

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

09 - 01 NPPES User Maintenance Tips

The following tips are offered for health care providers who have obtained National Provider Identifiers (NPIs) and have records in the National Plan and Provider Enumeration System (NPPES). The Centers for Medicare & Medicaid Services (CMS) recommends that each health care provider, including individual physicians and non-physician practitioners:

- Know and maintain their NPPES User Ids and passwords.
- Reset their NPPES passwords at least once a year. (See the NPPES Application Help page regarding the 'Reset Password' rules. The rules indicate the length, format, content and requirements of NPPES passwords.)
- Review their NPPES records in order to ensure that the information reflects current and correct information.

Health care providers should maintain their own NPPES account information (i.e., User ID, Password, and Secret Question/Answer) for safety and accessibility purposes.

Providers can view their NPPES information in one of two ways:

1. By accessing the NPPES record at <https://nppes.cms.hhs.gov/NPPES/Welcome.do> and following the NPI hyperlink and selecting Login. The user will be prompted to enter the User ID and password that he/she previously created.

If the provider has forgotten the password, enter the User ID and click the "Reset Forgotten Password" button to navigate to the Reset Password Page. If the provider enters an incorrect User ID and Password combination three times, the User ID will be disabled. Contact the NPI Enumerator at 1-800-465-3203 if the account is disabled or if the provider has forgotten the User ID.

2. By accessing the NPI Registry at <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>. The NPI Registry gives the provider an online view of Freedom of Information Act (FOIA) disclosable NPPES data. The provider can search for its information using the name or NPI as the criterion.

Providers can correct, add, or delete information in their NPPES records by accessing their NPPES records at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>. Please note: Required information cannot be deleted from an NPPES record; however, required information can be changed/updated to ensure that NPPES captures the correct information. Certain information is inaccessible via the web, thus requiring the change/update to be made via paper application. The paper NPI Application/Update Form can be downloaded and printed at <http://www.cms.hhs.gov/cmsforms/downloads/CMS10114.pdf>.

Providers can apply for an NPI online at <https://nppes.cms.hhs.gov> or can call the NPI Enumerator to request a paper application at 1-800-465-3203.

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09- 02 Medicaid ID Cards

The new identification card for Utah Medicaid recipients is now in use. Currently, there are two types of medical cards being distributed to clients who reside within the new eligibility system (E-REP) implementation areas. Office personnel may see both card types being presented for services. Either is valid for the date range printed on the card.

The number of new cards will continue to increase as the rollout of E-REP expands to include additional cases and areas throughout the state.

For more detailed information about the new card, see the July 2008 Medicaid Information Bulletin or visit the Medicaid website.

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09- 03 Improved Electronic Eligibility Responses

Medicaid has implemented a more robust electronic eligibility response (271) to give providers more information regarding benefits, copayments, and eligibility specific to their provider specialties. This enhanced response should reduce the need for contacting our office by telephone for additional eligibility information.

If your system does not currently create an electronic eligibility request (270), a tool is available through the Utah Health Information Network (UHIN). If you currently have a trading partner number for electronic claims submission through UHIN, this tool is available free of charge.

Medicaid providers can contact the UHIN Member Relations Coordinators at 801-466-7705, option 1, to receive a tutorial.

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09- 04 Reporting Medicaid Fraud

Recipient Fraud

The Department of Workforce Services has established a Payment Error Prevention Unit. If you are aware of any individuals misusing Public Assistance, please contact: 1-800-955-2210 or email: wsinv@utah.gov.

Provider Fraud

The Medicaid Program Integrity unit can be reached at (801) 538-6155 or toll-free at 1-800-662-9651, press option 3, then option 7.

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09 - 05 Medicaid Payment for Pharmacist Administered Flu Vaccines

Once again, for the 2008-2009 flu season, Medicaid will pay for pharmacist administered flu vaccines through the pharmacy point of sale system. The reimbursement for the vaccines will be the lower of EAC, usual and customary, or any applicable MAC, plus a \$3.90 dispensing fee for urban providers or a \$4.40 dispensing fee for rural providers.

When billing for flu vaccines through the pharmacy point of sale (POS) system, do not use the NPI of the pharmacy in the prescriber field. This will result in a rejected claim. In Utah, pharmacists may dispense and administer flu vaccines to patients under "collaborative pharmacy practice agreements" with prescribers. If a pharmacy has such an agreement with a prescriber, that prescriber's NPI needs to be placed in the "prescriber ID" field when the flu vaccine is billed through the pharmacy POS system.

All prescriptions paid for by Utah Medicaid must comply with state and federal regulations governing the practice of pharmacy. Flu vaccine claims without legitimate prescriber identifiers do not meet this requirement.

Legal Reference:

Pharmacy Practice Act 58-17(b)-102

- (16) "Collaborative pharmacy practice" means a practice of pharmacy whereby one or more pharmacists have jointly agreed, on a voluntary basis, to work in conjunction with one or more practitioners under protocol whereby the pharmacist may perform certain pharmaceutical care functions authorized by the practitioner or practitioners under certain specified conditions or limitations.
- (17) "Collaborative pharmacy practice agreement" means a written and signed agreement between one or more pharmacists and one or more practitioners that provides for collaborative pharmacy practice for the purpose of drug therapy management of patients and prevention of disease of human subjects.

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09 - 06 State MAC Update

Historically, Utah has used a state MAC (state maximum allowable cost) price as well as a Federal MAC price. Due to recent budget cuts, Medicaid has aggressively expanded the state MAC list. New MAC prices will be posted to the point of sale program as they are determined. A current list of state MAC prices will be posted on the Medicaid Pharmacy Services website at <http://health.utah.gov/medicaid/pharmacy>.

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09 - 07 PDL Update

The Medicaid Preferred Drug List continues to expand on a monthly basis. The P&T Committee has recently considered short acting beta agonists, long acting beta agonists, and long acting beta agonists / corticosteroid combination inhalers, and leukotriene receptor antagonists for asthma. The following classes of drugs are now on the Medicaid Preferred Drug List:

- 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
- Insulins

Please refer to <http://health.utah.gov/medicaid/pharmacy> for more detailed information. *All preferred drugs and diabetic supplies are NDC specific. Please refer to the website for a list of NDCs.*

Reminder: When overriding the PDL, prescribers must *hand write* “**Dispense As Written - Medically Necessary**” on the prescription and document medical necessity in the patient’s chart.

The P&T Committee meets on the third Thursday of every month. The schedule for upcoming drug class reviews has been updated as follows:

Jan 2009: Migraine Agents & Combos

Feb 2009: Skeletal Muscle Relaxants & Combos

Mar 2009: Alzheimer’s Cholinomimetics

Continue to watch the P&T Committee website at <http://health.utah.gov/medicaid/pharmacy/ptcommittee/directory.php> for important updates regarding the P&T Committee schedule. You may also contact Duane Parke, R. Ph., MPA, directly at (801) 538-6841 or dparke@utah.gov with any questions regarding the P&T Committee schedule.

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09 - 08 Pharmacy Coverage Highlights

Effective January 1, 2009, the following drugs will require prior authorization:

- Hydroxyprogesterone Caproate Powder (17-p)
- Relistor

Criteria sets for prior authorization can be found at <http://health.utah.gov/medicaid/pharmacy> .

Effective immediately, Chantix no longer needs a prior authorization and will be covered under the Utah Medicaid smoking cessation policy.

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09 - 09 Home Health

The Home Health Manual, Section 4-1, Selection Criteria has been modified for January 1, 2009.

When reviewing requests for home health service, the emphasis is on medical necessity, severity of illness and intensity of service. Every 60 days, the RN is required to complete the nursing assessment and submit a clinical summary as part of the 485 form. When a request for home health service is received, Medicaid Prior Authorization staff will use the criteria listed below to evaluate the home setting for appropriateness and safety.

- Diagnosis, condition, prognosis, and reason for the request.
- Recent hospitalizations, illnesses, injuries/falls, doctor visits, or anything that could impact the patient's condition.
- Any rehabilitation stays including SNF or ECF.
- If receiving wound care, a side by side comparison needs to be included with wound dimensions.

Home Health Clarifications

1. Drawing antibiotic levels: When the patient is on an antibiotic, like Vancomycin, the nurse is responsible for drawing the trough prior to providing the next dose of Vancomycin during a home health visit. The physician needs to coordinate the need for antibiotic levels with the home health agency so that they can be drawn during home health nursing visits. When this is not possible, the patient should go to the laboratory to have the peak Vancomycin level drawn. Exceptions must meet medical necessity for approval of an additional home health visit which should be extremely rare.
2. Wound Vac: Patients receiving negative pressure wound vacuum services, because of a donation of the wound vac device, must meet the requirements for home health nursing services. There must be a physician order, a nursing assessment with the plan of care, and the requirements for skilled nursing home health service must be met. When home health services are authorized for a wound vac which has not been authorized by Medicaid, home health nursing service will continue as long as the Medicaid requirements for continuation of the wound vac are met which includes weekly wound measurements documenting continued wound healing.
3. Wound Management: Patients who are able to leave their home should see their physician for wound care management. During the initial nursing assessment, instructions for simple dressing changes (not requiring packing) must be provided to the patient and caregiver. When the patient meets the requirements for home health nursing service and requires dressing changes with wound packing, home health wound management services will be reviewed for coverage authorization.
4. Certification or Re-certification: The request for home health nursing service must be submitted within one business day (24 hours) of the certification period. Submission of the worksheet is sufficient when all the information for the 485 is not available. Holidays and weekends will be taken into account with the requirement for submission within one business day. Services not requested in a timely manner will not be authorized. It is expected that re-certification will be requested prior to the end of the period. When the deadline for re-certification has been missed, discharging the patient and readmitting them to recoup lost days will not be accepted.
5. Home health is not a covered service in a skilled nursing facility. The location of the patient must be documented in the request for home health services (i.e. own home, group home, assisted living center).

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09 - 10 Polysomnography

Effective January 1, 2009, Polysomnography without titration (i.e. CPAP, BiPap, ViPap) will no longer be covered for adults. Code 95810 will only be covered for children and pregnant adults when medical necessity for the procedure is identified.

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09 - 11 HCPCS 2009 Codes

Covered Codes Effective January 1, 2009

- 00211 Anesthesia for intracranial procedures; craniotomy or craniectomy for evacuation of hematoma
- 00567 Anesthesia for direct coronary artery bypass grafting; with pump oxygenator
- 27027 Decompression fasciotomies, pelvic (buttock) compartments (i.e. gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle), unilateral
- 27057 Decompression fasciotomies, pelvic (buttock) compartments (i.e. gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle), with debridement of non-viable muscle, unilateral
- 35535 Bypass graft, with vein; hepatorenal
- 35570 Bypass graft, with vein; tibial-tibial, peroneal-tibial, or tibial/peroneal trunk-tibial
- 35632 Bypass graft, with other than vein; ilio-celiac
- 35633 Bypass graft, with other than vein; ilio-mesenteric
- 35634 Bypass graft, with other than vein; ilio-renal
- 43273 Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s) (list separately in addition to codes for primary procedure)
- 46930 Destruction of internal hemorrhoids by thermal energy (i.e. infrared coagulation, cautery, radio-frequency)
- 49652 Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible
- 49653 Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated
- 49654 Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible
- 49655 Laparoscopy, surgical, repair, incisional hernia(includes mesh insertion, when performed); incarcerated or strangulated
- 49656 Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible
- 49657 Laparoscopy, surgical, repair, recurrent incisional hernia(includes mesh insertion, when performed); incarcerated or strangulated
- 55706 Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling including imaging guidance
- 62267 Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes
- 64455 Injections, anesthetic agent and/or steroid, plantar common digital nerves (i.e. morton's neuroma)
- 64632 Destruction by neurolytic agent; plantar common digital nerve
- 87905 Infectious agent enzymatic other than virus (i.e sialidase activity in vaginal fluid)
- 88720 Bilirubin, total, transcutaneous
- 90681 Rotavirus vaccine, human attenuated, 2 dose schedule, live for oral use
- 90696 Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTAP-IPV), when administered to children 4 through 6 years of age, for IM use
- 90951 End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month
- 90952 End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month
- 90953 End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with one face-to-face physician visits per month
- 90954 End-stage renal disease (ESRD) related services monthly, for patients younger than 2-11years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month
- 90955 End-stage renal disease (ESRD) related services monthly, for patients younger than 2-11years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month

- 90956 End-stage renal disease (ESRD) related services monthly, for patients younger than 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with one face-to-face physician visits per month
- 90957 End-stage renal disease (ESRD) related services monthly, for patients younger than 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month
- 90958 End-stage renal disease (ESRD) related services monthly, for patients younger than 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month
- 90959 End-stage renal disease (ESRD) related services monthly, for patients younger than 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with one face-to-face physician visits per month
- 90960 End-stage renal disease (ESRD) related services monthly, for patients 20 years of age or older; with 4 or more face-to-face physician visits per month
- 90961 End-stage renal disease (ESRD) related services monthly, for patients 20 years of age or older; with 2-3 face-to-face physician visits per month
- 90962 End-stage renal disease (ESRD) related services monthly, for patients 20 years of age or older; with one face-to-face physician visits per month
- 90967 End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age
- 90968 End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 2-11 years of age
- 90969 End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age
- 90970 End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older
- 93228 Wearable mobile cardiovascular telemetry with electrocardiographic recording concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; physician review and interpretation with report
- 93229 Wearable mobile cardiovascular telemetry with electrocardiographic recording concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, analysis, and physician prescribed transmission of daily and emergent data reports
- 93279 Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; single lead pacemaker system
- 93280 Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; dual lead pacemaker system
- 93281 Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; multiple lead pacemaker system
- 93282 Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; single lead cardioverter-defibrillator system
- 93283 Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; dual lead cardioverter-defibrillator system
- 93284 Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; multiple lead cardioverter-defibrillator system
- 93285 Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; implantable loop recorder system
- 93286 Peri-procedural device evaluation and programming of device system parameters before and after surgery, procedure, or test with physician analysis, review and report, single, dual, or multiple lead pacemaker system
- 93287 Peri-procedural device evaluation and programming of device system parameters before and after surgery, procedure, or test with physician analysis, review and report, single, dual, or multiple lead implantable cardioverter-defibrillator system
- 93288 Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual or multiple lead pacemaker

- 93289 Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual or multiple lead implantable cardioverter-defibrillator system, including analysis of heart rhythm derived data elements
- 93290 Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable cardiovascular monitor system, including analysis of one or more recorded physiologic cardiovascular data elements from all internal and external sensors
- 93291 Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable loop recorder system, including heart rhythm derived data analysis
- 93292 Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; wearable defibrillator system
- 93294 Interrogation device evaluations (remote), up to 90 days; single, dual, or multiple lead pacemaker system with interim physician analysis, reviews and reports
- 93295 Interrogation device evaluations (remote), up to 90 days; single, dual, or multiple lead implantable cardioverter-defibrillator system with interim physician analysis, reviews and reports
- 93296 Interrogation device evaluations (remote), up to 90 days; single, dual, or multiple lead pacemaker system or implantable cardioverter-defibrillator system remote data acquisitions, receipt of transmissions and technician review, technical support and distribution of results
- 93297 Interrogation device evaluations (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of one or more recorded physiologic cardiovascular data elements from all internal and external sensors, physician analysis, reviews and reports
- 93298 Interrogation device evaluations (remote) up to 30 days; implantable loop recorder system, including analysis of recorded heart rhythm data, physician analysis, reviews and reports
- 93299 Interrogation device evaluations (remote) up to 30 days; implantable cardiovascular monitor system, or implantable loop recorder system, remote data acquisitions, receipt of transmissions and technician review, technical support and distribution of results
- 93306 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete with spectral doppler echocardiography, with color flow doppler echocardiography
- 93351 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision
- 95992 Canalith repositioning procedures (i.e. epley maneuver, semont maneuver) per day
- 96360 IV infusion for hydration, initial up to one hour
PRIOR APPROVAL: Not Required CRITERIA: Attach documentation to claim. ¹
Note: Hydration therapy is not a covered service in Medicaid without medical record documentation of dehydration by electrolyte panel. These codes will not be paid in addition to the evaluation and management service when submitted with a J code.
- 96361 IV infusion for hydration, each additional hour
PRIOR APPROVAL: Not Required CRITERIA: Attach documentation to claim. ¹
Note: Hydration therapy is not a covered service in Medicaid without medical record documentation of dehydration by electrolyte panel. These codes will not be paid in addition to the evaluation and management service when submitted with a J code.
- 96365 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug), initial, up to one hour
- 96366 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug), each additional hour (list separately in addition to code for primary procedure)
- 96367 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug), each additional sequential infusion up to one hour (list separately in addition to code for primary procedure)
- 96368 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug), each additional concurrent infusion up to one hour (list separately in addition to code for primary procedure)
- 96369 Subcutaneous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug), initial up to one hour, including pump set-up and establishment of subcutaneous infusion sites
- 96370 Subcutaneous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug), each additional hour (list separately in addition to code for primary procedure)
- 96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
- 96373 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug), intra-arterial
- 96374 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug), intravenous push, single or initial substance/drug
- 96375 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug), each additional sequential intravenous push of a new substance/drug (list separately in addition to code for primary procedure)
- 96376 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug), each additional sequential intravenous push of the same substance/drug provided in a facility (list separately in addition to code for primary procedure)

- 99460 Initial hospital care per day for evaluation and management of normal newborn infant. Note: Free standing birthing center is not covered.
- 99462 Subsequent hospital care per day for evaluation and management of normal newborn infant
- 99463 Initial hospital care per day for evaluation and management of normal newborn infant admitted and discharge on the same date Note: Free standing birthing center is not covered.
- 99464 Attendance at delivery (requested by the delivering physician) and initial stabilization of newborn
PRIOR APPROVAL: Not Required . . . CRITERIA: Approved for neonatologists, pediatricians, and rural family practitioners only. Refer to Criteria #30 ²
- 99465 Delivery/birthing room resuscitation, provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output
- 99468 Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less
PRIOR APPROVAL: Not Required . . . CRITERIA: Approved for board certified NEONATOLOGISTS only
- 99469 Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less
PRIOR APPROVAL: Not Required . . . CRITERIA: Approved for board certified NEONATOLOGISTS only
- 99471 Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age
PRIOR APPROVAL: Not Required CRITERIA: Approved for board certified Neonatologists only
- 99472 Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age
PRIOR APPROVAL: Not Required CRITERIA: Approved for board certified Neonatologists only
- 99475 Initial inpatient pediatric critical care per day for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age
- 99476 Subsequent inpatient pediatric critical care per day for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age
- 99478 Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present weight less than 1500 grams)
PRIOR APPROVAL: Not required CRITERIA: Approved for board certified neonatologists, board certified pediatric intensivists, and board certified high risk pediatricians only.
- 99479 Subsequent intensive care, per day for the evaluation and management of the recovering very low birth weight infant (present body weight of 1500-2500 grams)
PRIOR APPROVAL: Not required CRITERIA: Approved for board certified neonatologists, board certified pediatric intensivists, and board certified high risk pediatricians only
- 99480 Subsequent intensive care per day for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams)
PRIOR APPROVAL: Not required CRITERIA: Approved for board certified neonatologists, board certified pediatric intensivists, and board certified high risk pediatricians only

Non-Covered Codes Effective January 1, 2009

- 20696 Application of multiplane (pins or wires in more than one plane, unilateral, external fixation with stereotactic computer-assisted adjustment (i.e. spatial frame) including imaging; initial and subsequent alignments, assessments, and computations or adjustment schedules
- 20697 Application of multiplane (pins or wires in more than one plane, unilateral, external fixation with stereotactic computer-assisted adjustment (i.e. spatial frame) including imaging; exchange (i.e. removal and replacement) of strut, each
- 22856 Total disc arthroplasty (artificial disc) anterior approach, including discectomy with end plate preparation (includes osteophylectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical
- 22861 Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical
- 22864 Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace, cervical
- 41512 Tongue base suspension, permanent suture technique
- 41530 Submucosal ablation of the tongue base, radio frequency, one or more sites per session
- 43279 Laparoscopy, surgical esophagomyotomy (Heller) type with fundoplasty, when performed
- 61796 Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); one simple cranial lesion
- 61797 Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion (list separately in addition to code for primary procedure)
- 61798 Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); one complex cranial lesion
- 61799 Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex (list separately in addition to code for primary procedure)
- 61800 Application of stereotactic head frame for stereotactic radiosurgery (list separately in addition to code for primary procedure)
- 63620 Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); one spinal lesion

- 63621 Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (list separately in addition to code for primary procedure)
- 65756 Keratoplasty (corneal transplant); endothelial
- 65757 Back bench preparation of corneal endothelial allograft prior to transplantation (list separately in addition to code for primary procedure)
- 77785 Remote afterloading high dose rate radionuclide brachytherapy; one channel
- 77786 Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels
- 77787 Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels
- 78808 Injection procedure for radiopharmaceutical localization by non-imaging probe study, intravenous (i.e. parathyroid adenoma)
- 83876 Myeloperoxidase (MPO)
- 83951 Oncoprotein; des-gamma-carboxy-prothrombin (DCP)
- 85397 Coagulation and fibrinolysis, functional activity, not otherwise specified (i.e. ADAMTS-13), each analyte
- 88740 Hemoglobin, quantitative, transcutaneous, per day; carboxyhemoglobin
- 88741 Hemoglobin, quantitative, transcutaneous, per day, methemoglobin
- 90650 Human papilloma virus (HPV) vaccine, types 16 and 18, bivalent, 3 dose schedule, IM use
- 90738 Japanese encephalitis virus vaccine, inactivated, for IM use
- 90963 End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
- 90964 End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
- 90965 End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
- 90966 End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age or more to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
- 93293 Transtelephonic rhythm strip pacemaker evaluations single, dual or multiple lead pacemaker system, includes recording with and without magnet application with physician analysis, review and reports, up to 90 days
- 93352 Use of echocardiographic contrast agent during stress echocardiography (list separately in addition to code for primary procedure)
- 95803 Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)
- 96371 Subcutaneous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug), additional pump set-up with establishment of new subcutaneous infusion sites (list separately in addition to code for primary procedure)
- 96379 Unlisted therapeutic, prophylactic, or diagnostic injection (specify substance or drug), intravenous or intra-arterial injection or infusion
- 99461 Initial care per day for evaluation and management of normal newborn infant seen in other than hospital or birthing center
- 99466 Critical care services delivered by a physician, face-to-face, during interfacility transport of a critically injured pediatric patient, 24 months of age or less; first 30-74 minutes of hands on care during transport
- 99467 Critical care services delivered by a physician, face-to-face, during interfacility transport of a critically injured pediatric patient, 24 months of age or less; each additional 30 minutes of hands on care during transport (list separately in addition to code for primary procedure)

Non-Covered Codes For Non-Traditional Medicaid Effective January 1, 2009

- 87905 Infectious agent enzymatic other than virus (i.e sialidase activity in vaginal fluid)
- 88720 Bilirubin, total, transcutaneous

Assistant Surgeon Not Allowed

43273 46830 55706 62267 64455 64632

Post Operative Days

Zero Post Op Days

43273 55706 62276

10 Post Op Days

46930 49652 49653 49654 49655 49656 49657 64455 64632 92980 92981 92986
92987 92990 92992 92993

42 Post Op Days

27027 27057 35535 35570 35632 35633 35634 93580

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09 - 12 Medical and Surgical Criteria Updates

Several criteria, which appear in the *Criteria for Medical and Surgical Procedures* list, have been updated for January 1, 2009. 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 #7 Inguinal Hernia/Orchiectomy, criteria #8 Orchiectomy, criteria #9 Amputation of Penis, criteria #39B Fetal Biophysical Profile, and criteria #40C PET/CT Imaging.

Criteria #7 Inguinal Hernia/Orchiectomy

1. Documentation requirements
 - a. Sterilization consent.
 - b. Consent must indicate the patient/parents of a child 20 years of age or less, were informed of the potential sterility that may result from the procedure.
 - c. If the documentation supports that the procedure is performed for medically necessary reasons (not for voluntary sterilization), the required 30-day waiting period for sterilization may be waived.
2. Physical examination confirms the inguinal hernia adversely affects the testicle and conservative treatment measures have failed.

Criteria #8 Orchiectomy

1. Documentation
 - a. Signed sterilization consent form.
 - b. Ultrasound indicates trauma, scrotal mass, calcifications, cryptochidism, testicular torsion, or abscess.
2. Indications
 - a. Clinical indications of testicular cancer by physical examination and ultrasound.
 - b. Treatment for prostate cancer.
 - c. Testicular atrophy or trauma.
 - d. Necrotic testicle.
 - e. Testicular abscess (i or ii)
 - i. Worsening symptoms after treatment (ALL)
 - (1) Findings (ONE)
 - (a) Increased temperature >38.3
 - (b) Increased WBCs >10,000
 - (c) Increased pain, erythema, and swelling/edema. NOTE: Pain should decrease after 1-3 days on antibiotics, but induration may take weeks to resolve.
 - (2) Antibiotics greater than two days and failure to improve after 72 hours of conservative medical management.
 - (3) I&D performed.
 - ii. Continued findings after treatment (BOTH)
 - (1) Antibiotic for three weeks or more
 - (2) I&D performed
 - f. Intra-abdominal testis. NOTE: Removal required if the testis cannot be brought to the scrotum or patient is post pubertal.

Criteria #9 Amputation of Penis

1. Documentation of signed sterilization consent form.
2. Indications
 - a. Carcinoma of penis confirmed by biopsy.
 - b. Fourniers gangrene. NOTE: Necrotizing fasciitis of penis and scrotum which may be caused by trauma or infection.
 - c. Giant Condylomata Acuminata and other premalignant dermatologic diseases.
 - d. Peyronie disease intractable to medical treatment and conservative surgical treatment has failed.

Criteria #39B Fetal Biophysical Profile

1. Documentation (ONE)
 - a. Fetal biophysical profile with nonstress test, code 76818 (ALL)
 - i. Fetal nonstress test.
 - ii. Fetal breathing movements (one or more episodes of rhythmic fetal breathing movements of 30 seconds or more within 30 minutes).
 - iii. Fetal movement (three or more discrete body or limb movements within 30 minutes).
 - iv. Fetal tone (one or more episodes of fetal extremity extension with return to flexion).
 - v. Quantification of amniotic fluid volume (a pocket of amniotic fluid that measures at least one cm in two planes perpendicular to each other).
 - b. Fetal biophysical profile without nonstress test, code 76819 (ALL)
 - i. Fetal breathing movements (one or more episodes of rhythmic fetal breathing movements of 30 seconds or more within 30 minutes).
 - ii. Fetal movement (three or more discrete body or limb movements within 30 minutes).
 - iii. Fetal tone (one or more episodes of fetal extremity extension with return to flexion).
 - iv. Quantification of amniotic fluid volume (a pocket of amniotic fluid that measures at least one cm in two planes perpendicular to each other).
2. Indications (ONE)
 - a. Multiple gestation
 - b. IUGR (intrauterine growth restriction)
 - c. Maternal disease (ONE)
 - i. Diabetes mellitus
 - ii. Connective tissue disease
 - iii. Isoimmunization
 - iv. Renal disease
 - v. Hypertension
 - vi. Preeclampsia or eclampsia
 - vii. Maternal exposure to infectious agent (ONE)
 - (1) Parvo virus
 - (2) Cytomegalovirus
 - (3) Rubella
 - (4) Toxoplasmosis
 - (5) HIV
 - d. Oligohydramnios
 - e. Polyhydramnios
 - f. Malpresentation of fetus
 - g. Known fetal anomaly
 - h. Known partial/complete placenta previa
 - i. Gestation >41 weeks
 - j. Alpha-fetoprotein (AFP) abnormal
 - k. Fetal nonstress test nonreactive or abnormal
 - l. Suspected fetal demise
 - m. Decreased fetal movement
 - n. Injury or accident

Criteria #40C PET/CT Imaging

Limitations, item B has been removed.

- B. In a patient with lymphoma, the PET/CT is covered prior to surgery or when documentation supports medically necessary because a change in radiation treatment is anticipated.

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09 - 13 Emergency Room Diagnosis Codes

The following ICD-9-CM codes have been updated on the *Authorized Diagnosis for Emergency Department Reimbursement* list, effective January 1, 2009.

- 038.12 Methicillin resistant Staphylococcus aureus septicemia
- 249.11 Secondary diabetes mellitus with ketoacidosis, uncontrolled
- 249.21 Secondary diabetes with hyperosmolarity, uncontrolled
- 249.31 Secondary diabetes mellitus with other coma, uncontrolled
- 249.41 Secondary diabetes mellitus with renal manifestations, uncontrolled
- 249.61 Secondary diabetes mellitus with neurological manifestations, uncontrolled
- 346.61 Persistent migraine with cerebral infarction, with intractable migraine, so stated without mention of status migrainosus.
- 346.62 Persistent migraine aura with cerebral infarction, without mention of intractable migraine with status migrainosus.
- 346.63 Persistent migraine aura with cerebral infarction, with intractable migraine, so stated with status migrainosus.
- 482.42 Methicillin resistance pneumonia due to Staphylococcus aureus
- 535.71 Eosinophilic gastritis with hemorrhage
- 695.12 Erythema multiform
- 695.13 Stevens-Johnson syndrome
- 695.14 Stevens-Johnson syndrome toxic epidermal necrolysis overlap syndrome
- 777.50-777.53 Necrotizing enterocolitis in newborn
- 780.60 Pyrexia of unknown origin
- 780.65 Hypothermia not associated with low environmental temperature

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09 - 14 Inpatient Hospital Emergency Diagnosis Codes

The following ICD-9-CM codes have been updated on the *Utah Medicaid Table of Authorized Emergency Inpatient Diagnoses* list, effective January 1, 2009.

- 346.60-346.63 Persistent migraine with cerebral infarction
- 535.71 Eosinophilic gastritis with hemorrhage
- 777.50-777.53 Necrotizing enterocolitis in newborn

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09 - 15 Inpatient Rehabilitation Services

Inpatient Rehabilitation Services, an attachment to the Hospital Manual, has been updated for January 1, 2009. Minor wording and numbering has been changed. Beginning January 1, 2009, cases will be manually reviewed by the program integrity unit to determine appropriateness of prior authorization of the service for payment.

Additions to Terms and Abbreviations:

- PT Physical Therapy
- OT Occupational Therapy
- SLP Speech Language Pathology, Speech Therapy
- FIM Functional Independent Modifier, a measurement tool
- ASIA American Spinal Injury Association Classification Score, a measurement tool
- RANCHO Rancho Los Amigos Scale of Cognition
- WISCI Walking Index for Spinal Cord Injury
- ABS Agitated Behavior Scale

Prior Authorization:

- A. *Inpatient hospital rehabilitation services* . . . Effective January 1, 2009, rehabilitation services will be manually reviewed by Medicaid Program Integrity staff following the provider evaluation of patient rehabilitation potential.
- C. *For approval, inpatient rehabilitation services must meet the following criteria:*
 - (2) Due to the patient's potential risk of significant changes in physical or mental states, close

supervision by the rehabilitation team under the supervision of a rehabilitation physician specialist is required.

- (5) The patient requires rehabilitation evaluation and management services in intensity, frequency, or duration that qualify the patient for an inpatient rehabilitation stay by a (i.e. FIM score, ASIA score, Rancho score, Disability Rating Scale (DRS), Walking Index for Spinal Cord Injury (WISC1), Agitated Behavior Scale) measurement tool which provides an objective measurement of the initial evaluation and lends itself to documenting progression toward rehabilitation goals.
- (6) *For review of prior authorization approval, the following medical record documentation must be submitted:*
- a. *The physiatry or physical medicine history and physical, with the rehabilitation, short and long term goals.*
 - c. *The hospital discharge summary, if available, with rehabilitation plan and number of hours of therapy estimated for any given discipline. NOTE: Discharge summary is often not available at the point of request for prior authorization, but is required for retro reviews of the patient record.*
 - d. Documentation supports at the time of admission to the rehabilitation unit, that *the patient's physical, cognitive, and sensory capacity allows...*
 1. Documentation of the *functional independent modifier (FIM) score for OT, PT, and Speech* with the discharge goals for each discipline must be submitted...
NOTE: If available, the audiology record should be submitted with the request for speech therapy.
 2. Measurement scores in addition to the FIM are required for stroke, head, or spinal cord injury.
- D. Rehabilitation services are non-covered when: (ONE)
- (1) The patient is not medically stable or requires acute inpatient hospital services.
 - (2) The patient condition and prognosis meets the requirements of placement in a long-term care facility, skilled nursing facility, or outpatient rehabilitation service.
 - (3) Deconditioning (i.e. cardiac or pulmonary rehabilitation).
 - (4) Bilateral hip or bilateral knee replacement surgery is completed at patient request. Documentation must support the medical necessity for completing either procedure bilaterally.

- E. Beginning January 1, 2009, prior authorization based on the appropriateness of the rehabilitation admission will be determined by the initial FIM score and other validated measurement tools ... The request must be sent in by FAX with all the pertinent information outlined in item C and D ... *FAX number is (801) 536-0161.*

Tables 800-804. The following information was added to the columns described:

Disease Specific:

Table 800 and 801: The ASIA score or other standardized measurement tool must be in the record.

Table 802: The Rancho Classification score must be in the medical record.

Table 803: 3. The rehabilitation service is for a separate focal CVA site than a previous admission.

Table 804: 4. Amputation: The patient must have been mobile prior to the injury. Supportive documentation must substantiate a rehabilitation stay will be beneficial to the patient. The stump must be healed to the point that physical therapy and rehabilitation education can be accomplished.

Comments:

Table 800 and 801: The patient is mentally and physically ready to learn adaptive techniques, transfer skills, and equipment use appropriate for the level of injury. There are well defined treatment goals.

Table 802: Documentation of well defined treatment goals for functional improvement. The patient is an evolving Rancho 3 or Rancho 4-6 with behavior management issues.

Table 803: Well defined treatment goals for functional improvement are documented.

Table 804: Other diagnosis list of covered diagnosis

1. Neurological Deficit: Amyotrophic lateral sclerosis (ALS), Multiple Sclerosis, Myopathy, Guillian-Barre Syndrome, Myelopathy (transverse myelitis infarction), Parkinson's Disease.
2. Congenital deformity (i.e. following dorsal rhizotomy)
3. Complex fractures (i.e. hip)
4. Amputation
5. Post neurosurgery of brain or spine (i.e. tumor)
6. Burns
7. Major multiple trauma (i.e. fractures, amputation)
8. Post meningo-encephalitis

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09 - 16 UB-04 Revenue Codes Updated

The revenue code list for inpatient and outpatient procedures for all three programs, Traditional Medicaid, Non-Traditional Medicaid, and Primary Care Network, has been updated to comply with the UB-04 March 2007 update. Discontinued codes have been closed in the reference file.

Please note the below program -specific information:

PCN

Code 760, General Observation/Treatment, has now been closed. Code 761, Treatment Room, and Code 762, Observation Room, have previously been closed.

Traditional Medicaid

Codes 761 and 762 will show as outpatient based on medical necessity only.

The following UB-04 codes were never addressed, but will be listed as non-covered:

0169 Room and Board Other
0241 All Inclusive Ancillary, Basic
0242 All Inclusive Ancillary, Comprehensive
0243 All Inclusive Ancillary, Specialty
0392 Storage of Blood and Stem Cells
0609 Oxygen Other
0663 Respite/Daily
0669 Respite/Other
0813 Unknown Donor Organ Acquisition
0948 Pulmonary Rehabilitation

Medicaid and Non-Traditional Medicaid

The following UB-04 codes are non-covered:

0760 General Observation and Treatment (billed for observation/treatment codes covered in 0761 / 0762)
0769 Other observation

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09 - 17 Medical Supplies HCPCS 2009 CodesCovered Code Effective January 1, 2009, Prior Authorization Required

A6545 Gradient compression wrap, non-elastic, below knee, 30-50 MM HG, each

Non-covered Codes Effective January 1, 2009

L2860 Addition to lower extremity joint, knee or ankle, concentric adjustable torsion style mechanism, each
L3890 Addition to upper extremity joint, wrist or elbow, concentric adjustable torsion style mechanism, each

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09 - 18 Medical Supplies Updates

Changed terminology: Removed the term HMO (Health Maintenance Organization) and replaced with MCP (Managed Care Plan). This is because the Health Plans offered by Medicaid are not always through an HMO.

Page 37 of the manual has been corrected to match page 3. This is regarding the maintenance and service for CPAP and BIPAP equipment. The paragraph now reads as follows:

“The maintenance and service fee is for maintenance and service on the DME as needed to keep the equipment operating properly and includes service and maintenance which were routinely supplied when the item was being provided as a monthly rental. Supplies, masks, tubing, etc. may be billed separately for CPAP and BIPAP’s.”

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09 - 19 Medical Supplies List Corrections

The *Medical Supplies List*, and attachment to the Medical Supplies Manual and Physician Manual, has been updated January 1, 2009.

1. Hearing aid codes were removed from the *Medical Supplies List* and put in the Audiology Manual.
2. All items requiring prior authorization will require written documentation to be included with the request. Telephone prior authorization has been eliminated. Also, please review the policy manual for criteria so that requests can be approved or denied based on criteria, rather than a denial for lack of documentation.
3. The wheelchair codes have been reordered to put them in numerical order based on the category. This update should facilitate finding codes more easily.
4. The following codes are covered, effective October 1, 2008, with prior authorization required:
 - K0861 Power wheelchair, group 3 standard, multiple power option, patient weight capacity up to and including 300 pounds.
 - K0862 Power wheelchair, group 3 heavy duty, multiple power option, patient weight capacity 301 to 450 pounds.
 - K0863 Power wheelchair, group 3 very heavy duty, multiple power option, patient weight capacity 451 to 600 pounds.
5. The following codes have been corrected to the appropriate code:
 - S6222 Corrected to A6222 Gauze, impregnated with other than water, normal saline, hydrogel pad size 16 sq. in. or less, with adhesive border.
 - S6223 Corrected to A6223 Same as A6222, pad size > 16 sq. in. but less than 48 sq. in. with adhesive border.
 - S6224 Corrected to A6224 Same as A6222, pad size < 48 sq. in., with adhesive border.
6. The following codes are covered, but were inadvertently left off the Medical Supplies List. See the Medical Supplies List for criteria, requirements, and comments.
 - A4209 Syringe with needle, sterile 5 cc or greater, each
 - A4411 Ostomy skin barrier extended = 4 Sq, with built in convexity, each
 - A4550 Surgical trays
 - A4627 Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler
 - A7025 High frequency chest wall oscillation system vest, replacement for use with patient owned equip, each
 - E0635LL Patient lift, electric with seat or sling
 - E0673RR Segment gradient pressure pneumatic appliance, half leg
 - E0710 Restraints, any type (body, chest, wrist, ankle)
 - E0930LL Fracture frame, free standing, includes weights
 - E0966 Manual wheelchair accessory, headrest extension, each
 - E2313 Power wheelchair accessory, harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware, each
 - E2365 Power wheelchair accessory, U-1 sealed lead acid battery, each (egl, gel cell, absorbed glassmat)
 - E2603 Skin protection wheelchair seat cushion, width less than 22 inches, any depth
 - K0010LL Standard-weight frame motorized/power wheelchair
 - K0011LL Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking
 - K0014LL Other motorized/power wheelchair base
 - K0015 Detachable, non-adjustable height armrest; base, each
 - K0077 Front caster assembly, complete, with solid tire, each
 - K0813 Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds
 - K0820 Power wheelchair, group 2 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds

K0821	Power wheelchair, group 2 standard, portable, captains chair, patient weight capacity up to and including 300 pounds
K0836	Power wheelchair, group 2 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds
K0837	Power wheelchair, group 2 standard, single power option, sling/solid seat and back, patient weight capacity 301 to 450 pounds
K0838	Power wheelchair, group 2 standard, single power option, captains chair, patient weight capacity 301 to 450 pounds
K0839	Power wheelchair, group 2 standard, single power option, sling/solid seat and back, patient weight capacity 451 to 600 pounds
K0840	Power wheelchair, group 2 standard, single power option, captains chair, patient weight capacity 451 to 600 pounds
K0842	Power wheelchair, group 2 standard, multiple power option, captains chair, patient weight capacity up to and including 300 pounds
L5500	Initial, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, direct formed
L5540	Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot, laminated socket, molded to model
L5645	Addition to lower extremity, below knee, flexible inner socket, external frame
L5685	Addition to lower extremity prosthesis, below knee, suspension/sealing sleeve, with or without valve, any material, each
L8507	Tracheo-esophageal voice prosthesis, patient inserted, any type, each
L8509	Tracheo-esophageal voice prosthesis, inserted by a licensed health care provider, any type
T4534	Youth-sized disposable incontinence product, protective underwear/pull-on, each

7. The following codes are obsolete and have been removed from the Medical Supplies List:

A4348	Male external catheter with integral collection compartment
A4359	Urinary suspensory without leg bag, each
A4260	Levonorgestrel contraceptive implant system...
B4184	Parenteral nutrition solutions; lipids, 10% with admin. Set
B4186	Parenteral nutrition solutions; lipids, 20% with admin. Set
E0953	Pneumatic tire, each
E0954	Semi-pneumatic caster, each
E0972	Wheelchair accessory, transfer board or device, each
E0997	Caster with a fork
E0998	Caster without a fork
E1001	Wheel, single
E1025	Lateral thoracic support, non-contoured, for pediatric size...
K0556	Addition to lower extremity, below/above knee...
K0064	Zero pressure tube (flat free inserts) any size, each
K0068	Pneumatic tire tube
K0075	Semi pneumatic caster tire, any size
L1870	KO, double upright, thigh and calf lacers, custom fabricated
L1880	KO, double upright, non-molded thigh and calf cuffs/lacers with knee joints...
L3986	Upper extremity fracture orthosis, combination of humeral, radius/ulnar, wrist...
L6725	Terminal device, hook dorrance, or equal, model #7
L6830	Terminal device, hand, APRL, VC

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09 - 20 Audiology Manual Change

Changed terminology: Removed the term HMO (Health Maintenance Organization) and replaced with MCP (Managed Care Plan). This is because the Health Plans offered by Medicaid are not always through an HMO.

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09 - 21 Physical Therapy (Independent / Group Practices)

Changed terminology: Removed the term HMO (Health Maintenance Organization) and replaced with MCP (Managed Care Plan). This is because the Health Plans offered by Medicaid are not always through an HMO.

09 - 22 Physical Therapy and Occupational Therapy Services in Rehabilitation Centers

Changed terminology: Removed the term HMO (Health Maintenance Organization) and replaced with MCP (Managed Care Plan). This is because the Health Plans offered by Medicaid are not always through an HMO.

09 - 23 Podiatry Manual Change

Changed terminology: Removed the term HMO (Health Maintenance Organization) and replaced with MCP (Managed Care Plan). This is because the Health Plans offered by Medicaid are not always through an HMO.

09 - 24 Vision Manual Change

Changed terminology: Removed the term HMO (Health Maintenance Organization) and replaced with MCP (Managed Care Plan). This is because the Health Plans offered by Medicaid are not always through an HMO.

09 - 25 Speech-Language Manual Change

Changed terminology: Removed the term HMO (Health Maintenance Organization) and replaced with MCP (Managed Care Plan). This is because the Health Plans offered by Medicaid are not always through an HMO.

Codes in the Speech-Language section have been reordered to put them in numerical order based on the category. This update should facilitate finding codes more easily.

09 - 26 Medical Transportation Manual Change

Codes open at same reimbursement rate as A0425, effective November 1, 2008:

A0435 Fixed wing air, per statute mile

A0436 Rotary wing air mileage, per statute mile

09 - 27 Oral Maxillofacial Surgeon Manual Change

Changed terminology: Removed the term HMO (Health Maintenance Organization) and replaced with MCP (Managed Care Plan). This is because the Health Plans offered by Medicaid are not always through an HMO.

Correction to codes to allow Oral Surgeons to provide services:

70355 Orthopantogram

21462 Treatment of mandibular fracture with interdental fixation.

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