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10- 49 April 2010 MIB Article, 10-41 CPT Code Updates, Modified

Several codes appearing in this article were either misprinted or inadvertently omitted from the lists. Below is the revised article with the changes in **bold** print.

Codes Added to Assistant Surgeons List:

23073 27045 27059 28039 28041

Covered Codes:

92025 Computerized corneal topography, unilateral or bilateral, with interpretation and report

Non-Covered Codes:

62287 Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method, single or multiple levels, lumbar
 62292 Injection procedure for chemonucleolysis, including diskography, intervertebral disk, single or multiple levels, lumbar
 87481 Candida species, amplified probe technique
 87482 Candida species, quantification
 87511 Gardenella vaginalis, amplified probe technique
 87512 Gardenella vaginalis, quantification

Consultation codes 99241-99245 are no longer covered for optometrists.

Codes Requiring Manual Review (see Physician Manuals for manual review coverage guidelines):

17000 Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g., actinic keratoses); first lesion
 17003 . . . second through 14 lesions, each (list separately in addition to code for first lesion)
 17004 Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g., actinic keratoses); 15 or more lesions
 17106 Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); less than 10 sq cm
 17107 Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); 10 to 50 sq cm
 17108 Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); over 50 sq cm
92610 Evaluation of oral and pharyngeal swallowing function

Codes Requiring Prior Authorization:

21175 Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
 Note: Will show as restricted code when PA requested and greater than one year of age with discussion in the Physician Manual.
59812 Treatment of incomplete abortion, completed surgically, any trimester
59820 Treatment of missed abortion, completed surgically, 1st trimester
59821 Treatment of missed abortion, completed surgically, 2nd trimester

Codes Removed from Prior Authorization:

33619 Repair single ventricle with aortic outflow obstruction and aortic arch hypoplasia (i.e. Norwood procedure)
 55650 Vasiculectomy, any approach

Codes Updated:

Codes 99460-99463 have been updated in the Certified Nurse Midwife Provider Manual and the Certified Family Nurse Practitioner/Pediatric Nurse Practitioner Provider Manual.

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10- 50 Clarification to CPT Codes

The Medical & Surgical Procedures (CPT List) in the Physician Manual has been updated for May 1, 2010, to remove discontinued codes and other typographical issues. Some lines after the code, stating a prior authorization is required or the service is not a covered benefit, have been inadvertently removed and have been replaced. Several of the medical surgical criteria related to manual review were integrated into the appropriate provider manual. Clarifications were added to the following codes:

- 00402 Reconstruction procedures on breast (i.e. reduction or augmentation mammoplasty, muscle flaps)
 Prior Approval: Written: ICD-9: 85.32, 85.50, 85.54, 85.82, 85.83, 85.84, 85.85
 Prior Approval: Written for the surgery; includes anesthesia approval.
- 00840 Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified. This code includes many procedures which do not require PA. This code cannot be used for any procedure related to sterilization, code 00851 must be used. In circumstances where the procedure may be with an unlisted procedure or cosmetic procedure, the anesthesia must be manually reviewed for payment.
 Prior Approval: Written for surgery; includes anesthesia approval.
- 00921 Anesthesia for vasectomy, unilateral or bilateral
 Prior Approval: Written: ICD-9: 63.70, 63.71, 63.72, 63.73.....Criteria: Attach documentation to claim.
 Prior Approval: Written for the surgery; includes anesthesia approval.....Refer to criterion #10A
- 33619 Repair of single ventricle with aortic outflow obstruction and aortic arch hypoplasia (hypoplastic left heart syndrome) (e.g., Norwood procedure)
 Removed from PA
- 55650 Vesiculectomy, any approach (Removed from PA, no back on requiring PA)
 Prior Approval: Written: ICD-9: 69.73.....Criteria: Attach documentation to claim.
- 59812, 59820, 59821 Incorrect code number (95812, 95820, 95821) with correct descriptor in April MIB.
- 59899 Unlisted procedure, maternity care and delivery (Code inadvertently left off file)
 Prior Approval: Written for procedures other than global delivery fee for birthing center.
- 73225 Magnetic resonance angiography, upper extremity with and without contrast (Code left off list)
 NOT A BENEFIT
- 73721 Magnetic resonance (for e.g., proton) imaging, any joint of lower extremity; without contrast material
 Only the knee joint will be considered for an MRI PA.
 PA for age 20 and older: Written: ICD-9: 88.9.....Refer to Criteria #40B²
- 73722 MRI any joint of lower extremity, with contrast material
 Only the knee joint will be considered for an MRI PA.
 PA for age 20 and older: Written: ICD-9: 88.94.....Refer to Criteria #40B²
- 73723 MRI any joint of lower extremity, without contrast material followed by contrast material and further sequences
 Only the knee joint will be considered for an MRI PA.
 PA for age 20 and older: Written: ICD-9: 88.94.....Refer to Criteria #40B²
- 75557 Cardiac magnetic resonance imaging for morphology and function without contrast material (code number corrected)

- 96116 Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, EG, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face with the patient and time interpreting test results and preparing the report.
Prior Approval: Written....Limited to 8 hours when documentation supports medical necessity. A request over 8 hours requires CHEC/UR committee review.
- 99349 Home visit for the evaluation and management of an established patient (moderate complexity)
Prior Approval: Written....for Medicaid under special care situations, see Physician Manual. Limited to hospice: approved for primary managing physician.
- 99468 through 99480 Neonatal and pediatric intensive care codes. See Physician Manual.

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10- 51 Wheelchair Codes

The Medical Supplies Manual has had several corrections made to the wheelchair section. Permission has been given to open approximately 100 additional codes dealing with wheelchair attachments and parts. This action is being taken to reduce the need to use the miscellaneous code K0108 for items that have an actual HCPCS code.

Please review the Medical Supplies List carefully to find the codes that have been added. Please note ALL codes that have been added to the wheelchair section require prior authorization, as do the codes that were previously open for attachments and parts.

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10- 52 Physician Manual Updates

After Hours Codes

The code 99058 describes an office visit delivered on an emergency basis for an established patient after hours or which disrupts scheduled office services. For example, if the provider adjusts the time for scheduled patients during the day to see the patient with an emergent condition, code 99058 may be billed.

Neonatal Intensive Care Codes

(added to definitions)

A "diplomat" in neonatology is a board-certified pediatrician who has completed a three-year fellowship in neonatology, is board eligible, plans to sit for the next available certification examination, and is working with a group of board-certified neonatologists.

(added after description of neonatal codes 99468-99469)

*Note: A temporary exception to neonatology board certification may be approved for up to 3 years to allow payment of the codes requiring neonatology board certification when all of the following conditions are met:

1. A written request must be submitted to the Bureau of Medicaid Operations, Provider Enrollment Unit, by the physician requesting the exception and by the hospital department director or senior member of the practice requesting the exception.
2. The neonatology diplomat must ensure copies are submitted of all of the following documents:
 - a. DOPL license confirming certification as a board-certified pediatrician.
 - b. Certificate, diploma, or letter from the fellowship director showing completion of a three-year fellowship in neonatology.
 - c. Statements of eligibility and intent to sit for the next available neonatology certification examination with the date of the examination.

Maternity Care

Global pregnancy is not to be unbundled . . . Diabetic glucose monitoring is part of the maternity global payment. Additional billings for an office visit, diabetes self-management training, or nutritional medical counseling for the purpose of diabetic glucose monitoring in pregnancy is not appropriate. Documentation must support the medical necessity of these services.

Not Covered for Assistant Surgeon

69990 Note: This is an attachment to the Physician Manual.

Private Room Payment Requirements

Correction to codes in both the Physician Manual and Hospital Manual.

072.1 - 072.2 Mumps Meningitis/Encephalitis

Diabetes Self-Management Program

Prior Authorization

3. These services must meet the requirements for the ADA courses. Use solely for glucose monitoring or nutritional counseling is not covered through this program.

OO. Radiology

1. Ultrasound and x-ray
Reimbursement for imaging studies for interpretation and report is limited to payment to the radiologist..
2. CT Scans
 - Chest CT Scan
 - a. The chest x-ray is the standard of practice. A review for medical necessity of CT of the thorax may be requested for a particular case. It is expected that the chest x-ray is used to evaluate patients who present with signs and/or symptoms suggestive of chest pathology prior to proceeding to a CT scan. However, in limited circumstances, a CT of the thorax is reasonable and necessary in cases in which the medical literature supports the CT scan as the primary diagnostic test for the condition being evaluated. The frequency of the exam must be reasonable and justified upon intermediary medical review.
 - b. The use of the scan must be medically appropriate considering the patient's symptoms and preliminary diagnosis. Documentation in the medical record should support the reasoning behind the decision for the CT scan.
 - c. CT may be indicated as medically necessary when:
 - * there is a suspected mass or growth
 - * clinical indicators suggest a possible metastasis to the pulmonary system from a known neoplasm site such as the brain or breast.
 - * evidence of a growth or mass requires biopsy guidance.
 - * the progression of a disease requires evaluation such as pulmonary fibrosis.
 - * clinical signs suggest pulmonary collapse (pneumothorax) or a lung abscess (empyema).
 - * the patient is presenting with chest pain when the differential diagnosis includes pulmonary embolism or aortic aneurysm and/or following trauma when an internal injury of the thorax is suspected.
 - * prior to bronchoscopy when a patient is HIV positive with suspected pulmonary tuberculosis and the chest film has non-specific interstitial infiltrates or the film is abnormal and it is difficult to identify whether there is cavitation.
 - d. Non-Coverage:
 - * as a screening test in the absence of signs or symptoms of disease or condition.
 - * CT of the thoracic for investigational or clinical trial purposes is not covered, including lung cancer screening or as part of the evaluation of a procedure or a clinical drug trial.
 - * a thoracic CT is not covered when the purpose is a sharper image of the chest x-ray.
 - * there are no protocols for use of thoracic CT for tuberculosis or other infectious disease screening through the Centers for Disease Control and Prevention or the American

College of Radiology. The chest x-ray is the standard of practice. A review for medical necessity of CT of the thorax may be requested for a particular case.

3. **PET/CT Scans**
The gold standard of care of initial diagnostic work-up for a tumor or cancer is the CT scan. The PET/CT scan is an invasive diagnostic test which combines the two studies with a lower level of radiation for the CT portion of the study. The PET/CT fusion procedure is currently under study by the National Oncological PET Registry (NOPR) under the request of Centers for Medicare and Medicaid Service (CMS). PET/CT fusion will only be considered for initial cancer evaluation by the Medicaid Utilization Review Committee after a 64-slice CT scan and before other procedures have been completed. A prior authorization may be obtained through the UR Committee on a case-by-case basis when documentation supporting medical necessity is submitted.
 - a. **Indications:** PET/CT is covered for initial cancer staging only when additional information is required prior to a procedure to determine the optimal anatomical location to perform an invasive diagnostic procedure to determine the feasibility of surgery for patients with an initial diagnosis of non small cell lung cancer, lymphoma, melanoma, colorectal cancer, esophageal cancer, or head/neck cancer.
 - b. **Limitations:**
 - * In a patient with melanoma, a PET/CT scan is covered to evaluate recurrence of melanoma prior to surgery and to assess extra nodal spread of malignant melanoma at initial staging.
 - * PET/CT scan is not covered for the evaluation of:
 - CNS disease such as dementia
 - cerebrovascular disease
 - metabolic nutritional disorders
 - infections
 - pulmonary disease, or for neoplasms of the liver, musculoskeletal system, ovary, pancreas, thyroid or parathyroid.
 - screening in the absence of specific signs and symptoms of disease or as a work-up of patients with multiple sites of disease.
4. **Radiation Therapy**
 - a. a treatment plan which is basically a mirror image will be reimbursed with one unit of payment (i.e., PA and AP of a specific site, right lateral and left lateral). There must be significant difference in the therapy plan to warrant additional payment of these services.
 - b. design blocks which are mirror images (i.e., AP and PA, right lateral and left lateral) are reimbursed with one unit of payment. There must be significant differences in the block design to warrant additional payment.
 - c. Payment is generally limited to 3 units per one anatomical site. Additional units will be considered when review indicates a separately identifiable service.

4-1 Retroactive Authorization Documentation Guidelines

There are limited circumstances under which a physician may request authorization after service is rendered. These limitations are described in SECTION I, Chapter 9-7, Retroactive Authorization. The provider must complete a prior authorization request form and submit the medical record documentation supporting the reason the service was provided before Medicaid authorization was given. The medical record documentation must meet Medicaid coverage requirements for coverage of the service retroactively.

A. Retroactive Medicaid Eligibility

When a client becomes eligible for Medicaid after receiving services which would have required prior authorization, the provider should explain this circumstance on the Request for Prior Authorization form, with the supporting documentation of the medical necessity of the service.

1. Complete a Request for Prior Authorization form according to instructions and provide justification for the request for retroactive authorization.
2. The procedure must be covered by Medicaid and documentation must meet Medicaid coverage requirements for prior authorization for consideration of retroactive authorization.
3. Include documentation from the medical record to support the medical necessity of the procedure.
 - * the history and physical examination and evaluation must be completed just prior to the decision for the procedure.
 - * appropriate conservative measures have been tried and failed.
 - * accepted standard tests and imaging studies must be completed prior to requesting an advanced study.
 - * clinical evaluation with signs and symptoms must support the need for the procedure.

B. Surgical and Other Emergency Procedures

1. Complete a Request for Prior Authorization form according to instructions and provide justification for the request for retroactive authorization.
2. The procedure must be covered by Medicaid and documentation must meet Medicaid coverage requirements for prior authorization for consideration of retroactive authorization.
3. Medical record documentation supporting the emergent nature of the condition or the surgical exception that occurred that required the procedure: (ALL)
 - * submit the admission history and physical including any diagnostic testing confirming the diagnosis prior to surgery.
 - * operative report
 - * supportive studies documenting the necessity of the procedure. Include all that apply:
 - pathology report
 - imaging studies
 - laboratory tests (i.e., CBC with differential, culture, etc.)
 - * discharge summary
4. Surgical and other emergency procedures that require prior authorization may be performed in a medical emergency before authorization is obtained from Medicaid. When a medical emergency occurs, Medicaid may consider the request for retroactive authorization and payment. To qualify, the procedure must have been performed in a life-threatening or justifiable medical emergency.

It is the responsibility of the surgeon to substantiate the emergency and provide all necessary documentation to support a prepayment review of the services for all providers concerned, including documentation from the medical record to support the emergent nature of the procedure.

5. A copy of the Operative Informed Consent form the client signed which documents the specific procedure(s) to be performed, and to which the client agreed. In addition, the appropriate informed consent for specified gynecological procedures (abortion, sterilization, or hysterectomy). Also refer to criteria for sterilization, abortion, and/or hysterectomy in the attached Criteria for Medical and Surgical Procedures, and to information for the abortion, sterilization or hysterectomy consent forms included with this manual.

C. Other Surgical Exceptions and Anesthesia

1. A copy of the Operative Informed Consent form the client signed which documents the specific procedure(s) to be performed, and to which the client agreed.
2. The procedure must be covered by Medicaid and documentation must comply with coverage requirements.
3. Medicaid may consider the request for retroactive authorization and payment when the conditions for a surgical exception are met (see Section I). To qualify, the provider must demonstrate that the need for the procedure was unexpected, was discovered during surgery, that the need for the procedure could not have been anticipated prior to the surgery, and there was no indication the procedure was anticipated among the differential diagnoses prior to performing the surgery.
4. For cases in which a surgical procedure requires prior authorization, the associated anesthesia codes are prior authorized as a component of the surgical prior authorization. For cases in which a surgical procedure does not require prior authorization, but the associated anesthesia codes do require authorization, retro authorization will be granted upon confirmation that the surgery was neither cosmetic nor investigational.

D. Other Exceptions

When a delay in prior authorization rests with Medicaid, the date of submission for prior authorization will be considered; however, the submitted documentation must meet the criteria for approval.

1. Complete a Request for Prior Authorization form according to instructions and provide justification for the request for retroactive authorization.
2. Documentation must meet Medicaid coverage requirements for prior authorization for consideration of retroactive authorization.
3. Include documentation for the medical record to support the medical necessity of the procedure.
 - * the history and physical examination and evaluation completed just prior to the decision for the procedure.
 - * appropriate conservative measures have been tried and failed.
 - * accepted standard tests and imaging studies completed prior to requesting an advanced study.
 - * clinical evaluation with signs and symptoms supporting the need for the procedure.

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10- 53 Updates on Section I

Retroactive authorization is approval given after a service has been provided. Retroactive authorization may be considered ONLY in the circumstances listed in this chapter. The provider must complete a Request for Prior Authorization form and include documentation for the reason service was provided before Medicaid gave authorization. The submitted medical record documentation must comply with Medicaid coverage authorization requirements for coverage of the service retroactively. Refer to Section 2, Physician Services, for documentation guidelines.

A. Retroactive Medicaid Eligibility

When a client becomes eligible for Medicaid after receiving services which would have required prior authorization, Medicaid may consider a retroactive review, rather than denying reimbursement solely because prior authorization was not obtained. The provider should explain this circumstance on the Request for Prior Authorization form, with documentation supporting the medical necessity for the service. Even under this condition, the submitted medical record documentation must comply with Medicaid coverage authorization requirements for coverage of the service retroactively.

B. Medical Supplies Provided in a Medical Emergency

Certain medical supplies and equipment that require prior authorization may be provided in a medical emergency before authorization is obtained from Medicaid. When a medical emergency occurs, Medicaid may consider the request for retroactive authorization and payment.

It is the responsibility of the medical supplier to substantiate the emergency and provide the necessary documentation to support a prepayment review. Providers must obtain prior authorization for all other services, supplies, and equipment, even if the client's circumstances appear to qualify as an "emergency."

C. Surgical Emergency

Surgical procedures that require prior authorization may be performed in a medical emergency before authorization is obtained from Medicaid. When a surgical emergency occurs, Medicaid may consider the request for retroactive authorization and payment. To qualify, the procedure must have been performed in a life-threatening or justifiable medical emergency.

It is the responsibility of the provider to substantiate the emergency and provide all necessary documentation to support a prepayment review of the services for all providers concerned, including documentation from the medical record to support the emergent nature of the procedure.

D. Surgical Exceptions

For cases in which a surgical procedure requires prior authorization, the associated anesthesia codes are prior authorized as a component of the surgical procedure prior authorization. For cases in which a surgical procedure does not require prior authorization, but the associated anesthesia codes do require prior authorization, retroactive authorization will be granted upon confirmation that the surgery was neither cosmetic, investigational nor a non-covered service.

For cases in which a surgical code that requires prior authorization is performed during a surgery that does not require prior authorization, retroactive authorization will be granted if the provider is able to demonstrate through written documentation that the need for the additional procedure was unexpected and was discovered during the surgery, that the provider could not have anticipated the need for the procedure prior to the surgery and there was no indication the procedure was anticipated among the differential diagnoses prior to performing the surgery.

E. Other Exceptions

When delay in prior authorization rests with Medicaid, the date of the submission for prior authorization will be considered. However, the submitted documentation must meet the criteria for approval.

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10- 54 Updates to Anesthesia Manual

The separate attachment, *List of Anesthesia Codes Requiring Prior Authorization*, has been deleted and integrated into the Anesthesia Manual.

8 Prior Authorization

...However, for any anesthesia code on the list titled, *CPT Codes Which May Require Prior Authorization*, included in this section,...

1. ...Procedures which require PA include, but are not limited to, cosmetic, sterilization and abortion. Medicaid staff review each request to ensure that all federal and state requirements are met. If so, staff assigns a PA number for the CPT procedure and enters the PA number and appropriate anesthesia code into Medicaid's computer system.
2. ...If the surgeon did not obtain a prior, Medicaid cannot reimburse either the surgeon or the anesthesiologist.

CPT Codes Which May Require Prior Authorization:

- 00402 Anesthesia for reconstructive breast procedures (reduction, augmentation, muscle flaps)
 00840 Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified. This codes includes many procedures which do not require prior authorization. This code cannot be used for any procedure related to sterilization, code 00851 must be used. In circumstances where the procedure may be with an unlisted procedure, non-covered procedure, or cosmetic procedure, the anesthesia should be manually reviewed for payment. Prior approval written for surgery, includes anesthesia approval.
 00851 Anesthesia for intraperitoneal procedures in lower abdomen, including laparoscopy; tubal ligation
 00921 Anesthesia for vasectomy
 00952 Anesthesia for hysteroscopy and/or hysterosalpingography
 01966 Anesthesia for induced abortion procedures.

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10- 55 Amended Provider Enrollment Sanction Policy

The Division of Medicaid and Health Financing is notifying providers of its amended Provider Enrollment Sanction Policy. The State would like providers to become familiar with the content and revisions to the existing policy. To view the sanction policy, go to <http://health.utah.gov/medicaid>, click on "Enroll as a Utah Medicaid Provider".

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10- 56 Outpatient Hospital and Ambulatory Surgical Center Reimbursement Updates

Effective July 1, 2010, Utah Medicaid will begin changing its reimbursement methodology for outpatient hospital services and ambulatory surgery services from a percent of charge payment to a fee schedule. The transition from a percent of charges payment methodology to a fixed fee schedule payment methodology will occur from July 1, 2010, through June 30, 2011. The new payment methodology will include separate payment schedules for urban hospitals, rural hospitals and ambulatory surgical centers. Ambulatory surgical centers will be paid based upon a fixed fee schedule beginning July 1, 2010.

Utah Medicaid asks that hospitals begin sending procedure code level details with their claims as soon as possible. The procedure code detail submitted should include all codes even if there are no submitted charges for the detail line. This request will become a requirement on July 1, 2010, and claims will be rejected if detail is not submitted when appropriate.

Fee schedules will be posted to the web, and updated monthly, at: <http://www.health.utah.gov/medicaid/>.

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10- 57 Changes to Physician/Hospital Manual Attachment, Criteria for Medical and Surgical Procedures

Criteria #3	Aspiration procedure, percutaneous, of nucleus pulposus; Injection procedure of chemonucleolysis. CPT codes 62287 and 62292: CODES CLOSED
Criteria #7	Inguinal Hernia: InterQual Criteria will be used
Criteria #8	Orchiectomy: InterQual Criteria will be used
Criteria #9A	Penectomy: InterQual Criteria will be used
Criteria #10A	Sterilization Checklist: Updated UDOH Criteria (to be used will all medical procedures, treatment or operation for the purpose of rendering an individual permanently incapable of reproducing)
Criteria #10B1	Hysterosalpingogram: Updated UDOH Criteria
Criteria #10C	Tubal Sterilization (Open): Updated UDOH Criteria
Criteria #10D	Tubal Sterilization (Laparoscopic): Updated UDOH Criteria
Criteria #10E	Vasectomy: Updated UDOH Criteria
Criteria #11	Laparoscopic, Diagnostic (Pelvic): Updated UDOH Criteria
Criteria #12	Myomectomy: Updated UDOH Criteria
Criteria #13	Surgical Hysteroscopy: Updated UDOH Criteria
Criteria #14A	Abdominal Hysterectomy: Updated UDOH Criteria
Criteria #14B	Radical Hysterectomy: Updated UDOH Criteria
Criteria #15A	Vaginal Hysterectomy (LAVH): Updated UDOH Criteria
Criteria #15B	Vaginal Hysterectomy: Updated UDOH Criteria
Criteria #15C	Vaginal Hysterectomy (Supracervical): Updated UDOH Criteria
Criteria #16	Emergency Procedures: Moved to Physician Manual
Criteria #17	Abortion: Updated UDOH Criteria
Criteria #20	Contact Lenses: Moved to Vision Manual
Criteria #24	Liver Transplants: Utah Administrative Rule R414-10A
Criteria #25	Bone Marrow Transplants: Utah Administrative Rule R414-10A
Criteria #26	Kidney Transplants: Utah Administrative Rule R414-10A
Criteria #27	Cornea Transplants: Utah Administrative Rule R414-10A
Criteria #28	Heart Transplants: Utah Administrative Rule R414-10A
Criteria #29	Lung Transplants: Utah Administrative Rule R414-10A
Criteria #30	Neonatal Care: Moved to Physician Manual

- Criteria #31 Intestinal Transplants: Utah Administrative Rule R414-10A
- Criteria #32C Spinal Cord Stimulator [SCS] Insertion: InterQual Criteria will be used
- Criteria #33A Trigger Point Injections: Moved to Physician Manual
- Criteria #33B Epidural and Nerve Blocks: Moved to Physician Manual
- Criteria #34 Removal of Benign or Premalignant Skin Lesions: Moved to Physician Manual
- Criteria #35A Corneal Topography: Moved to Vision Manual
- Criteria #36 Urinalysis, Urine Culture: Moved to Laboratory Manual
- Criteria #37 Helicobacter Pylori: Moved to Laboratory Manual
- Criteria #38 Cardiac Ablation: Moved to Physician Manual
- Criteria #39A Ultrasound in Pregnancy: Moved to Physician Manual
- Criteria #39B Fetal Biophysical Profile: Moved to Physician Manual
- Criteria #40A Imaging, CT Scans: Moved to Physician Manual
- Criteria #40C PET/CT Imaging: Moved to Physician Manual
- Criteria #41 Fiberoptic Endoscopic Evaluation of Swallowing (FEEST): Moved to Physician Manual
- Criteria #43A Sleep Study for Adult (CPT 95811 is the only covered CPT code): Updated UDOH Criteria
- Criteria #43B Sleep Study for Pediatrics: Updated UDOH Criteria
- Criteria #46 Craniectomy or Craniotomy Decompression: Moved to Physician Manual

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10- 58 Changes to Medical Supplies Manual

- CPAP/BIPAP Adult and Senior Criteria: InterQual Criteria will be used

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