implementation of the above requirements will require support of both prescribers and pharmacies. Please contact the Medicaid Pharmacy team at (801) 538-6293 or (801) 538-6495 if you have any questions.

Remember: All prescriptions paid for by Utah Medicaid must comply with all state and federal regulations governing the practice of pharmacy.

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08 - 60 Immunization Reimbursement Methodology Update

Effective immediately, Medicaid will utilize Centers for Disease Control (CDC) pricing information and Estimated Acquisition Cost (EAC), which is calculated as AWP - 15%, in determining the reimbursement rates for immunizations paid by fee-for-service Medicaid. Medicaid will continue to use lesser logic and reimburse the lower of CDC and EAC.

CDC pricing information can be found at <http://www.cdc.gov/vaccines/programs/vfc/cdc-vac-price-list.htm> .

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08 - 61 State Maximum Allowable Cost Policy

Utah Medicaid's pharmacy program has traditionally utilized a State Maximum Allowable Cost (SMAC) list on a small number of products to assist in managing costs. In the coming months, Utah Medicaid will be expanding the SMAC list. More information will be published in the Amber Sheet, MIB, and on the Medicaid Pharmacy Services Website as this program is expanded.

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08 - 62 Restriction Program Authorized Prescriber Policy

Effective July 1, 2008, pharmacy claims for restricted recipients will deny if the prescriber is not an authorized prescriber. The Medicaid Care Coordination and Restriction Program policy states that prescriptions written by prescribers other than the recipient's primary care physician (PCP) are not a benefit. Family planning products are not subject to this policy and may be dispensed and billed when written by any prescriber.

A recipient may routinely see a physician assistant or may get medications from a mental health provider. As a convenience, the PCP may choose to preauthorize up to two additional prescribers by either sending Medicaid written notice or by calling the number below. Prescribers must be known to the Medicaid prescriber database to be preauthorized.

To report preauthorized prescribers, please contact:

Department of Health
Division of Health Care Financing
Attn: Restriction Program
P.O. Box 143108
Salt Lake City, UT 84114-3108
(801) 538-9045 or toll free 1-800-662-9651 ext #900

Medicaid notifies pharmacies in writing when a recipient is restricted to their pharmacy. The notice includes the name of the PCP and the names of any additional authorized prescribers. Pharmacies are also notified when there is a change of PCP or authorized prescriber.

The National Provider Identifier (NPI) of the prescriber will be edited against the Restriction Program file. If the NPI does not match the PCP of record, or a preauthorized prescriber for the date of service, the claim will deny with the message, "Not an Authorized Prescriber for Restricted Recipient."

PCP Authorized Override: The PCP can authorize prescriptions from other prescribers by countersigning the prescription. The authority for the PCP to do this is not limited. The pharmacist is instructed to return the prescription to the recipient explaining that Medicaid will not pay for the medication. Or the pharmacist may choose to call the PCP printed on the recipient's Medicaid card to request authorization to fill, and then submit an override code which will allow the claim to pay. The pharmacist must document the authorization in the patient's record.

For PCP Authorizations: Enter "1" in the Intermediary Authorization Type field, and
Enter PCP's NPI in the Intermediary Authorization ID field.

Emergency Override: If the PCP is not available, the pharmacist may choose to contact the prescribing physician to determine if it is safe to wait for an authorization from the PCP, or if the need for the medicine is emergent. The pharmacy must inform the PCP on the next working day that a three-day supply was dispensed. If the need is emergent, the pharmacy may bill Medicaid for a maximum three-day supply of medication by following the emergency override procedures outlined below. Products that are pre-packaged as more than a three-day supply are allowed up to package limitations. Example: inhalers, ointments, creams, etc. are packaged as more than a three-day supply. If the day's supply is greater than three days, the claim will deny.

For Emergency Overrides: Enter "99" in the Intermediary Authorization Type field.
Intermediary Authorization ID field should be left blank.

PCP authorizations and emergency overrides DO NOT override any other pharmacy benefit policy.

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08 - 63 Audiology Coding Correction

92586 Audiology Evoked Potentials evoked response, limited. This code may be used when the recipient is over age one and receiving a hearing screening exam, instead of code V5008. Code V5008 should only be used for children under the age of one.

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08 - 64 Dental Coding Correction

Dental codes D3425, D3426, and D3430, as listed in the dental manual, are limited to exclude permanent third molars. Second and third molars are also excluded for non-pregnant women and adults age 21 and older.

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08 - 65 Medical SuppliesClarification on Date of Service

If you have ever questioned whether the date of service is the date the product is shipped to a provider or the date the product is delivered to the client, the correct answer is the date the product is delivered/received by the client. It is imperative that providers verify the client is still eligible for Medicaid on that date.

New Codes

K0672 Addition to lower extremity orthosis, removable soft interface, all components, replacement only, each, every 5 years.

L3808 Wrist, hand, finger orthosis, rigid, without joints, may include soft interface material; straps, custom fabricated, includes fittings and adjustments.

Deleted Codes

L3800

L3805

Code Clarification

E1399 Durable medical equipment, miscellaneous. The restriction of "three per year for medically necessary replacement items for patient owned equipment" has been removed. Use of this code still requires a prior authorization. Please review the criteria and instructions for this code prior to billing.

Provider Manual Changes

Pneumatic tires or balloon tires on wheelchairs are not a benefit unless the medical condition of the patient is such that the tires are necessary in the patient's residence. Section 10, Non-Covered Services, #12 has been updated for July 1, 2008.

The following codes are now listed in the manual with the following limitations:

E0165 P or LL Commode chair, mobile or stationary, with detachable arms. Limited to 1 every 5 years or rental per month.

K0042 LL Standard size foot plate, each. Physician ordered. Limited to rental per month.

E0247 Transfer bench tub/toilet, with or without commode opening. Limited to 1 every 5 years.

Nutrition - General, Section 2-1, has been rewritten for July 1, 2008, with the intent of making the policy easier to understand and to regroup the various parts of the policy into a more logical format.

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08 - 66 Oxygen Concentrators

There continues to be some confusion amongst providers regarding the oxygen concentrator contract. The contract is awarded to a single provider, who will provide all oxygen concentrators required by Utah Medicaid recipients who meet the following parameters:

1. The client is a Utah Medicaid recipient residing within the State of Utah.
2. The recipient has a physician's order that requires at least six hours of oxygen a day, and
3. The rate prescribed is between 1/16th liters per minute through 10 liters per minute of oxygen.

Oxygen needs that do not fall within the above description, may be met by any willing Utah Medicaid provider licensed to supply oxygen.

The current contract for oxygen concentrators expires on June 30, 2008. Medicaid has completed the bid process for a new contract. The contract has been awarded to Petersen's Medical Supply, effective July 1, 2008. They may be contacted at 1-800-888-5137.

If you have questions or concerns, contact Anita Hall, Health Program Manager, at (801) 538-6483 or ahall@utah.gov .

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08 - 67 Transportation Services

Medicaid clients received a letter with their May Medicaid cards advising them that the new FrontRunner train service from Ogden to Salt Lake City and the Express buses are not a covered benefit, even to those Medicaid clients who receive a UTA bus pass. The UTA bus passes are to be used for transportation to medical appointments on UTA buses and TRAX only.

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08 - 68 Vision Services

Medicaid clients received the following notice effective March 1, 2008:

Traditional Medicaid Clients - Beginning March 1, 2008, Medicaid WILL cover eyeglasses and frames for non-pregnant adults. (Adults who receive a purple Medicaid card). A \$3.00 co-payment will be required.

Non-Traditional Medicaid Clients - There is no change to the vision program for Non-Traditional Medicaid clients. (Adults who receive a blue Medicaid card). Medicaid will continue to cover one annual eye exam.

Note: Medical treatment for eye diseases continues to be a benefit for both Traditional Medicaid and Non-Traditional Medicaid clients.

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08 - 69 NDC Reporting on Physician-Administered Drugs for Outpatient and End Stage Renal Dialysis (ESRD) Claims

Medicaid Coverage and Reimbursement Policy strongly encourages those providers who bill for outpatient and ESRD services to reference the article that was published in the April 2008 MIB. The article entitled, "NDC Reporting on Physician-Administered Drugs for Outpatient and End Stage Renal Dialysis (ESRD) Claims," can be found in the April 2008 MIB, article number 08-39.

The MIB can be located on the Medicaid web page <http://health.utah.gov/medicaid/provhtml/bulletins.html> .

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