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1 GENERAL POLICY

A. Physician Services

The physician services program provides a scope of service to meet the basic medical needs of eligible categorically and medically needy individuals. The program is based on the art and science of caring for those who are ill through the practice of medicine or osteopathy by a practitioner who (1) meets all requirements necessary to participate in the Utah Medicaid program, (2) who agrees to abide by Department rules to render medically necessary physician services in accordance with a specific, signed provider agreement, and (3) who accepts Utah Medicaid reimbursement as payment in full. A Medicaid patient cannot be billed for services provided, except under the conditions stated in SECTION 1 of this manual, Chapter 6-8, Exceptions to Prohibition on Billing Patients. Physicians in other states can provide services to Utah Medicaid clients providing they are licensed, meet the requirements of participation in the Medicaid program in their state of residence, and become enrolled providers in the Utah Medicaid program.

Physicians may participate in a private practice, with a Managed Care Plan (MCP) that has a contract with the Department, a federally qualified Health Center (FQHC), or other organized entity recognized by the Department for providing physician services. With the cooperation and advice of the Utah Medical Care Advisory Committee, the Department has established standards and regulations governing care for which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for reasonable and necessary medical services and supplies subject to the exclusions and limitations set forth in policy and rules.

Physician services are a mandatory Medicaid, Title XIX program authorized by Sections 1901 and 1905(a) (1) of the Social Security Act, 42 CFR 440.50, and Sections 26-1-5 and 26-18-3, Utah Code Annotated.

B. Physician Assistant Services

An individual who has met the requirements of federal regulation and state law is authorized to participate in the Medicaid program serving patients in cooperation with a supervising provider. The working relationship between physician and physician assistant allows the physician and physician assistant to determine the appropriate amount of supervision and how that supervision will be documented. Under the practice rules, the following applies:

1. The supervising physician shall provide supervision to the physician assistant to adequately serve the health care needs of patients and ensure that the patient’s health, safety and welfare will not be adversely compromised.
2. A Delegation of Services Agreement, maintained at the site of practice, shall outline specific parameters for review that are appropriate for the working relationship.
3. There shall be a method of immediate consultation by electronic means whenever the supervising physician is not present and immediately available.
4. The supervising physician shall review and co-sign sufficient numbers of patient charts and medical records to ensure that the patient’s health, safety, and welfare are not adversely compromised.

A physician assistant can provide services consistent with the practice of the physician with whom he works. If the physician is a primary care provider, then by definition the physician assistant working with that physician would be providing primary care services. Often, the physician assistant is the first person to evaluate a patient presenting for service at the physician’s office. Under the statute, the physician assistant works under the supervision of a physician, is not an independent practitioner, and cannot bill independently.

Physician assistant services will be subject to applicable limitations and exclusions set forth in Medicaid policy. The physician assistant must have a committed and documented practice relationship under the supervision of a physician. Physician assistants working as employed staff in clinics or other facilities do not qualify to have their services separately billed. Refer to Chapter 1 - 7, Physician Assistant Services: Limitations, for limitations on applicable physician assistant services.

C. Advanced Practice Nurse Services

Procedures approved by Medicaid for coverage when delivered by a family nurse practitioner, a pediatric nurse practitioner, a certified nurse midwife, or a certified nurse anesthetist are open for their provider type. Procedures completed outside of the procedures approved by Medicaid are not reimbursable. When a non-covered procedure (i.e. lumbar puncture) is provided by a nurse practitioner then billed through the collaborating physician, the bill is not considered appropriate. When program integrity identifies non-covered procedures billed through the physician, a refund will be required. Nurse practitioners who have been approved by the Department to perform a specific procedure, based on their training and certifications, are the only individuals who will receive reimbursement for these services.

1 - 1 Clients Enrolled in a Managed Care Plan

A Medicaid client enrolled in a managed care plan or Prepaid Mental Health Plan (PMHP) must receive all health care services through that plan. Refer to SECTION 1 of this manual, Chapter 5, Verifying Eligibility, for information about how to verify a client’s enrollment in a plan. For more information about managed health care plans, please refer to SECTION 1, Chapter 4, MANAGED CARE PLANS. Each plan may offer more benefits and/or fewer restrictions than the Medicaid scope of benefits explained in this section of the provider manual. Each plan specifies services which are covered, those which require prior authorization, the process to request authorization and the conditions for authorization.

All questions concerning services covered by or payment from a managed care plan must be directed to the appropriate plan. Medicaid does NOT process prior authorization requests for services to be provided to a Medicaid client who is enrolled in a capitated managed care plan when the services are included in the contract with the plan. Providers requesting prior authorization for services for a client enrolled in a managed care plan will be referred to that plan.

A list of MCPs and PMHPs with which Medicaid has a contract to provide health care services is included as an attachment to this provider manual. Please note that Medicaid staff makes every effort to provide complete and accurate information on all inquiries as to a client’s enrollment in a managed care plan. Because eligibility information as to which plan the patient must use is available to providers, a fee-
Mental Health Services and Prepaid Mental Health Plan

If you think an individual may qualify for Medicaid, you should contact the appropriate PMHP to obtain authorization for mental health services. Even if the individual is not yet enrolled with a PMHP, he or she may be entitled to retroactive Medicaid eligibility. (See SECTION 1 of this manual, Chapter 1 - 3, Retroactive Medicaid). If so, the PMHP contractor will be responsible for services.

Also, unless there are extenuating circumstances, a provider must request authorization from the client’s Prepaid Mental Health Plan for inpatient mental health services within 24 hours of admission. If the provider does not have a contract with the PMHP responsible for the inpatient stay, the PMHP may choose to transfer the individual to one of its contracting hospitals.

There are some exemptions for children who need mental health services outside the Prepaid Mental Health Plan to which he or she is assigned. When the child is exempt, the Medicaid card will say: INPT PSYCH: (Name of PMHP provider) OUTPT PSYCH: ANY PROVIDER

Physicians who provide outpatient mental health services to an exempt child may bill the CPT-4 codes directly to Medicaid. In some instances, the child’s Medicaid card may have already been printed for the month and, therefore, will not yet contain information on the exemption. If you are unsure whether the child is exempt, contact Medicaid Information. For adoptees, contact Merrila Erickson, Division of Medicaid and Health Financing, at (801)538-6501.

1 - 2 Clients NOT Enrolled in a Managed Care Plan (Fee-for-Service Clients)

Medicaid clients who are not enrolled in a managed care plan may receive services from any provider who accepts Medicaid. This provider manual explains the conditions of coverage for Medicaid fee-for-service clients.

1 - 3 Billing

Physician services may be billed electronically or on paper, using the CMS-1500 claim (08/05) format. Medicaid encourages electronic billing. Mistakes can be corrected immediately, and your claim is processed without delays. Electronic claims may be submitted until noon on Friday for processing that week.

Providers who use the paper claim form should contact the Utah Health Information Network (UHIN) for standard instructions. Providers may call (801) 466-7705.

1 - 4 Definitions

Definitions of terms used in multiple Medicaid programs are in SECTION 1 of this manual, Chapter 13, Definitions. Definitions particular to the physician program are below.

Clinical Laboratory Improvement Amendments (CLIA)
The federal CMS program which limits reimbursement for laboratory services based on the equipment and capability of the physician or laboratory to provide an appropriate, competent level of laboratory service.

**Cognitive Services**
Non-invasive diagnostic, therapeutic, or preventive office visits, hospital visits, therapy, and related nonsurgical services.

**Direct Supervision**
The physician must be present and immediately available to render assistance and direction through the time persons under supervision are performing services.

**Family Planning**
Diagnosis, treatment, medications, supplies, devices, and related counseling in family planning methods to prevent or delay pregnancy.

**In-home Hospice Services**
Care given to a terminally ill individual who, with the family, has elected the hospice benefit that includes medical, palliative, psychosocial, spiritual, bereavement, and supportive care and treatment provided in the home.

**Package Surgical Procedure**
The preoperative office visit and preparation, the operation per se, local infiltration, topical or regional anesthesia when used, and the normal, uncomplicated follow up care extending up to six weeks post surgery.

**Personal Supervision - Physician Supervision**
The critical observation and guidance by a physician of medical services provided by non-physician provider’s within their licensed scope of practice, to assure that the health, safety and welfare of patients is not compromised.

**Physician Assistant**
An individual who meets the applicable education, training, experience, and other state requirements governing the qualifications for assistants to primary care physicians. (42 CFR 405.2401(b) and 42 CFR 491.2)

**Physician Services**
Services provided in the office, the home, a hospital, or elsewhere, by a) physician within the scope of practice of medicine or osteopathy; and b) by or under the personal supervision of an individual licensed to practice medicine or osteopathy.

**Primary Care**

a) Basic and general health care services given when a person seeks assistance to screen for or to prevent illness and disease, or for simple and common illnesses and injuries; and

b) Care given for the management of chronic diseases. (Utah Code Annotated, Title 26, Chapter 18, Part 3).

**Professional Component**
That part of laboratory or radiology service that may be provided only by a physician capable of analyzing a procedure or service and providing a written report.

**Services**

The types of medical assistance specified in Sections 1905(a)(l) through 25 of the Social Security Act and interpreted in the 42 Code of Regulations, Section 440.

**Technical Component**

That part of a laboratory or radiology service necessary to secure a specimen and prepare it for analysis, or to take an x-ray and prepare it for reading and interpretation.

**1-5 Co-payment Requirement**

Effective November 1, 2001, many adult Medicaid clients will be required to make a co-payment for physician services. Services include those performed in a Federally Qualified Health Center (FQHC). Both MCP and fee-for-service clients can have a co-pay. The client’s Medicaid Identification Card will state when a copayment is required and for what type of services. The provider is responsible to collect the co-payment at the time of service or bill the client. The amount of the client’s co-payment will automatically be deducted from the claim reimbursement. Requirements specific to physician services are stated below.

For general information about the co-payment requirement, clients required to make a co-pay, exempt clients, and an example of the co-payment message on the Medicaid Identification Card, refer to SECTION 1 of this manual, GENERAL INFORMATION, Chapter 6 - 8, Exceptions to Prohibition on Billing Patients, item 3, Medicaid Co-payments.

**A. Clients Exempt from Co-payments**

If there is not a co-payment message under a client’s name, the client does not have a co-payment. Also, do not require a co-payment for services to a pregnant woman, even if there is a co-pay message by her name on the Medicaid Identification Card. Add pregnancy diagnosis V22.2 to the claim. Encourage the woman to report her pregnancy to the Medicaid eligibility worker, who can change her co-pay status to exempt on future Medicaid cards.

**B. Services Exempt from Co-payments**

Clients are not required to make a co-payment for the following types of services:

1. Family planning services.
2. Emergency services in a hospital emergency department.
3. Lab and X-ray services, including both technical and professional components.
4. Anesthesia services.

**C. Co-payment per Medical Visit**

Except for exempt clients and exempt services described in items A and B above, Medicaid clients have a co-payment for physician visits, including a visit in a Federally Qualified Health Center (FQHC).
1 - 6 Prospective Payment System for Federally Qualified Health Centers

The Utah Department of Health, Division of Medicaid and Health Financing, will implement, effective January 1, 2001, the Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) as described at Section 1902(a) of the Social Security Act, as amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, (H.R. 5661 as incorporated into the Consolidated Appropriations Act, 2001), (PubLNo106-554). For complete information, refer to the special attachment to this manual titled Prospective Payment System for Federally Qualified Health Centers and Rural Health Clinics.

1 - 7 Physician Assistant Services: Limitations

1. Any service limited or excluded from service for physicians is also limited for the physician assistant.
2. The services of an assistant surgeon are specialty medical services to be covered only by a licensed physician and only on very complex surgical procedures. A physician assistant is not authorized to function as an assistant surgeon or as assistants at surgery.
3. Other exceptions could be indicated as necessary for supervised physician assistant participation in designated rural areas or in federally designated health professional shortage areas.
4. Physician assistants working in federally designated Rural Health Clinics or Federally Qualified Health Centers function under the federal regulations governing services in such facilities.
5. Physician assistants employed as staff working in locally operated hospitals or clinics are not authorized to have their services separately billed.

2 COVERED SERVICES

Physician services involve direct patient care and securing and supervising appropriate diagnostic ancillary tests or services, within the parameters of established Medicaid policy, to diagnose the existence, nature, or extent of illness, injury, or disability. In addition, physician services involve establishing a course of medically necessary treatment designed to prevent or minimize the adverse effects of human disease, pain, illness, injury, infirmity, deformity, or other impairments to a client’s physical or mental health.

Supervision by a Physician

1. Physician’s services must be personally rendered by a physician licensed under state law to practice medicine or osteopathy, or by an individual licensed to serve the health care needs of a practice population under a physician’s supervision.
   a. Physician Supervision means:

   The critical observation and guidance by a physician of medical services provided by non-physician providers within their licensed scope of practice, to assure that the health, safety and welfare of patients is not compromised.
The acceptable standard of supervision is availability by telephone when the physician maintains written protocols embodying care standards and supervisory procedures along with the Delegation of Services Agreement maintained at the practice site. Medical records must have sufficient documentation signed by the physician to reflect active participation of the physician in supervision and review of services provided by staff under supervision.

b. Direct Supervision means:

The physician must be present and immediately available to render assistance and direction through the time persons under supervision are performing services.

When licensure laws, policy, education protocols, coding definitions, or service being provided require “Direct Supervision”, the acceptable standard of supervision is availability in the facility, not necessarily within the same room, but within 10 minutes of reaching the person being supervised to provide assistance, consultation or direct care. Medical records must have sufficient documentation signed by the physician to reflect presence and participation of the physician in direct supervision.

2 Physical examinations are covered only in the following circumstances:

a. Preschool and school age children, including those who are EPSDT (CHEC) eligible, participating in the ongoing CHEC program of scheduled services and follow-up care.

b. New patients seeing a physician for the first time with an initial complaint where a physical examination, including a medical and social history, is necessary.

c. Medically necessary examinations associated with birth control medication, devices, and instructions for those of childbearing age, including sexually active minors. The office visit submitted with supportive documentation, indicating time required to provide contraceptive counseling, may be reimbursed with the initial implantation of the Implanon contraceptive device.

3. Medicaid covers after-hours add-on codes 99050 and 99058 when added to the basic evaluation and management office visit for a new patient (codes 99201-99205) and an established patient (codes 99212-99215). When the services are provided during regularly scheduled office hours in the evenings, weekends, or holidays, the provider may bill with the after-hours code 99051. “Evening” means after 6:00 PM and “Holiday” means any federal or state-recognized holiday. Only one of the after-hours office codes can be used per visit in addition to the E/M or service code.

Limitations on use of the after-hours office visit codes:

a. They cannot be used in a hospital setting, including the Emergency Department, by a private or staff physician under any circumstances;

b. They cannot be used for standby or waiting time for surgery, delivery, or other similar situations.
4. Surgical procedures are covered as “package” or global services. The package service and payment includes:

   a. All pre-operative and post-operative education and training related to the surgery. Associated education and training cannot be billed to either the Medicaid program or the Medicaid patient separately. Billing for these services is prohibited under Section 1, subsection 11-3(C) of the Medicaid physician provider manual.

   b. The preoperative examination, initiation of the hospital record, and development of a treatment program either in the physician’s office on the day before admission, or in the hospital or the physician’s office on the day of admission to the hospital;

   c. The operation per se;

   d. Any topical, local, or regional anesthesia; and

   e. The normal, uncomplicated follow-up care covering the period of hospitalization and office follow-up for progress checks or any service directly related to the surgical procedure for up to six weeks.

   f. Interpretation: A physician may not bill for an office visit the day prior to surgery, for preadmission or admission work up, or for subsequent hospital care while the patient is being prepared, hospitalized, or under care for a “package” service.

   g. Procedures identified as "add on" will be adjudicated according to the multiple surgery ranking.

5. Surgical services requiring prior authorization but provided under emergency circumstances as a life saving measure will be considered for coverage by an “after the fact review”. Sufficient documentation as outlined in Chapter 4 - 1, Retroactive Authorization, of this Section must be provided in order to make an appropriate review of the circumstances and determination of coverage. Additional information on the authorization process may be found in SECTION 1 of this manual, Chapter 9, Prior Authorization Process.

6. Consultation services are covered for a consulting physician only when consultation and no other service are provided. When a consulting physician admits and follows a patient, independently or concurrently with the primary physician, only admission codes and subsequent care codes may be used.

   a. Consultation services are considered physician services and reimbursed only to the physician. Under incident to service in Utah Medicaid, the nurse practitioner or physician assistant may complete the history and examination to assist the physician in working the patient up for a consultation. However, it is the expectation that the physician will complete a hands-on examination. The physician consultant must clearly document in the medical record that he or she completed the primary components of the examination related to the reason for the consultation request which impact determinations of the differential diagnoses, summarize conclusions, and formulate the treatment plan.
b. The physician and the nurse practitioner or physician assistant must personally document in the medical record his/her portion of the consultation. An initialed checklist and statement that the physician agrees with the nurse practitioner or physician assistant evaluation and management plans will not be sufficient as documentation for a consultation service.

c. For reimbursement of consultation service the medical record must include, 1) documentation of the written or verbal request for the consultation from an appropriate source and the need for the consultation; 2) the consultant’s opinion and documentation supporting a given E&M level per the 1995 or 1997 documentation guidelines; and 3) the written report to the requesting physician. This written report is a separate document and cannot replace documentation in the medical record. NOTE: In an audit, the provider must stipulate whether they are using the 1995 or 1997 E&M guideline.

7. Preoperative examination and planning are covered as separate services only in the following circumstances:

a. When the preoperative visit is the initial visit for the physician and the patient’s severity of condition require significant additional time for evaluation to establish a diagnosis and determine the need for a specific surgical procedure, beyond the amount of time normally expected within the global surgical procedure.

b. When the preoperative visit is a consultation and the consulting physician does not assume care of the patient; or

c. When diagnostic procedures, not part of the basic surgical procedure, are determined necessary during the immediate preoperative period.

8. Procedures which may be exempt from the "package definition" are identified in the CPT Manual as “separate procedures.”

a. Some of these procedures are relatively minor with variable pre and post-operative periods. Separate payment of the E/M visit may be made.

b. Complications, exacerbations, recurrence, or the presence of other diseases or injuries requiring service concurrent with the initial surgical procedure during the listed period of normal follow-up care, may warrant additional charges only when the record shows extensive documentation and justification for the complexity of the additional services.

9. When additional medically necessary surgical procedures, adjunct to the initial procedure, are carried out within the listed period of follow up care for the initial surgery, the follow up periods continue concurrently to their normal terminations.

10. The services of an assistant surgeon are specialty services to be provided only by a licensed physician and covered only on very complex surgical procedures. A listing of procedure codes which are not authorized are in the list titled Codes Not Authorized for Assistant Surgeon which is included with this manual.
If there are extenuating circumstances involved in a case, a physician may request a review of the case by the Medicaid physician consultant for consideration for payment of an assistant. In such cases, a copy of the history and physical exam, the operative report, the pathology report and the discharge summary must be submitted to the Prior Authorization Unit for review.

The AS modifier, indicating the assistant surgeon is a PA or NP is not covered under Medicaid. It has always been Utah Medicaid policy that the modifier 80–assistant surgeon is payable strictly to a qualified surgeon. Physician Assistants and Nurse Practitioners cannot be reimbursed as the assistant surgeon through the physician’s provider number as an incident to service.

11. Payment of E&M and Procedure Codes:
Coverage of an E&M code is adjusted when a procedure is completed during the office visit. Medicaid uses editing programs to determine coverage which is affected by the date payment is requested and complexity of the service.

12. Incidental edits occur when a procedure is considered an integral component of another procedure. Diagnostic procedures performed along with larger, major therapeutic procedures are considered incidental to the major procedure, and no additional payment is warranted. Examples are a diagnostic laparoscopy and an open surgical procedure, or a diagnostic arthroscopy and a surgical arthroscopy. The diagnostic procedure is incidental or included within the surgical procedure. Payment will not be made for both procedures on the same day or during the same operative session. Venipuncture and IV therapy codes normally completed during critical care service are included within the critical care time payment. The laryngoscopy procedure codes are included within the anesthesia time. Some codes which are considered minor procedures such as removal of cerumen, straight catheterization or other catheterization method strictly for the purpose of obtaining a urine specimen, and chemical cauterization of granulation tissue are included in the evaluation and management service as incidental to the service.

13. Separate procedures as identified in the CPT guidelines are commonly carried out as an integral part of a total service and, as such, do not warrant separate payment. Diagnostic examination performed prior to a therapeutic procedure is considered integral to the global service represented by the primary therapeutic procedure. Some of these separate procedures have the potential to be carried out independently of other services as a distinct or unrelated procedure. Modifier 59 or a subset of 59, i.e.-X{EPSU} should only be appended to the designated "separate procedure" to indicate that the procedure was completely unrelated to the other procedures provided or the procedure was clearly distinct and separate from the other procedures provided. (Refer to Limitations, # E, in this manual, for details regarding modifier 59 and subsets.)

14. A modifier provides a means by which a physician can indicate that a service or procedure has been altered by some specific circumstances, but not changed in definition or code. Modifier definitions and instructions for use are found in the CPT Manual. Some limitations may apply. Unusual services or those requiring excessive time or resources can be considered for coverage by use of the 22 modifier. A prepayment review of the medical
15. Add-on codes by definition must be submitted with the base code to follow correct coding. Prolonged service codes require documentation review of face to face physician evaluation and management service. Review of records is not covered under the prolonged service code. A time line must be submitted to support face to face evaluation and management services beyond those provided within the procedure code. This would include the history, physical, and counseling time. Documentation of the total E&M service time must be in the record along with the time spent specifically for coordination of care and counseling patient and/or family. The neonatal critical care service codes (99293-99296 and 99298-99299) are global codes for 24 hours of evaluation and management service; and therefore, ineligible for reimbursement of a prolonged service code. The base codes which allow the addition of the prolonged service code are listed in the CPT® - AMA manual. Prolonged service codes 99354-99357 remain open to indicate service for covered prolonged services.

Per the CPT® - AMA manual, the echocardiogram code 99307 includes services of add-on codes 99320 and 99325. Therefore, an incidental edit will post with the claim. The add-on codes 99320 and 99325 cannot be billed alone. They must be accompanied by one of the base codes listed in the CPT® - AMA manual, such as 99308.

16. Observation codes 99218-99220 and 99234-99236 are used for observation services to determine if patient condition warrants hospital admission.

17. Medically necessary services for complications of non-covered or non-authorized procedures which are done at the choice of provider or client will be considered for coverage only after normal recovery period for the procedures has passed. Coverage will be determined by medical review of the procedure, the circumstances, and the complications. Established criteria will be used in the review.

18. Coverage of drugs and biologicals is based on individual need and orders written by a physician when the drug is given in accordance with accepted standards of medical practice and within the protocol of accepted use for the drug. Coverage requirements are described in the Utah Medicaid Provider Manual for Pharmacy Services. A copy of the Pharmacy Manual may be obtained on the Medicaid website at: https://medicaid.utah.gov, or contact Medicaid Information.

   a. Medicaid covers most medications prescribed by qualified practitioners as a Medicaid benefit, in compliance with Federal law (42 CFR 440.120).

   b. Medicaid has additional requirements for drugs identified on the Drug Criteria and Limits List attached to this manual, including limits or requirements for prior authorization.

   c. Nonprescription, over-the-counter items are limited to those OTC drugs on the Over the Counter Drug List attached to this manual.

19. Brand name drugs require a prior approval (see chapter 4, section A) if an ‘AB’ rated generic alternative is available. The Utah Pharmacy Practice Act mandates use of a generic unless...
the treating physician demonstrates to the Department of Health a medical necessity for dispensing the non-generic, brand-name legend drug. Prior approval can be obtained by faxing a copy of the information from the patient’s medical record that documents that the patient has had an unacceptable adverse drug reaction to the generic version that does not occur with the name brand or has failed to achieve therapeutic efficacy with the generic version. [42 Code of Federal Regulations § 447.331(C) and § 447.331(C) (3)]. If the prescription does not meet coverage requirements, brand name reimbursement is not covered, and Medicaid will retract the entire payment. Telephone orders are not acceptable for brand name drugs unless the pharmacist has received the faxed documentation ruling out use of a generic. The pharmacist can then forward that FAX to the Medicaid prior approval unit. Pharmacists will still have to activate the DAW override loop to get full reimbursement on a brand name once a prior approval has been obtained. DAW is not available in the Non-Traditional Medicaid (NTM) program or the Primary Care Network (PCN) program.

Patient preference does not constitute a medical necessity.

If the brand name is not covered, and the client chooses the brand name drug, the client is responsible for the entire payment. For example, Valium® is not covered by Medicaid because the manufacturer does not participate in the rebate program. If the prescription is for Valium®, and the client chooses Valium over the generic product, the client must pay the entire cost.

20. Injectable medications approved in HCPCS are identified in the Injectable Medications List. The list is included with this manual. In order to comply with provisions of the Deficit Reduction Act of 2006, section 6002, billings for medications administered in the physician’s office must include the National Drug Code (NDC) from the container from which the medication is obtained, and the number of units administered, in addition to the J-Code normally used. Billings for all drugs administered in the physician’s office without the NDC information will be denied for payment beginning with the reporting deadline of January 1, 2007, specified in the DRA for single source drugs.

21. The injectable medication code, or J-Code (NDC), covers only the cost of an approved product.

22. An injection code which covers the cost of the syringe, needle and administration of the medication may be used with the injectable medication code, or J-Code (NDC), when medication administration is the only reason for an office call. Note: An office visit, J-Code (NDC), and an administration code cannot be used all for the same date of service. Only two of the three codes can be used at any one time or at any one visit.

23. IV Infusions and Injections, including Chemotherapy Administration

a) When a visit to the physician’s office is for administration of a medication or chemotherapy agent, only the J code (NDC) for the medication and the administration code (96400-96549) will be paid. An office visit will not be paid. The administration fee covers the skill, evaluation, and management required to administer the chemotherapy agent. However, when there are significant separately identifiable services, those services must be reported using modifier 25. Reporting the evaluation
and management service with modifier 25, requires review of supportive
documentation for significant separately identifiable service beyond the E&M services
expected with chemotherapy administration.

b) When administering multiple infusions, injections, or combinations, only one initial
service code should be reported, unless protocol requires that two separate IV sites
must be used. If an injection or infusion is of a subsequent or concurrent nature, even
if it is the first such service within a group of services, then a subsequent or concurrent
code from the appropriate section should be reported.

c) Hydration therapy requires a diagnosis and medical record documentation supporting
the therapy for electrolyte imbalance and/or dehydration for reimbursement coverage.

d) IV line flush between drugs is considered part of the drug administration service and
not reimbursed separately.

e) One payment for a heparin flush is covered at the conclusion of the infusion.

f) Most of the January 2006 CPT Manual hydration, therapeutic, prophylactic and
diagnostic injections and infusion codes will be open for at least a one-year study
period. Coverage and reimbursement of these codes will be determined after
completion of the analysis of use patterns.

24. Methylphenidates, amphetamines, and other central nervous system stimulants require prior
authorization for adults 19 and older and may be provided to both children and adults under
very strict protocols. Refer to the Drug Criteria and Limits List attached.

25. Nutrients are covered only for patients with a missing or damaged digestive organ that
requires total nutrition.

26. Surgical supply reimbursement is included in "package" surgical procedures in an office.
Separate payment will not be made. Procedure code 99070 will not be covered for the
purpose of obtaining "incidental supplies" for procedures provided in the office. This code is
incidental to the office visit and/or service, and additional payment will not be made.

27. In the occasional, unusual circumstance that additional supplies may be warranted by the
nature of the surgical procedure performed, a surgical tray can be billed using code A4550.

28. Supplies and Equipment from a Medical Supplier

Procedure code 99070 is intended to cover one incidental item per day. Payment for this
code is very minimal. It is intended to be used for incidental supplies not covered under an
otherwise covered procedure completed during an office visit. This code is not intended to be
a miscellaneous code for billing medical supplies or equipment available from a medical
supplier.

a. The Utah Medicaid Program covers medical supplies and equipment under four
conditions: (1) The supplies and equipment are medically necessary; (2) they are ordered by a
physician; (3) they meet the standards stated in policy and the Medical Supplies List, and
they are within the limits specified; and (4) they are on the Medical Supplies List included
with this manual. Coverage requirements are described in the Utah Medicaid Provider Manual for Medical Supplies. A copy of this manual may be obtained by contacting Medicaid Information.

(1) Medical necessity does not include use primarily for hygiene, education, exercise, convenience, cosmetic purposes, or comfort. The physician’s order must list each item required, a medical necessity, and be signed and dated by the physician or other licensed medical practitioner. An item simply marked on a preprinted multiple item order sheet is not acceptable.

b. The Child Health Evaluation and Care (CHEC) Program may approve medical supplies and medical equipment which are medically necessary for children less than 21 years of age. For specific information, please refer to the Utah Medicaid Provider Manual for Child Health Evaluation and Care (CHEC) Program Services. A copy of this manual is available on the Medicaid website at: https://medicaid.utah.gov, or contact Medicaid Information.

29. Medicaid restricts hemophilia blood factors to a single provider. The purpose is to provide a uniform hemophilia case management support program to the patient and patient’s physician and to achieve economies in the purchase of blood factor through a sole source contract. Medicaid will reimburse only the sole source provider for hemophilia case management, blood factors VII, VIII and IX. No other provider will be paid for blood factors VII, VIII or IX supplied. Medicaid clients who choose not to participate in the Medicaid Hemophilia program must make their own arrangements for procurement and payment of the blood factor.

The contract affects only the procurement and management of the prescribed blood factor. The patient’s physician continues to be responsible to develop a plan of care and to prescribe the blood factor. The contract with the sole source provider specifies the provider must work closely with the patient’s Primary Care Provider physician or managed care plan.

Managed care plans which contract with Medicaid continue to be responsible for hemophilia-related services such as physical therapy, lab work, unrelated nursing care, and physician services.

As of October 2000, the sole source provider is University Hospital Home Infusion Services. Please direct questions concerning hemophilia case management and blood factors VII, VIII and IX to this provider: (801) 466-7016.

30. Telemedicine or telehealth services are an additional method of delivering health care to patients. Refer to Section I: General Information, at the Utah Medicaid website at: https://medicaid.utah.gov.

31. Diabetes Self-Management Training

Effective October 1, 1999, code S9455, Diabetes Self-Management Training, is available for use by authorized diabetes self-management programs.

Requirements
Diabetic self-management training services:

- Must be provided through a:
  - Nationally recognized American Diabetes Association (ADA) certified diabetes educator [refer to http://www.diabetes.org]
  - American Association of Diabetes Educators (AADE) [refer to http://www.diabeteseducator.org]
- Require prior authorization.
- Are limited to an initial 10 sessions per year.

Note: Self-management training for the sole use of glucose monitoring or nutritional counseling is not covered through this program.

For complete criteria for this service, refer to https://medicaid.utah.gov, criteria.

To enroll as a Medicaid-authorized diabetes self-management program, contact Medicaid Provider Enrollment at https://medicaid.utah.gov.

32. Nutritional Counseling

Nutritional counseling and an evaluation and management are not covered for the same provider on the same date of service. Medicaid does not pay two evaluation and management codes on the same date of service. The evaluation and management service may be billed with a prolonged service code to include the time for nutritional counseling with supportive documentation.

- Coverage of nutritional counseling for malnutrition or obesity is covered under code S9470 for pregnant adults (14 visits) and EPSDT eligible (unlimited).
- Benefits for coverage of initial and subsequent individual nutritional counseling CPT codes are limited to one hour each for pregnancy.
- Adults who are not pregnant may receive one hour of initial and one subsequent hour of nutritional counseling for a BMI > 30 with supportive documentation.
- EPSDT eligible clients with malnutrition or a BMI > 27 are covered with supportive documentation of medical necessity and progress. See web tool criteria.

33. Maternity Care

Maternity Care is a global service billed with an appropriate code at the conclusion of pregnancy. Maternity care is generally routine and uncomplicated, but can be associated with risk factors which must be managed. Treatment of complaints that accompany most pregnancies including, but not limited to, nausea, vomiting, backache, headache, lumbago, cystitis, urinary tract infection, malaise, mild anemia, etc., must be included as part of the routine care and not billed as separate service.

Global pregnancy is not to be unbundled. Some group practices have expressed an opinion that they should be able to unbundle the global pregnancy fee so that each physician in the group practice receives payment for a visit during the pregnancy. This is incorrect billing which may be
subject to post payment review. As described in the manual, additional evaluation and management codes are not paid when the patient sees another physician in the group practice or the emergency room for the same or similar issues on the same date of service. The physician or group practice is to bill the evaluation and management code for the level of service provided on the date of service. When the same physician or group practice sees the patient throughout the pregnancy, the global delivery code is to be billed. If payment has been made through Baby your Baby, fee-for-service, or another managed care organization for antepartum care, the payments are to be returned when the global delivery fee is paid by the managed care group at the time of delivery. 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.

A. Antepartum Care

The initial office visit to a physician is not a separate billable service. It must be included as part of the global maternity service. Special laboratory work at the time of the initial visit is an exception, but must be billed by the laboratory completing the tests and not by the physician.

Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressure, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery.

B. Labor and Delivery

Services include admission to the hospital, history and physical, management of labor, and the delivery -- vaginal, with or without forceps, or cesarean section delivery.

1. False labor

False labor may occur after 37 completed weeks of gestation. At this point in a pregnancy, changes begin to occur, and contraction-like activity may be present. It is often difficult to identify true labor, especially for a first time mother. If the threatened labor is of such a nature that a hospital admission is determined necessary by the physician, but does not progress to delivery through the current admission, a payment separate from the global maternity fee can be made for the service. The hospital should identify the admission with ICD.9.CM code 644.13 and appropriately selected Evaluation and Management codes. Repeated admissions through the final three weeks of pregnancy will be reviewed through the post payment review process.

2. Woman with an Emergency Services Only Card

Only labor and delivery codes are billable for a woman with an Emergency Services Only card. Other maternity care services (prenatal and postpartum) are not payable as an emergency. Physicians may be reimbursed for the following procedure codes under the Emergency Services Only Program:

- High risk vaginal delivery code 59409–22,
- High risk cesarean delivery code 59514–22
All other deliveries described by the following CPT procedure codes: 59409, 59514, 59612, 59620

For more information on the Emergency Services Program, refer to SECTION 1 of this manual, Chapter 13 - 6, Emergency Services Program For Non-Citizens.

C. **Postpartum Care**

Includes hospital and office visit follow up for up to six weeks following the delivery.

D. **Complications**

Complications during the antepartum, labor or delivery period may be significant enough to compromise the pregnancy, the mother or the fetus. To warrant consideration for additional payment such complications should be of major significance, separately identifiable by an ICD.9.CM diagnosis code, require separate and distinct therapy from the usual services of pregnancy, and be clearly identified in the record. Some examples are hyperemesis gravidarum with metabolic disturbance; diabetes mellitus, uncontrolled; eclampsia; severe anemia with systemic implications; pre-term labor; or drug dependence.

E. **High Risk Pregnancy**

When complications or risk factors pose a risk to the pregnancy, the circumstances should be carefully documented, and a risk assessment form submitted for billing to assure payment for services. Billing for the risk assessment must be received before a high risk delivery can be billed.

Two risk assessments can be completed and billed during a 10-month period. One assessment should occur at intake and another at 36-38 weeks gestation or earlier if problems arise. (The full risk assessment policy is in the Utah Medicaid Provider Manual for Enhanced Services to Pregnant Women.)

1. **Codes**

In addition to the codes for Maternity Care found in the CPT Manual, the following codes are also available for use:

Code H1000 Low risk assessment (limited to two)
Code H1001 High Risk Assessment (limited to two)

Modifier 22 Beginning July 1, 2009, all obstetrical and delivery procedure codes submitted with modifier 22 will require submission of documentation (e.g., operative report) for review prior to payment. Clarification as to what services are considered part of the procedure and which services may be considered for enhanced payment with the 22 modifier is provided through the American College of Obstetricians and Gynecologists (ACOG). The following is a summary of the information:

The 22 modifier is appropriately applied to the obstetrical delivery when there are multiple gestations or complications during the delivery which place the mother or fetus at risk of adverse outcome. When applying the 22 modifier, it is important to document the additional or unusual services provided. Just listing a diagnosis is not enough. According to ACOG,
the following are examples of services which are included in the global delivery package which should not be reported separately:

- first and second degree lacerations
- induction of labor (indicated induction)
- rupture of membranes (premature, spontaneous, or part of induction AROM)
- admission to the hospital for delivery
- labor management
- fetal monitoring
- postpartum orders
- ferning test
- elevated maternal temperature
- laceration, not repaired
- post-term pregnancy
- shoulder dystocia or “difficult delivery” without any documentation
- IV oxytocin
- Cytotec (Misoprostol)

The following are examples of occurrences which should be reported with a 22 modifier and the appropriate supportive documentation:

- third and fourth degree lacerations
- shoulder dystocia
- maneuvers used in difficult delivery
- lacerations (with documentation of repair and time spent)

2. **Other Services**

Other medical problems treated by the obstetrical provider for a pregnant woman which are not related to the pregnancy, may be covered by using the appropriate ICD.9.CM diagnosis code and an evaluation and management office visit procedure code.

Fetal Non-stress Test (code 59025) will be covered only for clinically documented high-risk pregnancy. Use of this test is considered appropriate for, but not limited to, patients who have hypertension, diabetes, other systemic diseases, a history of previous stillbirth, or when there is a decrease or absence of fetal movement.

Indications, repetition, frequency and utilization of the fetal non-stress test will be evaluated through documentation in the record of any pregnancy case being reviewed.

3. **Incomplete Obstetrical Care**

When a physician provides all or part of the antepartum care, but does not complete the delivery due to termination of pregnancy or referral to another physician, one of the antepartum codes (only one) in the CPT Manual which covers the number of antepartum visits provided can be billed.

4. **Services for pregnant women not eligible for Medicaid**
Women who do not meet regular United States residency requirements (undocumented) are eligible only for the Emergency Services Only Program. Labor and delivery are considered emergency services. Only labor and delivery will be covered. Prenatal care cannot be reimbursed with Medicaid funds.

“Emergency Services Only ” is printed on the Medicaid Identification Card. Information about the program can be found in SECTION 1 of this manual, Chapter 13 - 6 Emergency Services Program For Non-Citizens. An example of this card is included with the attachments to this manual.

F. Coding for Maternity Care

The Physician’s Current Procedural Terminology Manual (CPT) and the Medicaid Physician Provider Manual have significant information on appropriate coding for maternity services. The following is additional information on appropriate coding.

1. Global fee. The services provided in uncomplicated maternity care should be covered by a global fee as the standard. The global fee should not be broken up and billed with separate components unless the appropriate circumstances warrant it. When a physician does not provide complete prenatal service, care should be taken to assure proper selection of codes to appropriately bill for the services provided.

2. Change of Provider.

Patients do change care providers whether by referral or by choice.

(a) Less than three visits to one provider at the beginning of a pregnancy should be billed by the initial provider using regular E/M codes.

(b) When a patient goes to a second provider, voluntarily or by referral, the second physician should carefully consider whether or not it is a true referral. There should be clear documentation from the referring physician, verifying referral and his plans to bill the E/M codes or one of the prenatal codes (59425 or 59426).

(c) The accepting provider should select appropriate billing codes based on the number of visits, the delivery and postpartum care. Seven or more visits, the delivery and postpartum care should be billed as the global service. (Billing by using code 59426, a vaginal or C-section delivery code and separate postpartum code (59430) by the same physician should never be submitted.)

(d) Billing of codes 59425 and 59426, for the same patient during the same pregnancy should never be submitted.

(e) Billing of code 59425, plus a vaginal or C-section delivery code with postpartum care would be unusual, but could be a possibility if only 4 to 6 prenatal visits are provided.

(f) Postpartum care only code 59430 is a separate procedure code and should be used only when no other prenatal or delivery service is provided by a physician.
(g) One of the prenatal care codes (59425 or 59426) could be used in conjunction with the postpartum care code (59430) providing the physician billing these codes did not provide the delivery.

(h) A delivery only code (59409 or 59514) could be used by a physician who only completes the delivery and no other service. (Probably on an emergency basis.)

3. Group Practice Maternity care involving group practice or physicians taking call and covering for each other, presents some unique issues. The practice relationships and office organization dictates how billing will be handled.

(a) One physician covering for another completes the delivery.

(1) In certain circumstances, multiple physicians may bill for unbundled services that, if done by one physician, would be paid under the global delivery code. For instance, one physician could bill for the delivery, while another physician bills for the prenatal and postpartum care visits. In compliance with stated policy, the sum of the unbundled services paid to the two physicians may not exceed reimbursement for the global delivery.

(2) In a group practice the OB services should not be unbundled.

(b) Can a physician bill a global fee and pay a second physician for the part of the service he provided?

No. This conflicts with SECTION 1 of this manual, Chapter 6 - 6, Billing Medicaid, which states:

“The provider may bill Medicaid only for services which were medically indicated and necessary for the patient and either personally rendered or rendered incident to his professional service by an employee under immediate personal supervision . . . .”

Physicians are not usually employed by each other, nor do they supervise each other. If each physician is to be paid individually and not under a group practice arrangement, each should complete the individual billing and receive payment accordingly.

G. Coding for Newborn Screening

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

Critical Congenital Heart Disease (CCHD) screening for all newborns is covered. Additional payment is included to the delivery DRG for urban facilities. Rural hospitals are reimbursed at 89% of charges and must bill CPT code 94761.

H. Ultrasound in Pregnancy
Ultrasound in obstetrics is a valuable tool for the evaluation of mother and fetus. Review of use indicates that the procedure has been performed multiple times routinely without indications of medical necessity. According to the ACOG Committee on Obstetrics, ultrasound should only be performed when there is diagnostic information to be obtained. The National Institutes of Health consensus conference recommends ultrasound in pregnancy be used for a specific medical condition and not for routine screening. If an abnormality is found during the office scan, the member should be referred to a perinatologist or perinatal center for a definitive diagnosis.

Ultrasound coverage includes:

1. All obstetrical ultrasounds must be completed through a perinatologist and/or a trained ultrasound certified physician, nurse practitioner, or doctor of osteopathy. The ultrasound must be read and interpreted by the physician or osteopath.
2. One routine office ultrasound for all pregnant women at about 18 weeks of gestation. When the member experiences complications at less than 14 weeks gestation, one ultrasound is allowed in addition to the one at 18-20 weeks. The screening ultrasound should be submitted with the addition of the diagnosis code V22.0, V22.1, or V23.3.
3. Indications for ultrasound in the first trimester include ectopic pregnancy, spontaneous abortion (threatened, incomplete, missed), molar pregnancy, first trimester bleeding, and intrauterine device.
4. Members with an incompetent cervix must be referred to a perinatal center for a transvaginal ultrasound. Abdominal ultrasound cannot diagnose an incompetent cervix and are non-covered.
5. Ultrasounds completed in the office are limited to normal scans. If a repeat scan is medically necessary, the patient should be referred to a perinatal center for the ultrasound.
6. When a limited ultrasound, code 76815, and follow-up or repeat ultrasound, code 76816 are billed on the same date, the repeat ultrasound will be denied. Documentation supporting medical necessity will be reviewed on appeal.
7. Ultrasounds completed for the purpose of obtaining a picture of the fetus or sex determination are not covered.

I. Fetal Biophysical Profile
   1. Required documentation for manual review by procedure
      A. Fetal biophysical profile with nonstress test
         1) Fetal nonstress test.
         2) Fetal breathing movements (one or more episodes of rhythmic fetal breathing movements of 30 seconds or more within 30 minutes).
         3) Fetal movement (three or more discrete body or limb movements within 30 minutes).
         4) Fetal tone (one or more episodes of fetal extremity extension with return to flexion).
         5) 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
         1) Fetal breathing movements (one or more episodes of rhythmic fetal breathing movements of 30 seconds or more within 30 minutes).
2) Fetal movement (three or more discrete body or limb movements within 30 minutes).
3) Fetal tone (one or more episodes of fetal extremity extension with return to flexion).
4) Quantification of amniotic fluid volume (a pocket of amniotic fluid that measures at least one cm in two planes perpendicular to each other).

C. For reimbursement coverage, documentation of the biophysical fetal profile with scoring is required. The non-stress test and amniotic fluid index alone will not be accepted for payment of code 76818.

2. Must be completed for one of the following documented indications:
   (a) Multiple gestation
   (b) IUGR (intrauterine growth restriction)
   (c) Maternal disease:
       - Diabetes mellitus
       - Connective tissue disease
       - Isoimmunization
       - Renal disease
       - Hypertension
       - Preeclampsia or eclampsia
       - Maternal exposure to infectious agent such as:
         - Parvo virus
         - Cytomegalovirus
         - Rubella
         - Toxoplasmosis
         - HIV
         - Oligohydramnios
         - Polyhydramnios
         - Malpresentation of fetus
         - Known fetal anomaly
         - Known partial/complete placenta previa
         - Gestation > 41 weeks
         - Alpha-fetoprotein (AFP) abnormal
         - Fetal nonstress test nonreactive or abnormal
         - Suspected fetal demise
         - Decreased fetal movement
         - Injury or accident

34. Neonatal and Pediatric Critical Care Services

   Neonatal and newborn codes 99436, 99293 - 99300 were replaced with codes 99464, 99468 - 99480. Note that the coverage for the codes remains the same.

   These Neonatal and Pediatric Critical Care Codes are bundled (global) codes to be:
• Used only to bill for care required by neonates/infants between birth and 24 months of age who require critical care or intensive care services.

• Billed only once for each 24-hour period.

• Inclusive of a broad range of services rendered by all physicians involved in the health care team which provides continuous management and care for the infant/child during the 24-hour period.

Provision of services and coding is selectively limited to Board Certified Neonatologists, Board Certified Pediatric Intensivists, High Risk Pediatricians, or Board Certified Pediatricians depending on the level of care required.

**Definitions**

Critical Care is the direct delivery by a physician(s) of medical care for a critically ill or critically injured patient. Critical Care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient’s condition.

Board Certified Neonatologist is a pediatric sub-specialty achieved beyond the primary care pediatric certification, completion of an additional three year fellowship program in neonatology, and successful completion of the certification examination from the sub-board of Neonatal/Perinatal Medicine of the American Board of Pediatrics.

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.

Pediatric Intensivist (PICU) is Board Certified in Pediatrics by the American Board of Pediatrics, followed by a three year fellowship in Pediatric Critical Care and certified in Pediatric Critical Care Medicine at an institution accredited by the Residency Review Commission of the American Association of Medical Colleges. And must provide a certificate showing certification from the Sub-board of Pediatric Critical Care Medicine of the American Board of Pediatrics. The PICU Intensivist specializes in the care of the infant 31 days to 24 months of age. (This provider type may not be available in all locations, if not; only the Board Certified Neonatologist can provide the care as designated.)

Board Certified Pediatrician is a specialist in pediatrics with current licensure in the state as a MD, has successfully completed the certification examination from the American Board of Pediatrics and is actively participating in a pediatric practice.

High Risk Pediatrician is a board certified pediatrician who has completed at least 3 months of NICU experience during pediatric residency, has current certification in Neonatal Resuscitation Program (NRP), completes ten hours of continuing medical education each year focused on neonatal medicine, and maintains neonatal medicine practice skills by providing NICU care for at least 30 patient days per year or participation for at least 30 days with a NICU team.

**Program Coverage**

**Neonatal Critical Care Codes: 99468 - 99469**
These CPT codes, for initial neonatal critical care and subsequent neonatal critical care, apply only during the first 28 days of life. Only neonatologists and pediatric intensivists who are board certified are authorized by Medicaid to bill under these codes.

*Note: A temporary exception to neonatology board certification may be approved up to three 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 in writing to the Bureau of Medicaid Operations, Provider Enrollment Unit, by the physician requesting the exception and from the hospital department director or senior member of the practice requesting an exception, and by the hospital department director or senior member of the practice requesting an 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.

**Pediatric Critical Care Codes: 99471 - 99472**

These CPT codes for initial pediatric critical care and subsequent pediatric critical care address critically ill infants or young children who are at least 29 days of age, but not older than 24 months of age. The infant no longer meets the neonate definition but requires continuing intensive care/critical care management. Both codes are bundled (global), 24-hour codes.

Code 99471 applies on the day of admission for infants age 29 days to 2 years who are admitted directly into the intensive care unit (NICU or PICU) from outside the hospital because of their need for pediatric critical care (including the same elements defined under the neonatal critical care codes 99468 and 99469).

Code 99472 applies to either of the following two groups of patients:

- Infants admitted as neonates under 99468 and require continued critical care are billed under code 99469 through 28 days of age.
- Subsequent critical care provided to infants admitted under 99471 or those remaining in intensive care past day 28.

Only neonatologists and pediatric intensivists who are board certified are authorized by Medicaid to bill under these codes.

**Intensive (Non-Critical) Low Birth Weight Services: 99478 through 99480**

This is a new category of service established for the physician directing the continuing intensive care of the very low birth weight Program Coverage (VLBW) or low birth weight (LBW) infant who no longer meets the definition of critically ill, but continues to require intensive observation
and frequent services and interventions only available in an intensive care setting. Both codes are bundled (global), 24-hour codes.

Code 99478, which was previously included under neonatal critical care codes, but has now been shifted to the new Intensive (Non-Critical) Care category. This code includes recovering very low birth weight (present body weight less than 1500 grams) infants requiring evaluation and management and continued monitoring and observation by the health care team under direct physician supervision. Only neonatologists, pediatric intensivists, and High Risk Pediatricians, board certified in their specialty, are authorized by Medicaid to bill under these codes.

Code 99479 is a new code for subsequent intensive care and management of recovering low birth weight (present body weight of 1500-2500 grams) infants, who require evaluation and management and continued monitoring and observation by the health care team under direct physician supervision. Neonatologists, Pediatric Intensivists, High Risk Pediatricians, and Pediatricians who are board certified in their specialty are authorized by Medicaid to bill under this code.

Code 99480 for subsequent intensive care and management of recovering low birth weight (present body weight of 2501-5000 grams) who are not critically ill but continue to require intensive cardiac and respiratory monitoring, continuous and/or frequent vital sign monitoring, heat maintenance, enteral and/or parenteral nutritional adjustments, laboratory and oxygen monitoring and constant observation by the health care team under direct physician supervision. Neonatologists, pediatric intensivists, high risk pediatricians, and pediatricians who are board certified in their specialty are authorized by Medicaid to bill under this code.

**Recovering Neonates** – Service to infants whose body weight exceeds 2500 grams, are not critically ill, but still in a guarded condition and in need of continuing critical care can continue to be served under codes 99478, 99479, and 99480 as long as the medical record reflects the need and the intensive care provided. Service in this category with use of code 99478 can be provided by board certified neonatologists, board certified pediatric intensivists or high risk pediatricians. Codes 99479 and 99480 can be utilized by all of the above physicians and the board certified pediatrician.

**Newborn Transitional Care** - The code 99477 is billed for the INITIAL DAY only for admission of a neonate who requires intensive observation, but NOT intensive therapy. The additional services required for intensive therapy are outlined in the CPT Introductory text for Inpatient Neonatal and Pediatric Critical Care and Intensive Services (CPT 2008, Prof Ed, p.20), “To report initial services [99477] ...” and then, “When a neonate or infant is not critically ill, but requires intensive observation, frequent interventions and other intensive care services, the Continuing Intensive Care Services codes (99478, 99479, 99480) should be used ... 5000 grams or less. When the present body weight... exceeds 5000 grams, the Subsequent Hospital Care Services Codes (99231-99233) should be used.”

The American Academy of Pediatrics Committee on Coding and Nomenclature indicates that the code 99477 fills a gap between the usual E/M codes for initial pediatric ward admission and full-fledged intensive care (i.e. 99468-99469) for which aggressive interventional support is required. The patient’s newly born status imparts an inherent instability when sick due to the presence of incompletely developed organs at birth that demonstrate dysfunction and require careful evaluation, continual monitoring, and frequent adjustments of therapy during even mild degrees of illness. Typically, these requirements lead to the management of such newborns in neonatal intensive care.
or special care nurseries where nursing expertise and monitoring equipment appropriate to meet their needs are available 24 hours a day. The code is not physician specialty-specific; therefore, family practitioners and pediatricians may also report this service with the adequate clinical documentation of the intensive observation required.

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

Report code 99460 for inpatient care of the normal newborn.

Report code 99468 for the care of the critically ill neonate.

Report code 99221-99223 for inpatient hospital care of the neonate not requiring intensive observation, frequent interventions, and other intensive care services.

The following is an example of the services rendered under code 99477: A 2250-g infant is born at 36 to 37 weeks of gestation by the vaginal route to a mother with unknown Group B Streptococcal disease status. At six hours of life, the baby develops the sudden appearance of tachypnea, grunting, thermal instability, mold tachycardia, and cyanosis responsive to supplemental oxygen. The physician is summoned to the nursery, examines the patient, and admits the infant to the neonatal intensive care unit. The physician undertakes a complete physical examination of the infant. After completion of the examination, a blood culture, complete blood count, chest X ray, and blood glucose are ordered. A spinal tap is obtained, an umbilical venous catheter is placed, and a flat plate of the abdomen is ordered to check the catheter position. The baby is placed on nasal cannula oxygen and a blood gas is obtained through a radial arterial sample. The physician speaks with the parents, the obstetrician, and the pediatrician.

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

Notes:

a. Care codes in any of the categories of service may not be assigned based only on a diagnosis, birth weight, or a level of nursing care, but rather on the type of monitoring, available technology, and experience of available physician and supporting staff as it relates to the complexity of medical decision making.

b. Under Medicaid, physicians who do not qualify as board certified neonatologists, pediatric intensivists, or high risk pediatricians, and admit a child in need of critical care for stabilization and/or transport to another facility, may use the regular critical care codes 99291-99292 regardless of patient age. Medicaid does not limit the use of the codes 99291 and 99292 to patients over 24 months as stated in the CPT manual.
particularly when the physician service is related to those services for stabilization and transport.

**Pediatric Codes 99475 - 99476** – These codes for the initial or subsequent pediatric evaluation and management of a critically ill child two through five years of age may be used by the pediatrician or family practice physician. There are 24 hour care codes to be used by the physician with the primary responsibility for care coordination of the child. Physicians providing short term critical care services to stabilize and transport the patient should use critical care service codes 99291-99292 for those services. Report code 99221-99223 for inpatient hospital care of the small child not requiring intensive observation, frequent interventions, and other intensive care services.

35. Pain Management Services

A. Provider pain medication management

1. Pain during delivery and acute postoperative pain is covered. For information regarding coverage of anesthesia and postoperative pain management services, refer to SECTION 3, Anesthesia.

2. Chronic pain is defined as pain continuing beyond six months. Chronic pain treatment is a medical benefit. The following outlines policy related to treatment of chronic pain:

   (a) Any willing Medicaid provider or pain management specialist may provide pain management services. The provider must use the appropriate ICD-9-CM, CPT, or HCPCS codes. Reimbursement will be according to the Utah Medicaid fee schedule. For covered medications, refer to the Utah Medicaid Pharmacy Provider Manual.

   (b) Treatment is available for all ages.

   (c) Chronic pain referrals do not require prior authorization.

   (d) Providers who wish to use the Utah Medicaid Chronic Pain Referral Form can download it from: [https://medicaid.utah.gov](https://medicaid.utah.gov). Do not send the form to Utah Medicaid. Send the form to the provider.

   (e) Medicaid will reimburse an approved psychiatrist or clinical psychologist (PhD) for a comprehensive psychiatric evaluation as a medical benefit when referred directly by a pain specialist or primary care provider (PCP) treating a patient with chronic pain. The psychiatrist or psychologist will schedule or contact the patient for an appointment.

      1. Services from an approved psychiatrist is reimbursed using code 99245 - HE.

      2. In areas where a psychiatrist is not available, an approved clinical psychologist (PhD) can provide treatment and is reimbursed for the psychiatric evaluation using code S5190 - HE.
3. Procedure code 96116 (neurobehavioral status exam) cannot be billed separately. It is considered part of the psychiatric evaluation.

4. To be reimbursed correctly, a psychiatrist/clinical psychologist must be identified (approved) in the MMIS system. A psychiatrist or clinical psychologist may call (801) 538-6149 to ask for information to become an approved provider.

(f) Recipients who are provided a pain consultation are not automatically enrolled in the Restriction Program.

3. Hospitalization for pain management is not a covered benefit. Intrathecal administration of morphine by pump is not a benefit.

B. Trigger Point Injections

a) Trigger points are self-sustaining hyperactive foci in skeletal muscle in response to strain from acute or chronic overload which produce a referred pain typical of the particular muscle group. Injection is achieved with needle insertion and the administration of a local anesthetic such as Lidocaine. Trigger points must be identifiable on palpation and the symptoms must have persisted for at least three months. Trigger injections may be indicated when noninvasive conservative medical management is unsuccessful or when the joint movement is mechanically blocked (i.e. coccygeus muscle – pelvis). The medical record must describe the assessment and evaluation which led to a diagnosis related to the need for a trigger point injection.

b) Conservative therapy including analgesics, physical therapy exercises, range of motion exercises, bed rest, heating or cooling modalities, massage, and pharmacotherapies such as muscle relaxants, non-steroidal anti-inflammatory agents and non-narcotic analgesics often resolves the myofascial pain syndrome. Conservative medical treatments must have been tried and failed with outcome specified in the documentation.

c) Acupuncture remains strictly a non-covered service even for trigger points.

d) Documentation of trigger point follow-up care, such as cold packs, massage, and muscle stretching exercises, should indicate a minimum of at least three days of therapy. The patient should be taught massage, appropriate use of heat or cold therapy, and muscle stretching exercises to continue long term, so that the myofascial pain syndrome does not return.

e) Payment for trigger point injections
   1. Limited to code 20552 and limited to one per day regardless of the number of injections with no more than three injections provided on a single date.
   2. Trigger point injections must be at least two weeks apart.
   3. Coverage for trigger point injections is limited to six billed charges per year.
   4. The recommended frequency of trigger point injections is > 2 months between injections when 50% of pain relief is obtained for 6 weeks.
   5. Nerve block injection codes 64400-64530 and code 20610 are not payable on the same day as trigger point injections.
6. Coverage will not be recognized for an unspecified or generalized diagnosis such as low back pain or myalgia.

C. Epidural and Block Injections

There are three types of injections: facet joint, epidural and sacroiliac. Steroids are given to reduce inflammation as treatment for chronic radiculopathy caused by nerve root irritation or pressure (i.e. spinal stenosis) when conservative medical treatments have failed. Anesthetic or narcotic injections are injected into the epidural space to achieve a sympathetic block for the diagnosis and treatment of reflex sympathetic dystrophy and para vertebral blocks are used when the patient has localized pain that is aggravated by motion of the spine without a strong radicular component or associated neurologic deficit. Coverage must meet the following:

- Medical record documentation must support the medical necessity of the procedure and the conservative measures that have been tried and failed. The documentation must include documentation of the symptoms supporting the complaint of pain and the efficacy of the nerve block or epidural for treating the pain described including the anatomical relationship of the injection to the pain treatment.
- Medical record documentation must indicate that the patient has tried and failed to improve after at least six weeks of conservative measures such as rest, systemic analgesics and/or PT. Non-drug therapies should be considered, including electrical stimulation, counter irritation, trigger point injection, spray and stretch, massage, and physical therapy. Cognitive techniques of pain control (i.e., relaxation training, distraction techniques, hypnosis, biofeedback) may be useful.
- Epidural injection or nerve blocks will not be considered until the patient has been evaluated for a pathological cause of pain such as a tumor or cancer.
- Epidural and nerve blocks injections are not intended for long-term or ongoing pain management.
- Coverage of fluoroscopic guidance will follow correct coding.
- Trigger point injections and blocks are not covered on the same date of service.
- Only one of the following injection types will be covered on a date of service.

1. Facet joint injections are covered when facet joint pain is suspected in patients with neck and/or back joint and aggravated by rotation or hyper extension of the spine.
   A. Facet joint injections are appropriate for the management of chronic back pain when pain has lasted more than three months despite appropriate conservative medical therapy. The injections must be used in conjunction with other noninvasive treatment methods, not as a standard therapy alone. (AHCPR position paper)
   B. A diagnostic or therapeutic facet joint nerve block (64490-64495) must have demonstrated that the patient received significant temporary or prolonged abolition of the pain. CPT codes 64491, 64492, 64494, and 64495 are intended to report each additional paravertebral facet joint level and not each additional nerve.
   C. When effectiveness has been demonstrated, injections will be covered up to a maximum of three sets of injections per calendar year. One set is defined as
a maximum of three anatomical sites at one session such as different level or different sides. If greater than three sets are required by the patient, the procedure is ineffective or there is an underlying condition that requires further evaluation and treatment.

D. When a set of facet blocks (3) is provided, additional injections used such as epidural, bilateral sacroiliac injections, and sympathetic nerve blocks are generally not necessary. Therefore, these injections will not be covered on the same date of service. If it is believed more than three injections are medically necessary prior authorization will be required. Documentation should include the clinical evidence in support of multiple injections for the condition under treatment and the anatomical relationship of the injections to the pain treatment.

2. **Sacroiliac Joint injections** are considered medically necessary to relieve pain associated with lower lumbosacral region disturbance when:
   A. Injections are covered in patients who have had back pain greater than three months, documentation indicates the conservative treatment methods which have been tried and failed, and pain is interrupting activities of daily living.
   B. The injections must be used in conjunction with other noninvasive treatment techniques, not as stand-alone therapy.
   C. Sacroiliac injections are limited to three injections over a calendar year. Documentation must support that an injection has provided at least 50% pain improvement over a six-week period before further injections are considered.

3. **Epidural injections** of corticosteroid medications with or without anesthetic agents are covered only when the pain is not spinal in origin (spinal tumor or lesion) and the patient has failed to improve after six weeks of conservative therapies.
   A. Low back pain radiating to the legs may be myofascial pain syndrome. Since nerve root pathology is not present with this syndrome, epidural injections are not covered.
   B. There is no separate payment for injecting the contrast material into the epidural space to confirm needle placement for pain management procedures. The CPT codes pertain to injection services. Non-invasive neuron blockade methods such as electroceutical neuron blockade devices are not covered.
   C. Epidural injections are limited to three per calendar year and must be provided as part of a comprehensive pain management program which includes physical therapy, psychosocial support, and oral medication.
   D. Only one injection code can be billed for a spinal region (cervical, thoracic, or sacral) regardless of the number of injections in that region on a date of service.
   E. Claims related to pain management will be reviewed periodically and are subject to post payment review. The following codes will be evaluated related to this policy: 20610 (major joint or bursa); 20796 (sacroiliac joint injection); 62310, 62311, 62318, 62319 (epidural injection); and 64479, 64480, 64483, 64484, 64490, 64491, 64492, 64493, 64494, 64495 (facet joint injection).
4. **Non-Pulsed Radiofrequency Rhizotomy** of cervical facet joints (C3-4 and below) and lumbar facet joints may be considered medically necessary when all the following criteria below are met:

- No prior spinal fusion surgery in the vertebral level being treated;
- Cervical or lumbar pain is suggestive of facet joint origin as evidenced by absence of nerve root compression as documented in the medical record H&P, and radiographic evaluation performed within the last 12 months;
- Pain has failed to respond to a minimum of 3 months of conservative treatment with oral pain medication (e.g. NSAID, analgesics, muscles relaxants);
- Pain has failed to respond to a minimum of 3 months of at least one of the following therapies within the last 6 months.(as documented in the medical record)
  - Physical therapy, with weekly visits for a period of 4 weeks;
  - Trial of manipulative therapy for a period of 4 weeks.
- A trial of controlled diagnostic medial branch blocks consisting of (2) separate positive blocks under fluoroscopic guidance that have each resulted in at least a 50% reduction in pain;
- Only 1 treatment procedure per level per side is considered medically necessary in a 6-month period.
- Repeat medial branch blocks are not necessary after 6 months or more following prior Radiofrequency rhizotomy if symptoms and treatment are at the same location(s), and presentation is similar to that of initial treatment.
- If no prior diagnostic medical branch blocks have been performed, even if the client has responded well to radiofrequency rhizotomy prior, the previous radiofrequency rhizotomy treatments are **not** a substitute for an initial trial of nerve block; medial branch blocks must be repeated before radiofrequency rhizotomy is performed.

**Note:** Utah Medicaid considers pulsed radiofrequency experimental and investigational for all indications because its effectiveness has not been established.

36. Laboratory Services: For information regarding coverage of lab services, refer to SECTION 4, Laboratory Services.

37. In-home Hospice Services are covered only for patients who have been diagnosed with a terminal illness that will result in death within a period of six months if the condition runs its normal course and who have filed an election of hospice benefit through a Medicare certified hospice agency. Procedure codes 99341 through 99348 and procedure code 99350 will only be covered for persons that have elected the hospice benefit prior to receiving the service. Prior authorization must be obtained at the time a patient is initially accepted to receive services covered by these codes in order to confirm the patient’s hospice status. If a patient revokes the election of the hospice benefit and then re-elects the benefit at a later time, a new prior authorization must be obtained for the re-election. Procedure code 99349 is covered for persons that have elected the hospice benefit prior to receiving the service. Prior authorization must be obtained at the time a patient is initially accepted...
to receive services covered by this code in order to confirm the patient’s hospice status. If a patient
revokes the election of the hospice benefit and then reelects the benefit at a later time, a new prior
authorization must be obtained for the re-election. Procedure code 99349 may also be used only by
a primary care physician to make a home visit for special care situations other than hospice.
Medicaid will consider coverage of a physician home visit when the patient has a condition which
makes travel (i.e. 50 miles) very difficult and they live in a rural area where access to medical care
is limited. All services will continue to require prior authorization.

38. Effective July 1, 2010, Utah Medicaid will cover polysomnography (CPT codes 95810 and 95811)
without prior authorization, with a limit of one of each procedure per client per 12 month period.
When apnea is identified during a hospitalization, every attempt should be made to perform
polysomnography prior to patient discharge from the hospital. When medically appropriate,
polysomnography with CPAP trial (95811) must be performed initially if the anticipated treatment
includes use of CPAP/Bi-PAP.

All prior authorization requests that exceed the allowable amount listed above will be subject to
review by prior authorization staff using the UDOH Custom Criteria for polysomnography
(Criteria for Medical and Surgical Procedures) and will require mandatory secondary review by
the appropriate Utilization Review committee before prior authorization approval will be given.

In all cases, it is the responsibility of the provider to determine whether prior authorization has been
approved before proceeding with the polysomnography.

Facility payment for the technical portion of the polysomnography is limited to a Utah Medicaid
approved sleep center. Medicaid coverage requires physician oversight of the center and a
minimum of one registered polysomnography technician at the center. Interpretation and report of
the sleep study must be completed by either a board-certified Sleep Medicine Diplomat or board-
certified Sleep Medicine Physician. The facility with one registered polysomnography technician
and a physician director may be considered for coverage only when the physician director has a
collaborative relationship with a sleep medicine physician to read the study.

When the physician has completed the training required by the American Academy of Sleep
Medicine or sleep medicine training approved by the board in their specialty (e.g. family practice,
internal medicine, pediatrics, neurology) and is eligible to take the examination for board
certification, the physician may be covered for up to one year as long as documentation of
eligibility is received.

- A letter from the program director that the required training-fellowship in sleep medicine has
  been completed.
- Board confirmation that the individual has completed training requirements and is eligible for
  the examination along with the date they are scheduled to take the board examination.

3 LIMITATIONS

Physician services may be provided only within the parameters of accepted medical practice and are
subject to limitations and exclusions established by the Department on the basis of medical necessity,
appropriateness, and utilization control considerations. The current edition of the Physicians’ Current
Common Procedure Coding System (HCPCS) published by CMS, are used to code and define covered
Medicaid services. Some limitations apply:

A. Cognitive services by a provider are limited to one service per client per day. These services are
defined in the CPT Manual as office visits, hospital visits except for those following a package
surgical procedure, therapy visits, and other types of nonsurgical services. When a second office
visit for the same problem or a hospital admission occurs on the same date as another service, the
physician must combine the services as one service and select a procedure code that indicates the
overall care given.

With the implementation of NCCI edits, payment issues are being identified which have not been
identified in the past. Utah Medicaid providers should be aware that if they bill a hospital
evaluation (admission or consultation) for a patient, then all subsequent evaluation and management
services for that patient should be billed as an established patient.

For example, the provider bills 99460 (initial hospital newborn evaluation and management), and
then two weeks later bills the code 99381, the initial comprehensive preventive medicine visit code
will be denied. The code 99381 will be denied, because the patient is considered an established
patient. The established patient code 99391 is the correct code to bill for payment.

B. Routine physical examinations are limited to:

- preschool and school age children, including those who are EPSDT (CHEC) eligible under
  the age of 21, participating in the ongoing CHEC program of scheduled services and follow-
  up care.

- New patients seeing a physician for the first time with an initial complaint where an
  examination and a medical and social history are necessary.

- Medically necessary examinations associated with birth control medications, devices, and
  instructions for those of childbearing age, including sexually active minors.

C. Coverage of some procedures identified by CPT codes is limited because of the nature, intensity, or
relationship to other procedures performed during or related to other services.

1. A minor procedure, in some cases, will be considered incidental to the E/M service, and the
   E/M code will be paid.
2. A duplicate procedure is the same procedure performed on a patient on the same date of
   service by the same provider and will be denied.
3. Mutually exclusive procedures are two or more procedures that are usually not performed
during the same patient encounter on the same date of service. The less clinically intense
procedure(s) will be denied.
4. Incidental procedures are relatively minor procedures performed at the same time as complex
   primary procedures and are clinically integral to the performance of the procedure. Therefore,
   the incidental procedure does not warrant additional payment.
5. Medical and Surgical Procedures identified by CPT code may only be provided by the
   physician or osteopath. Procedures may not be completed by ancillary personnel including
nurse practitioners and physician assistants; unless a specific exception for a specific code is described as Medicaid policy in this manual.

6. **B bundle status codes** are Medicare codes which are considered part of the procedure and not paid separately under Medicare. Currently, Medicaid has followed B status code payment except for after-hours physician service in established patients. Codes added to the B bundled list in Medicaid include, code 20930 (spinal bone allograft add-on), code 20936 (spinal bone allograft local), and code 22841 (insert spine fixation device).

7. Effective October 1, 2012, the providing physician will no longer be paid when a procedure designated as inpatient-only is done on an outpatient basis.

D. **Physician home visits** – Medicaid will consider coverage of a home visit by a primary care physician in certain situations. For example, the patient has a condition which makes travel very difficult and they live in a rural area where access to medical care is limited (i.e. they live 50 or more miles from the physician’s office). CPT codes 99347, 99348, 99349, or 99350 are used to bill for a home visit. Home visits require prior authorization.

E. **Modifiers** as defined in the CPT Manual have some limitations in Medicaid policy. Current edits are applicable and will remain. New limitations are implemented with the clinically based auditing program.

- **Modifier 22:** (Unusual procedural services) Modifier 22 is suspended for manual review. If approved, it will be paid at an additional 10% of the established fee schedule. Exception: multiple gestation births.

- **Modifier 24:** (Unrelated evaluation and management (E/M) service by the same physician during a postoperative period) Modifier 24 is only allowed for post-operative pain management as appropriate for anesthesia providers and is recognized for manual review. Otherwise, this modifier will not be recognized for manual review.

- **Modifier 25:** (Significant and separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) Medicaid will not recognize modifier 25. The system will pay according to policy, the editing program, and correct coding initiative edits. Manual review has found an overwhelming number of claims submitted with modifier 25 when the E&M code is the only service, with a minor procedure such as drawing blood, or the services are those included within the procedure. Extensive review of provider documentation on manual review found claims warranting modifier 25 a rare occurrence. Claims submitted with modifier 25 will be denied. Denied claims with unpaid modifier(s) 24 and/or 25 continue to have hearing rights.

- **Modifier 26 and TC:** Certain procedures and services have both a professional and a technical component. In procedures having a recognized technical/professional split the following coding guidelines should be followed.
  - Append modifier 26 only for the professional (physician) component of a billed service.
  - Append modifier TC when only the technical component is being billed. In the event that the provider owns the radiology overhead and also reads the exam, then submit one line for the professional component with modifier 26 and a second line for the technical component unmodified to ensure reimbursement for the global service.
Modifier 26 and TC have separate fees in the payment schedule and pay according to the established fee schedule.

- **Modifier 27**: (Multiple Outpatient Hospital Evaluation and Management Encounters on the Same Day) Medicaid will not recognize Modifier 27. Modifier 27 is only appended to facility based services performed in the hospital outpatient setting. Medicaid does not reimburse for services attached to Modifier 27.

- **Modifier 50**: (Bilateral Procedures) Medicaid will not recognize modifier 50.

- **Modifier 51**: (Multiple Procedures) When more than one procedure is performed during an operative session the surgeries are subject to the multiple surgery rules and are ranked in descending order by the Medicaid fee schedule allowed amount.

- **Modifier 52**: (Reduced Service) Modifier 52 is paid at 50% of the established fee schedule.

- **Modifier 53**: (Discontinued Procedure) Modifier 53 is paid at 50% of the established fee schedule.

- **Modifier 54**: (Surgical Care Only) Modifier 54 is paid at 70% of the established fee schedule.

- **Modifier 55**: (Post-Operative Management Only) Modifier 55 is paid at 20% of the established fee schedule.

- **Modifier 56**: (Pre-Operative Management Only) Modifier 56 is paid at 10% of the established fee schedule.

- **Modifier 57**: (Decision for surgery) Medicaid will not recognize modifier 57. Decision for surgery performed for the purposes of hospital accreditation requirements that indicate every patient must have an initial hospital history and physical, is not a covered service and is integral to the surgical global fee.

- **Modifier 58**: (Staged or related procedure or service by the same physician during the postoperative period) Modifier 58 is suspended for manual review.

  Submit CPT modifier 58 to indicate that the performance of a procedure or service during the postoperative period was either:
  - Planned prospectively at the time of the original procedure (staged)
  - More extensive than the original procedure
  - For the therapy following a surgical procedure

- **Modifier 59**: (Distinct Procedure Service) and subset modifiers (-X{EPSU})
  - XE Separate encounter: A service that is distinct because it occurred during a separate encounter
- **XP** Separate practitioner: A service that is distinct because it was performed by a different practitioner
- **XS** Separate structure: A service that is distinct because it was performed on a separate organ/structure
- **XU** Unusual non-overlapping service: The use of a service that is distinct because it does not overlap usual components of the main service.

Modifier 59 and the subset modifiers are the modifiers of “last resort" and should not be used when a more descriptive modifier is available. The subset modifiers are more selective versions of the 59 modifier so it would be incorrect to include both modifiers on the same line.

Use modifier 59 and subsets to describe distinct unrelated service from the other submitted procedures. These should not be used to circumvent correct coding initiative edits. The purpose of this modifier and subsets is to identify procedures or services that are not usually reported together, but appropriate under the circumstances. The following circumstances are unusual to encounter or be performed on the same day by the same individual.

- Different surgical session
- Different surgeon
- Different site or organ system
- Separate incision or excision (this excludes multiple port sites integral to endoscopy surgery)
- Separate lesion
- Separate injury (or area of injury in extensive injuries)

Do not append modifier 59 or subsets to an E&M service (per CPT).

A claim with a 59 modifier or a subset modifier is processed and denied based on Medicaid’s editing program. The provider may submit medical records supporting the distinct or independent identifiable nature of the service. Modifier 59 or a subset modifier, are considered for manual review only after editing program denial.

- **Modifier 62**: (Two surgeons of a different specialty are required to perform a specific procedure) Modifier 62 is suspended for manual review and requires each co-surgeon to submit a separate operative report clearly describing the separate portions of the procedure that each surgeon completed. Modifier 62 is paid at 62.5% of the established fee schedule.

- **Modifier 66**: (Surgical Team) Modifier 66 is suspended for manual review and is priced by Medicaid physician consultants.

- **Modifier 73**: (Discontinued outpatient hospital/ambulatory surgical center (ASC) procedure prior to the administration of anesthesia) Modifier 73 is to be utilized by facilities when an outpatient service is only partially completed or discontinued by the physician prior to completion of the service. This modifier may not be submitted by the operating surgeon. Only ASCs should submit this modifier. This modifier is to be paid at 50% of established fee schedule.

- **Modifier 74**: (Discontinued outpatient hospital/ambulatory surgical center (ASC) procedure after the administration of anesthesia) Modifier 74 is to be utilized by facilities when an outpatient service is only partially completed or discontinued by the physician prior to completion of the
service. This modifier may not be submitted by the operating surgeon. Only ASCs should submit this modifier. This modifier is to be paid at 50% of established fee schedule.

- **Modifier 76**: (Repeat Procedure by Same Physician) Modifier 76 is paid at 100% of the established fee schedule.

- **Modifier 77**: (Repeated Procedure(s)) Modifier 77 is paid at 100% of the established fee schedule.

- **Modifier 78**: (Unplanned return to the operating room by the same physician following initial procedure for a related procedure during the postoperative period) Modifier 78 is suspended for manual review.

- **Modifier 80**: (Assistant at Surgery) Modifier 80 for assistant surgeon is limited to 20% of the established fee schedule.

- **Modifier 81**: (Minimal assistant at surgery) Medicaid does not reimburse for services attached to Modifier 81.

- **Modifier 91**: (Repeat clinical diagnostic laboratory test) Modifier 91 is suspended for manual review. Used to report laboratory tests performed more than once on the same date to obtain subsequent, multiple test results. Submit documentation supporting the claim that separate services were provided for a distinct medical purpose.

Inappropriate usages of Modifier 91 include, but are not limited to:
- Used for a rerun of a laboratory test to confirm results
- Due to testing problems for the specimen
- Due to testing problems of the equipment
- When another procedure code describes a series test
- When the procedure code describes a series of tests
- For any reason when a normal one time result is required
- Repeat a test for quality control purposes

F. Use of Checklists and Templates

Correct use of the Checklist in Evaluation and Management Documentation as outlined in Medicare Part B, June 2006, has been adapted for review of office visits. Keep the following important documentation guidelines in mind when using a template and/or checklist:

1. Examination templates and checklists are acceptable documentation provided the provider has clearly indicated what was examined and the findings to support the level of service billed.
2. A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings.
3. Abnormal or unexpected findings of the examination of the unaffected or asymptomatic body area(s) or organ system(s) must be described.
4. The provider must document and describe any specific and pertinent abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s). A notation of “abnormal” without elaboration is insufficient documentation. A key explaining checklist symbols must be available, if requested.

5. Signature requirements remain the same in the use of checklists. Per NCP PHYS-001, “an indication of a signature in some form needs to be present.” Documentation must support legible identification of the billing provider, per the 1995 or 1997 Evaluation and Management Documentation Guidelines.

6. The Review of Systems (ROS) and Past Family Social History (PFSH) may be recorded by ancillary staff or completed by the patient, on a form or checklist. The checklist must have a place for the physician to document that he/she reviewed the information and make a notation supplementing or confirming the information recorded by others. If the ROS and/or PFSH are unchanged from an earlier encounter, it does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may be documented by noting the date and location of the earlier ROS and/or PFSH with a description of any new findings and/or a statement that all other elements are unchanged.

7. When referring to an earlier encounter to document the ROS and/or PFSH, all elements documented and performed in the earlier visit must be reviewed in the current visit. Any variation or elements not reviewed must be documented in the current note.

8. Only the provider can perform the History of Present Illness (HPI). The provider is ultimately responsible for submitting appropriate documentation. Each item on a checklist requires an active response for each exam component performed or question asked. It is not appropriate to use a common template which states that all components listed were performed unless otherwise noted by the physician.

9. In addition, there must be a written summary of the assessment, and a treatment plan. The primary components of the E&M service as outlined in the 1995 or 1997 E&M guidelines must be clearly documented. For example, a template used for education is not a covered service. At the time of an audit, the provider must stipulate which one of the E&M guidelines they are using.

G. Laboratory procedures

Laboratory services provided by a physician in his office are limited to the waived tests or those laboratory tests identified by CMS for which each individual physician is CLIA certified to provide, bill and receive Medicaid payment.

When the Affirm Test for DNA probes, CPT codes 87660, 87510, or 87480 are billed, only one of the three codes will be paid to the physician. DNA probe testing by the amplified method is not covered for these organisms.

Unspecified laboratory codes will no longer be accepted when there is a specific test available. The specific test must be ordered for reimbursement. Examples of this policy include:

- The code 87797 or 87798–Infectious agent not otherwise specified; direct probe technique will no longer be accepted when the test completed is Trichomonas vaginalis, direct probe, code 87660.

- The code 87800–Infectious agent detection, direct probe technique will no longer be accepted when the test is Chlamydia trachomatis, direct probe, code 87490.
Medicaid follows the recommendations of the editing program which includes payment recommendations from the American Society of Microbiology. (i.e. code 87621 allowed once)

Clinical diagnostic laboratory tests that are sent to an outside independent laboratory to be completed must be billed by the laboratory completing the service. The physician cannot bill for these services and seek payment from Medicaid.

- Urinalysis using a code like 81002 is incidental to an office visit and use of an appropriate E/M code.
- Blood Gas determination (82800) is considered clinically integral to the primary procedure, anesthesia, or critical care. No additional payment will be made for this procedure.
- Pulse oxymetry (94760, 94761) is a non-invasive measurement of oxygen saturation which requires a minimal amount of time and is considered incidental to an E/M code or anesthesia administration. No additional payment will be made for this procedure.

Drug screening tests, codes 80100 or 80101, should be ordered to reflect only those drugs likely to be present based on the patient’s medical history, or current clinical presentation. Urine and serum tests which are for the same class are considered duplicative, and therefore, are not covered. Medicaid considers drug screening for medico-legal purposes or employment purposes as not medically necessary. The medical necessity of completing additional tests beyond those of abuse must be well documented by the diagnoses submitted.

H. A specimen collection fee is limited only to specimens drawn under the supervision of a physician to be sent outside of the office for processing and only to specimens collected by the following method:

- Drawing a blood sample through venipuncture, i.e., inserting a needle attached to a syringe into a vein and withdrawing a sample of blood. (Code 36415 is used to bill this fee.)

1. Venipuncture is not a covered service when finger or heel sticks are done for a reagent strip test with codes like the following:

   82948, blood glucose by reagent strip
   82962, glucose blood home monitoring device
   83036 with QW modifier, glycated hemoglobin
   85013, spun microhematocrit,
   85014 with QW modifier, hematocrit
   85610 with QW modifier, prothrombin time
   86318, immunoassay for infectious agent by reagent strip

   None of these are venipuncture procedures. Therefore, code 36415 for venipuncture will be considered mutually exclusive to any of the CPT codes used for reagent strip testing. However, if other blood specimens are ordered which require venipuncture, 36415, payment will be allowed.
2. Obtaining a pap smear is limited to and included in the reimbursement for an office visit. A specimen collection fee is not separately billable for this service. When the codes 88142, 88143, 88174, and 88175 are billed only one of the four codes will be paid.

3. Collection of urine by catheterization must be supported by documentation of medical necessity.

I. Finger/heel/ or ear sticks are limited only to infants under the age of two years by use of CPT Code 36416.

J. Eye examinations are limited to one each calendar year.

K. Contact lenses are covered only for aphakia, nystagmus, keratoconus, severe corneal distortion, cataract surgery and in those cases where visual acuity cannot be corrected to at least 20/70 in the better eye. Contact lenses will not be provided for moderate visual improvement and/or cosmetic purposes.

L. Psychiatric services or psycho social diagnosis and counseling are specialty medical services, and whether provided in a private office, a group practice, or private clinic are limited to direct provision, documentation and billing by the private physician. Charting and documentation must clearly reflect the private physician’s direct provision of care. The personal supervision policy, R414-45 cannot be applied to psychiatric services.

1) Codes 96150 through 96155—health and behavior assessment covered within FQHC’s and RHC’s is intended for use by non-physician providers; the focus is not on mental health.

2) When physicians are performing these services (96150-96155), the appropriate evaluation and management service should be billed.

M. Organic Brain Disease is limited to treatment by the primary care provider. This diagnosis is not covered under the Prepaid Mental Health Plan.

N. Admission to a general hospital for psychiatric care by a physician requires prior authorization and is limited to those cases determined by established criteria and utilization review standards to be of a severity that appropriate intensity of service cannot be provided in any alternate setting.

O. Psychiatric evaluations are requested by the Department as part of the prior authorization process for patients who request specialty medical or surgical procedures. These procedures may be very traumatic, require long periods of recovery, require compliance with treatment regimens which may be limiting, challenging, and even necessitate some life style changes or adjustments in activity and life participation. These required psychiatric evaluations are limited to provision by a Board Certified or Board Eligible Psychiatrist. Patients seeking these selected surgical procedures will be referred to a psychiatric consultant through the Utah Department of Health, Division of Medicaid and Health Financing, Utilization Review Committee. Any patient not referred through this process will not be eligible for this service. Emphasis of the evaluation is on the following:

Objective: To obtain a complete detailed or comprehensive psychiatric evaluation, provided in narrative form, by a Board Certified or Board Eligible Psychiatrist who is a Medicaid Provider.
Purposes:

- To determine stability of the individual – socially and emotionally.
- To determine the potential for compliance following surgery -- Medication, diet, lifestyle changes, follow-up.
- To identify support systems available to the individual.
- To assess ability of the individual to understand the procedure to be done and the consequences of the procedure.

The Centers for Medicare and Medicaid Services (CMS) with considerable input from the American Psychiatric Association (APA) clarified and standardized elements necessary for patient examinations. The psychiatric evaluation authorized through Utilization Review committee requires a written report to the requesting physician or other appropriate source.

The elements of a psychiatric examination as required by Medicaid must address the multi axial system as well as include evaluation and descriptions of the following:

1. Speech: rate, volume, articulation, coherence, and spontaneity.
2. Thought Process: rate of thoughts, content, (logical versus illogical), abstract reasoning and computation.
3. Associations: (loose, tangential, circumstantial, intact).
4. Abnormal or psychotic thoughts: (Including hallucinations, delusions, preoccupation with violence, homicidal or suicidal ideation, and obsession).
5. Judgment: Concerning everyday activities and social activities.
6. Insight: Concerning psychiatric status
7. Mental status examination including: a) orientation to time, place, and person, b) recent and remote memory c) attention span and concentration , d) Language (naming objects, repeating phrases), e) knowledge and awareness of current events, history, vocabulary, potential risks of surgery f) mood and affect: depression, anxiety, agitation, hypomania, lability, mania, personality disorders, including addiction and substance abuse g) ability to manage stress, h) the patient must understand the surgery will create the need for a permanent lifestyle change - the expressed expectations of surgery are realistic and j) document the patients legal status for making an informed decision.
8. Commitment of patient to comply with treatment is crucial to many surgical procedures. a) Assess the patient’s motivation to comply with the long term follow-up of the procedure under consideration. Review medical and social history issues of failure to keep medical appointments, leaving the hospital against medical advice, and evidence of compliance issues with prior medical treatments. b) Assess patients’ current lifestyle, attitude, degree of determination and motivation to make long term lifestyle changes. For example when considering surgical treatment for weight loss discussion and evaluation should include the patients plan for a) daily exercise based on current physical abilities, b) awareness of eating triggers, knowledge eating as a coping mechanism could cause serious postoperative
complications, knowledge of a healthy diet regimen and/or need for nutritional counseling, c)
understanding of the effect tobacco, alcohol and/or drug use on surgical outcome including
need to discuss medication change with physician, and/or quit habits which are adverse to
surgical outcome, and d) willingness to continue supervised behavior modification therapy
for at least one year.

9. Support system: evaluate the patient’s family and social history, current family support,
social network, awareness of community resources and willingness to participate as a team
member in the effort to maintain successful surgical outcome (weight loss, organ transplant
regimen).

Billing

Use Comprehensive consultation Code 99245.

The Evaluation and Management elements of this code are:

Comprehensive History Comprehensive Examination, and

Medical decision making of high complexity.

Typically, 80 minutes are spent with the patient or family

A CMS-1500 (08/05) claim form must be submitted to Medicaid and Health Financing using CPT
code 99245. Pricing is established in the Reference File.

P. Services to pregnant women who do not meet United States citizenship requirements as defined
in the Medicaid Eligibility Manual §205-6, Emergency Medicaid, are limited only to labor and
delivery services.

The following criteria must be met for covering “Emergency Only Services”:

• The condition manifests itself by sudden onset.
• The condition manifests itself by acute symptoms (including severe pain).
• The condition requires immediate medical attention.
  ○ Immediate medical attention will require attention within 24 hours of the onset of
    symptoms or within 24 hours of diagnosis whichever comes earlier (no delay for
    scheduled or convenient time for service).
• The condition requires acute care, and is not chronic (Does not include any chemotherapy or
  follow-up care).
• Coverage will only be allowed until the condition is stabilized sufficient that the patient can
  leave the acute care facility, or no longer needs constant attention from a medical
  professional.
• The condition is not related to an organ transplant procedure.
• Prenatal or postpartum care is not covered.

Diagnosed conditions in the prenatal period can arise to a level requiring “immediate medical
attention” that can reasonably be expected to result in serious health consequences if not treated.
A physician rendering treatment for a diagnosed prenatal emergency condition, if coded
appropriately, warrants payment without prior review.
Prenatal testing, observation, pain management, counseling and/or care for any of the following codes are considered as prenatal care and are not a covered benefit unless involving a diagnosed emergency condition.

Medical records may be subject to review if selected during the mandated monthly sample and/or targeted for a focused review. The following code(s) are approved and may bypass prepayment review when reflecting treatment to resolve a diagnosed emergency medical condition as specified below:

1. Diagnosis Code V22.2 - Pregnant state incidental must appear on every claim as one of the diagnosis codes.

2. Vaginal Bleeding – Diagnosis Codes 641.01, 641.03, 641.11, 641.13, 641.21, 641.23, 641.31, 641.33, 641.81, 641.83.

3. Threatened Abortion – Diagnosis Code 640.03 - Payable only in the emergent situation defined as uterine bleeding and cramping without cervical change before 20 weeks gestation, but the pregnancy is not terminated.

4. Spontaneous Abortion – Diagnosis Codes 634.1, 634.2, 634.3, 634.4, 634.5, 634.6, 634.7, 634.8 - The appropriate related diagnosis and procedure codes must be on the claim for payment to be made without review.

Note: An incomplete abortion (Code 634.91), which requires a D&C or vacuum extraction to complete, must have medical (manual) record review, including operative and pathology reports, for approval before payment.

5. Missed Abortion – (Fetal death without spontaneous abortion) Diagnosis code - 632 CPT codes for physicians - 59820 or 59821. Abortion will inevitably occur, but D&C or D&E may be indicated to prevent any maternal complications.

Missed abortion, or fetal demise, requires medical staff review, but does not require completion of the abortion consent form. Documentation of fetal demise by ultrasound is required for post payment review. The abortion consent form is required only in a therapeutic abortion and is part of the required medical record documentation reviewed by medical staff to ensure all legal requirements are met.

A copy of the Abortion Acknowledgement Form can be found under the “Forms” section at https://medicaid.utah.gov.

It is the responsibility of the provider to assure that the code(s) being billed are correct for the diagnosis and procedure performed.

6. Premature Rupture of Membranes – Diagnosis code 658.13 requires documentation for review. If delivery occurs within 24 hours of admission; no separate payment is warranted for the ruptured membrane services. Labor and Delivery codes only should be billed.

7. Premature Labor -- Diagnosis code 644.03. Regular uterine contractions with cervical change after 22 weeks, but before 37 completed weeks of gestation without delivery. Cervical change is defined by vaginal exam or Transvaginal Ultrasound. Indications of possible early labor with an ER visit that only involves testing, monitoring, counseling or pain management singly or in combination is prenatal care and not an emergency medical
condition. The early labor must be advancing at a level where the physician must treat the patient to stall early labor and preserve the pregnancy for further development of the fetus. Any follow up or continuing care following the stabilization will not be covered.

8. Decreased Fetal Movement – Diagnosis code 655.73 is subject to review. Decreased fetal movement may be a symptom which may or may not require emergency services. Fetal evaluation and monitoring is required to establish fetal wellbeing. Fetal monitoring includes Non-Stress Test (NST), Amniotic Fluid Index (AFI), Biophysical Profile (BPP), and Contraction Stress Test. All codes associated with evaluating decreased fetal movement with no related emergent condition are inappropriate and will be denied payment.

If fetal demise occurred then treatment would be under a missed abortion code. Emergent situations that are reimbursable would be indications of and treatment for fetal distress.

9. All services beyond those listed above, must be edited and reviewed before payment. Codes which may be associated with the above services are listed below. Codes should be selected carefully based on the condition and the necessary services to stabilize the clients’ condition. Documentation must support the billed service(s). Appropriate diagnosis to procedure edits must apply. All codes will not be appropriate for all complaints and may not be associated in the system editing and payment will be denied. Codes including but are not limited to:

- Physician office visit codes – 99201 – 99205
- Physician Emergency Department visit codes - 99281 – 99285
- Ultrasound CPT code - 76805 or 76815
- CLIA approved CPT lab codes for physician office (Diagnosis to procedure edit must agree)
- Fetal non-stress test – ICD.9 Procedure code 75.35 CPT Code 59025 (If done in a hospital must have the revenue code plus the CPT code.)
- Fetal Monitor - 59050 – 59051.

Special Limitations

- Routine prenatal care remains non-covered for this population.
- Post partum care only is also non-covered.
- Global codes should never be paid for service to this population. Edits in the system will only allow payment for codes 59409, 59514, 59612, or 59620.
- Abortion or early induced labor and delivery because of fetal anomalies, are non-covered services.

Q. Seeking additional payment for services is limited to those cases where the circumstances are so unusual and severe that excess time is required to safely monitor and treat the patient. Documentation in the medical record must clearly show the extenuating circumstances and the unusual time commitment to warrant medical review and consideration of additional reimbursement.

R. Transfer of patients between physicians or between hospitals is limited to those circumstances where medically necessary, appropriate care cannot be provided by the physician or in the initial facility. Convenience or patient choice is not an adequate reason for transfers.
S. Treatment of alcoholism or drug dependency in an inpatient setting is limited to acute care for detoxification only.

T. Abortion procedures are limited to those consistent with the Hyde Amendment restrictions. The Hyde amendment allows for the use of federal funds for abortions to terminate a pregnancy under two conditions:

1. Resulting from an act of rape or incest; or

2. Life of the mother would be endangered if the fetus is carried to term. (42 CFR 441.203 and Public Law Number 105-78 Section 509 and 510, pertaining to revisions of the Hyde Amendment, 1998).

Refer to the instruction for Criteria #17 - Abortion in the attached Criteria for Medical and Surgical Procedures.

U. Genetic Counseling and Genetic Testing

1. The services of masters prepared genetic counselors are not covered in Medicaid. Until there are CPT codes available and provider payment issues are determined through CMS, the services will be non-covered.

2. In Utah there are thirty-six genetic screening tests which are recognized for coverage in the newborn. These newborn screening tests, sponsored through the State Laboratory, are covered under the hospital DRG. Sometimes the infant is born outside of the hospital. The code S3620 submitted with the BL modifier is to be used by certified nurse midwives or clinics to bill for the State Laboratory newborn screening kit when the procedure is completed through them instead of the hospital. The State Laboratory newborn screening kit code includes the initial lab tests and a follow-up test about two weeks from birth. The venipuncture code may be billed in addition to S3620-BL.

3. Medicaid does not cover testing completed for general population screening where there is no symptomatic evidence or family history of genetic disease, nor is screening covered for investigational or research purposes. Medicaid will only consider additional genetic screening tests for coverage when there is a significant family history of a treatable genetic disorder occurring within a three-generation family group sheet. For specific genetic coverage, refer to the laboratory section of this manual (e.g., BRCA1/BRCA).

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

Cytogenetics studies 88230 through 88299 are not covered services. Molecular diagnostic tests in the code range 83890 to 83914 will be reviewed for medical necessity when greater than 2 units are billed. Some tests are necessary for infectious disease testing, while others are used to determine the hereditary potential of a disease or syndrome. Medicaid must look at the efficacy and medical reasonableness of the test completed for reimbursement. The mutation test (e.g., laboratory code T315I) is covered as medically necessary when required in determining salvage therapy and the decision for bone marrow transplant. Direct sequencing includes the following molecular diagnostic tests: 83902x1, 83898x4, 83896x3, and 83913x1.
5. CPT code S3854, gene expression profile panel for use in management of breast cancer treatment, will be used for Oncotype DX testing. Oncotype DX testing in women and men with breast cancer may be used to determine recurrence risk for deciding whether or not to undergo adjuvant chemotherapy. Current guidelines consider medical necessity to include newly diagnosed patients whose breast cancer is stage I or II, node-negative, and estrogen receptor positive. For reimbursement of the service, documentation must be submitted for medical review.

V. Sterilization and hysterectomy procedures are limited to those which meet the requirements of 42 CFR 441 Subpart F. Refer to the instructions for Criteria #10, Sterilization Checklist, in the attached Criteria For Medical and Surgical Procedures.

W. Cosmetic, plastic, or reconstructive surgery is limited to medically necessary services which:
   - Correct a congenital anomaly;
   - Restore body form or function following an accidental injury; or
   - Revise severe disfiguring and extensive scarring resulting from neoplastic surgery.
   - Reconstruction of the cancer-affected breast may only be approved for a repeated constructive surgery based on medical necessity. Examples of a medically necessary secondary surgery include implant rupture, wound dehiscence, or wound infection.

X. Removal of Benign or Premalignant Skin Lesions

I. Removal of certain benign skin lesions that do not pose a threat to function or health are considered cosmetic and are not covered by Medicaid. Lesion removal may be considered covered for medical necessity when:
   1. The lesion is in anatomical area subject to recurrent physical trauma, and there is documentation that such trauma has in fact repeatedly occurred or the lesion obstructs an orifice or clinically restricts vision. Lesions in sensitive anatomic locations that are not problematic do not qualify for removal coverage based on location alone.
   2. A prior biopsy suggests or is indicative of lesion malignancy, or based on the lesion’s appearance, such as recent changes in color or enlargement, malignancy is a realistic consideration.
   3. Lesions which may be considered for coverage may include those which bleed, itch intensely and/or are painful.
   4. To consider removal of a benign lesion not cosmetic, medical records maintained by the physician must clearly document the medical necessity for lesion removal. A record statement of “irritated skin lesion” is not sufficient justification for lesion removal when based on the patient’s complaint or the physician’s physical findings. Similarly, use of ICD-9 code 702.11, inflamed seborrheic keratosis, is not sufficient to justify lesion removal without medical record documentation of the patient’s symptoms and physical findings.
   5. Codes will be considered for coverage only when the diagnosis code is listed in the group below. However, benign or premalignant skin lesions must also meet the requirements stated under Limitations (which follows the list of ICD-9 codes below).
      a) 078.0 Molluscum contagiosum
      b) 078.11 Condyloma acuminatum
      c) 078.19 Other specified viral warts
      d) 171.0 Malignant neoplasm of connective and other soft tissue, head, face and neck
e) 173.0-173.8 Other specified malignant neoplasm of skin  
f) 216.0-216.4 Benign neoplasm specified as skin of lip, eyelid, ear, nose or scalp  
g) 221.1-221.2 Benign neoplasm female genital organs  
h) 222.2-222.4 Benign neoplasm male genital organs  
i) 232.0-232.4 Carcinoma in situ of skin of lip, eyelid, ear, scalp, other specified face  
j) 232.5-232.7 Carcinoma in situ of skin of upper and lower limb, trunk except scrotum  
k) 686.1 Pyogenic granuloma of skin and subcutaneous tissue  
l) 701.0 Circumscribed scleroderma  
m) 701.2 Acquired acanthosis nigricans  
n) 707.11-707.19 Ulcer of thigh, other specified lower limb  
o) 707.8 Chronic ulcer of other specified sites  
p) 919.7 Superficial foreign body (splinter) of other, multiple, and unspec. sites, infected

II. Limitations:  
- Benign lesions such as seborrheic keratoses, hemangiomas, lipomas and sebaceous epidermoid cysts, are not covered.  
- Benign lesion excision/removal, codes 11200, 11300-11313, 11400-11446 and 17000-17111, may be reviewed under this policy. Submitted medical record documentation must include the number of lesions and their anatomical location, size, shape, character, and color. Pathology reports must also be included with the documentation for review when applicable. Medical record documentation must support the medical necessity of surgical excision over another removal procedure and support that the removal was not for cosmetic purposes.  
- Since actinic keratosis on the ear, lip, bald head, or eye area have a great chance of developing into squamous cell carcinoma, coverage is appropriate for these areas. Treatment may be completed by cryosurgery or excision. When there are extensive areas of actinic keratosis, topical cream applications are recommended.  
- Laser treatment of broken vessels for superficial vein removal is cosmetic and not covered (i.e. rosacea, spider veins).  
- If the physician does not believe that removal of the skin lesion would be covered by Medicaid, or authorization is denied, but the patient wants the lesion removed, the physician must notify the patient that the surgery is not covered. In order for the physician to bill the Medicaid client for a non-covered service, the provider must exactly follow the conditions listed in SECTION I, of the Utah Medicaid Provider Manual, Chapter 6-8, Exceptions to Prohibition on Billing Patients, Item 1, Non-Covered Services.  

Y. Prolotherapy is a procedure for strengthening lax ligaments by injecting proliferating agents or sclerosing solutions directly into torn or stretched ligaments or into a joint or adjacent structure to create scar tissue. The injection material is usually dextrose, glycerine, phenol, and lidocaine (described as P2G), but zinc sulfate and psyllium seed oil have also been used. Often triamcinolone or another steroid is added to the injection. Currently, evidence-based, controlled trials are insufficient to determine whether prolotherapy exceeds the effects of a placebo. This procedure is non-covered in Medicaid because it is considered investigational, experimental, and unproven. Codes noted to be used for this procedure (i.e. 20550, 20600-20610) are subject to post payment review.  

Z. Exploratory laparotomy procedures confirm a diagnosis and determine the extent of necessary treatment. Payment for exploratory procedures is limited to those cases where the exploratory
procedure is the only procedure performed during an operative session. When additional surgical procedures, identified and billed by separate identifiable procedure codes, are completed in addition to the laparotomy, reimbursement for the laparotomy will be denied. The additional procedures will be reimbursed in accordance with the multiple procedure methodology.

AA. Brachytherapy for Prostate Cancer

Brachytherapy using permanent transperineal implantation of radioactive seeds may be considered medically necessary in treatment of localized prostate cancer when used as monotherapy or in conjunction with external beam radiation therapy (EBRT).

Medicaid defines prostate cancer risk using the following criteria:

**LDR GUIDELINES:**

1. Low Risk: PSA 10 ng/mL or less, Gleason score 6 or less, and clinical stage T1c or T2c
2. Intermediate Risk: PSA greater than 10 but 20 ng/mL or less, or Gleason score 7, or clinical stage T2b
3. High Risk: PSA >20 ng/mL, Gleason score 8-10, or clinical stage T2c

**HDR GUIDELINES**

1. Low Risk: PSA 10 ng/mL or less, Gleason score 6 or less, and clinical stage T1c or T2c
2. Intermediate Risk: PSA greater than 10 but 20 ng/mL or less, or Gleason score 7, or clinical stage T2b
3. High Risk: PSA >20 ng/mL, Gleason score 8-10, or clinical stage T3a for clinical localized disease and T3b-T4 for locally advanced disease

To determine CPT coverage, refer to the online Coverage and Reimbursement Lookup Tool available on the Medicaid website at: [https://medicaid.utah.gov](https://medicaid.utah.gov).

BB. Magnetic resonance imaging (MRI) is limited to coverage only for service to the brain, spinal cord, hip, thigh and abdomen. MRI of the spinal cord requires prior approval. Refer to the Utah Medicaid website at: [https://medicaid.utah.gov](https://medicaid.utah.gov) criteria.

Prior approval may be denied for an MRI related to a musculoskeletal problem when the patient has not followed through with the prescribed conservative therapy regimen, including physical therapy appointments. Repeated examinations are subject to post payment review of the medical record documentation. Since the technical portion of an MRI in inpatients is covered under the DRG, radiologists may obtain payment for the professional component of inpatient MRIs by submitting the CMS-1500 (08/05) claim with the site of service as 1, hospital. As of July 1, 2014, failure to obtain a prior authorization for outpatient MRIs completed in independent radiology centers or hospitals may result in denial of reimbursement for the technical and/or professional components.

CC. Organ transplant services are limited to those procedures for which selection criteria have been approved and documented in R414-10A. (Kidney and cornea transplantations are an exception and do not require prior authorization.) When an organ transplant procedure is done without authorization because the procedure does not meet the established criteria, payment will be denied for all services related to the transplant up to the outlier threshold days for the specific type of transplant. Medically necessary services beyond the initial denial period may be considered for payment. Medicaid does not cover corneal transplant tissue or other organ procurement separately.
from the DRG. The payment for organ preparation is included with the DRG payment to the hospitals. Therefore, the procurement of corneal tissue for corneal transplant (code 65710) is not covered in an ambulatory surgery center.

DD. Hearing screens for infants are limited to those under the age of one year and in accordance with the nationally recommended strategy to have all infants receive a hearing screen. The recommendation is to have the screening completed as soon as possible after birth, while the infant is still hospitalized. Payment methodologies for this screening are limited by the type of service provider covering the child, e.g., MCP or fee for service.

EE. Vitamins may be provided only for:

1. Pregnant women: Prenatal vitamins with 1 mg folic acid. [Prenatal vitamins are not covered post-delivery.]
2. Children through age five: Children’s vitamin drops with or without fluoride.
3. Adults and children of any age: Fluoride supplement.

FF. Drugs and biologicals are limited to those approved by the Food and Drug Administration or Utah Medicaid’s Drug Utilization Review Board, which has the authority to approve off-label use of drugs. Effective July 1, 2007, drug eluting stents are no longer a benefit. Payment of angioplasty and stents are covered only when performed for the following diagnostic codes: 410.9 (acute myocardial infarction) and 411.1 (acute coronary syndrome).

GG. Human growth stimulating hormones are limited to CHEC eligible children under the age of 15 who meet the established criteria for coverage. Criteria are specified on the attached Drug Criteria and Limits List.

HH. Nonprescription, over-the-counter items are limited to those OTC drugs on the Over the Counter Drug List attached to this manual.

II. Most immunizations for both adults and children, when administered in-office, are a covered benefit. To verify CPT coverage, please visit the online Coverage and Reimbursement Lookup Tool available on the Medicaid website at: https://medicaid.utah.gov.

On January 1, 2013, new Procedure to Procedure (PTP) edits were implemented in the Medicare and Medicaid National Correct Coding Initiative (NCCI) methodologies that immunization administration codes (CPT codes 90460-90474) as column one codes with preventative medicine Evaluation & Management (E & M) codes (CPT codes 99381-99397) as column two codes. Historically and up until this mandated policy change, Medicaid policy would allow reimbursement of the E & M code and deny the immunization administration code if billed together on the same date of service. If the provider billed the E & M code with the 25 modifier, Utah Medicaid’s reimbursement system ignored the modifier. This new policy will allow the 25 modifier to be recognized for additional payment if the provider performed a comprehensive preventative medicine evaluation, in addition to the immunization administration. If a provider administers immunization(s) and performs a significant, separately identifiable preventive medicine E&M service on the same date of service, reporting the E&M service with modifier 25 will bypass the NCCI PTP edit.

On January 1, 2013, new edits were implemented that allow immunization administration codes and preventative medicine Evaluation & Management (E & M) codes to pay on the same claim. This
new policy will allow use of the 25 modifier to receive additional payment. Historically and until this mandated policy change, Medicaid policy would allow reimbursement of the E & M code and deny the immunization administration code if billed together on the same date of service. Now, if a provider administers immunization(s) and performs a significant, separately identifiable preventive medicine E&M service on the same date of service, reporting the E&M service with modifier 25 will bypass the edit and allow payment.

Injection administration codes 90471 and 90472 are limited to use with immunization codes 90476 through 90479. The existing limitation on other administration codes also applies to these codes. The limitation is that a provider may bill for two of the three following services, but not all three: E & M service, immunization administration and vaccine or toxoid product.

Covered Pediatric Immunizations:
Prescribers may participate in the Vaccines for Children (VFC) program, in which drug products are supplied to the provider at no cost. Prescribers who participate in the VFC program are reimbursed for E & M services and immunization administration, but not the drug product. The VFC program is administered by the Centers for Disease Control and Prevention (CDC). More information can be found at [http://www.cdc.gov/vaccines/programs/vfc/providers/index.html](http://www.cdc.gov/vaccines/programs/vfc/providers/index.html).

Note: For updates on current adult vaccination recommendations and issues, visit the CDC website at [http://www.cdc.gov/vaccines/schedules/hcp/adult.html](http://www.cdc.gov/vaccines/schedules/hcp/adult.html).

Please note that some vaccines are also available for administration at a pharmacy. For discussion of vaccines as a pharmacy benefit, refer to the Pharmacy Services Provider Manual.

JJ. Administration codes - Allergen Immunotherapy:

CPT procedure code 95165 is used to report multiple dose vials of non-venom antigens. CPT code 95165 is now defined as a one- (1) cc aliquot from a single multidose vial. Providers should report the number of units representing the number of 1cc doses of antigen concentrate (extract) being prepared. The billing unit is not any of the following: the number of antigens, the number of vials, the number of injection services that the patient is expected to receive, or the concentration of the antigen. When billing code 95165, providers should report the number of units representing the number of 1cc doses being prepared. A maximum of 10 doses per vial is allowed for billing, even if more than ten preparations are obtained from the vial. In cases where a multidose vial is diluted, Medicaid should not be billed for diluted preparations in excess of the 10 doses per vial allowed under code 95165. There are program edits which will deny payment for code 95165 when the number of doses billed exceeds 20 over a nine-month period of time. Injections are billed separately. Single injection dose allergen supervision and provision is a non-covered service in Medicaid.

KK. Neonatal Care

CPT code 99464, Attendance at Delivery, is available for use by board certified neonatologists and board certified pediatricians in urban or rural areas. Family practice physicians trained in neonatal care who practice in rural areas will be recognized and included for reimbursement. This code can be used when a high risk delivery is expected, Neonatal Risk Factor Classification Levels three or four are met, and stabilization of the newborn is anticipated. The delivering physician must request
the attendance of a qualified neonatologist, pediatrician or family practitioner at the high risk delivery. When resuscitation is required, CPT code 99465 would be used in place of 99464. The two codes cannot be used together.

Fetal/Neonatal Risk Factors are outlined below:

**Class I** (Attendance at delivery rarely required)

- a) Vaginal vertex or C-Section at term birth with no identified fetal risk factors
- b) Term delivery: prolonged labor > 24 hours or ROM > 18 hours without fetal distress/amnionitis
- c) Labor post term > 42 weeks without fetal distress
- d) Non insulin dependent diabetes without fetal distress

**Class II** (Attendance at delivery may be necessary)

- a) Meconium staining with no other risk factors
- b) Term vaginal breech birth or premature labor at 35-36 weeks
- c) Maternal drug/alcohol abuse, maternal medication, severe preeclampsia, Rh-sensitized mother or maternal disease that may affect the mother
- d) Term twins born vaginally or by C-Section with no fetal distress

**Class III** (Attendance at delivery necessary)

- a) Meconium staining with any other risk factor
- b) Significant vaginal bleeding or prolapsed cord or compressed cord
- c) Signs of fetal distress:
  - o Persistent late decelerations
  - o Prolonged variable decelerations with slow recovery
  - o Loss of beat to beat variability > 30 minutes
  - o Persistent fetal tachycardia (HR > 170 for 30 minutes)
  - o Fetal scalp pH < 7.2
  - o Prolonged bradycardia (HR > 80)
- d) Indicators of lung immaturity:
  - o Lecithin-sphingomyelin ratio L/S < 2 (surfactant)
  - o Phosphatidyl glycerol (PG) negative
  - o Surfactant albumin ratio S/A < 35
  - o Foam stability index FSI < 0.47
  - o Fluorescence Polarization FPOL < 290m
- e) A previous infant with RDS near term
- f) Complicated multiple gestation < 36 weeks
- g) Deviation in neonatal size from expected developmental stage, weight < 2500 gm or > 4000 gm
- h) Ultrasound or amniocentesis identified fetal anomaly, low biophysical ultrasound profile, or high/low alpha-fetoprotein in maternal blood
- i) Oligohydramnios or polyhydramnios except in an infant of a mother with diabetes
- j) Insulin dependent diabetes
- k) Premature labor < 34 weeks or prolonged 2nd stage of labor > 2 hours
1) Chorioamnionitis or known group B streptococcus or serious maternal infection
m) Erythroblastosis

Class IV

a) Massive vaginal bleeding
b) Prolonged amniotic leak > 30 days with olighydramnios (pulmonary hypoplasia suspected)
c) Prematurity: single fetus < 28 weeks, twins < 30 weeks, triplets or more < 34 weeks
d) Hydrops (any etiology)
e) Major fetal anomalies diagnosed antenataly or anticipated extraordinarily ill newborn

Neonatal and Pediatric Critical Care Services are limited to those infants who meet the CPT definitions of critically ill and qualify for critical care services. The Neonatal and Pediatric Critical Care codes are designed to be global, covering a 24 hour period, and limited to billing only once each day per patient. The coverage and coding includes all physicians involved in care of the infant/child during the 24 hour period. Provision of Neonatal and Pediatric Critical Care Services is limited to Board Certified Neonatologists or Board Certified Pediatric intensivists.

Intensive (non-critical) low birth weight services provide for continuing intensive care of the very low birth weight or low birth weight infant, at or beyond 29 days of life, who no longer meets the definition of critically ill. Although no longer critically ill, the infant is still in need of Intensive Care with monitoring and constant observation by the health care team under direct physician supervision. Coding for Intensive, non-critical, very low birth weight or low birth weight services is by global 24 hour code requiring the same qualifications as those for critical care services. Services are bundled as outlined for the other neonatal and pediatric critical care services. Provision of non-critical services is limited to either a Board Certified Neonatologist, Board Certified Pediatric Intensivist, or a Board certified pediatrician.

LL. Neonatal Jaundice (Hyperbilirubinemia): Hospital Readmissions within 30 Days

Readmissions within 30 days of previous discharge, refer to Utah Administrative Rule R414-1-12. When a hospital reimbursement is based on a diagnosis-related group payment and a Medicaid client is readmitted to the hospital within 30 days of a previous discharge for the same or a similar diagnosis, Medicaid will evaluate both claims to determine if they should be combined into a single payment or paid separately.

MM. Private Room Payment Requirements

Medicaid will pay for a private room when clinically indicated to prevent the spread of an infectious disease and in cases where the patient is colonized with a multi-drug-resistant organism which may present a serious risk of spread to other patients. Coverage will be based on current Centers for Disease Control and Prevention (CDC) guidelines.

A. Indications for Coverage

1. Payment for patient isolation in a negative pressure room will be limited to patients requiring isolation to prevent the spread of infectious disease through airborne droplets. This category includes patients with active infection with Mycobacterium Tuberculosis
(pulmonary or laryngeal), Measles (Rubeola), Chickenpox (Varicella) or disseminated Shingles (Herpes Zoster in an immuno-compromised patient).

2. Since the infectious respiratory droplets may be spread within a five foot radius of the patient, provision for a private room will be covered for those diseases transmitted by respiratory droplets. Infections in this category include meningitis, pneumonic plague, pharyngeal Diphtheria, Whooping Cough (Pertussis), Mycoplasma pneumonia, Small pox (Variola), Rubella (German Measles), or Mumps (Infectious parotitis).

3. Contact isolation for some infectious diseases is required until appropriate treatment has been provided or infectious period has passed. Diseases in this category include African hemorrhagic fevers (Marburg, Ebola, Lassa), cutaneous diphtheria, cutaneous tuberculosis, herpes zoster, bubonic plague, impetigo, and resolving viral infections in which infectious lesions are still present (Varicella, Variola). Diseases in this category which apply just to infants and young children include respiratory syncytial virus, adenovirus, parainfluenza viral infection, enteroviral infection, staphylococcal cutaneous infections and group A streptococcus.

4. Patients colonized with multi drug resistant organisms may not have a severe infection themselves but because of the nature of the organism may pose a threat to others. Patients infected or colonized with methicillin-resistant Staphylococcus aureus (MRSA), Vancomycin-resistant enterococci, and multi-drug-resistant Streptococcus pneumonia may be eligible for a private room. Documentation of drug resistance should be submitted. Cohorting or placing patients with the same infection into the same room should be done whenever feasible.

5. Infectious disease codes (ICD-9) which qualify for a private room until the infectious stage wanes or antibiotic therapy is sufficient to ensure the patient is no longer infectious may be found in the provider and hospital sections of the Medicaid manual.

B. Limitations/Non-coverage

- Neutropenic patient with a neutrophil count < 500 are more at risk for picking up serious life threatening infections. The Center for Disease Control states that these patients can be in a regular room if standard precautions are followed. Therefore, these patients are excluded from the private room policy.
- A private room is no longer covered when the appropriate antibiotic therapy has been provided, making the patient no longer infectious. For those diseases with a known infectious period, a private room is no longer covered when the duration of infectiousness has passed.

C. ICD.9 Codes

Resistant organisms of concern must be listed with appropriate V code (V09.0-V09.91):

041.04 Enterococcus or Streptococcus type D
041.11 Staphylococcus aureus
041.2 Streptococcus pneumoniae or pneumococcus
041.3 Klebsiella pneumoniae
041.4 Escherichia coli
041.85 Other gram negative (Acinetobacter baumanii, Klebsiella oxytoca, Enterobacteriaceae)

Other:
002.0 Typhoid fever listed with meningitis code 320.7
003.21 Salmonella meningitis
008.67 Coxsackie virus and echovirus (enteroviral infection)
011.0-011.8 Pulmonary tuberculosis
012.3 Laryngeal tuberculosis
013.0 Tuberculosis meningitis
020.0-020.5 Bubonic/Pneumonic plague
027.0 Listeriosis with meningitis code 320.7
032.1-032.3 Nasal pharyngeal/laryngeal Diphtheria
033.0 Bordetella pertussis
033.9 Whooping cough with meningitis code 320.7
034.0 Group A streptococcus pharyngitis
036.0 Diplococcal, meningococcal meningitis
039.8 Actinomycosis with meningitis code 320.7
047.0 Coxsackie virus related meningitis
047.1 Echo virus meningitis
047.8 Other specified viral meningitis
047.9 Unspecified viral meningitis
049.0 Lymphocytic choriomeningitis virus
049.1 Meningitis related to adenovirus or enterovirus
050.0-050.9 Small pox
052.0-052.9 Varicella or chickenpox
053.0 Herpes Zoster with meningitis
053.79 Herpes Zoster with other specified complication –must specify in the medical record that infection is disseminated in immunocompromised patient.
054.72 Herpes simplex meningitis
055.9 Rubeola
056.9 Rubella
072.1- 072.2 Mumps Encephalitis, Mumps Meningitis
078.89 Other unspecified disease due to virus Marburg, Lassa, Ebola
079.6 Respiratory syncytial virus
079.82 SARS-associated coronoavirus
094.2 Syphilitic meningitis
112.83 Candidal meningitis
114.2 Coccidioidal meningitis
115.91 Histoplasmosis meningitis
320.0-320.9 Bacterial meningitis
321.0 Cryptococcal meningitis with code 117.5
321.1 Meningitis from fungal disease with a code from range 110.0 to 118
321.2 Viral meningitis with a code from range 060.0 to 066.9
480.0 Adenoviral pneumoniae
480.1 Respiratory syncytial pneumonia
480.2 Parainfluenza
483.0 Mycoplasma pneumonia
488.0-488.1 Avian or H1N1 Influenza
684 Impetigo - Staphylococcal infection
NN. Allergen Immunotherapy Testing

The code 86001 - IgG Allergen specific testing is non-covered. There is insufficient evidence that the presence or quantity of food allergen specific IgG produced as a result of normal exposure is related to allergic disease. The measurement of subclass specific IgG antibodies to foods have been inconsistent between various studies and therefore of questionable diagnostic value. The issue is still listed as controversial at the American College of Allergy and Asthma and considered investigational. The code 86003 - Allergen specific IgE will require submission of medical record documentation to support medical necessity of IgE testing. This service should not be a screening method for allergy. Skin patch testing is the standard of care. Providers billing with code 86003 must include documentation of the history of the suspected allergy, duration, severity, results of other allergy tests, any previous treatment of the disorder, and an attachment to support the medical necessity of the IgE testing including at least one of the following:

1. Direct skin testing is impossible due to infancy, extensive dermatitis or the patient has marked dermatographism.
2. Patient is unable to discontinue medication (i.e. tricyclic antidepressant, prednisone, or beta blocker, antihistamine) that interferes with skin testing.
3. Direct skin testing is negative despite clinical indications of an allergic condition and specific IgE tests have been determined.

The testing will be reimbursed only for testing of suspected allergens. Use as a multiple allergy screening tool is not covered. An initial allergy screen is twelve tests. Coverage will be limited to one panel with a unit limit of 12 tests. If all tests are negative, an additional testing beyond the initial 12 tests is not considered medically necessary. Providers may submit documentation to support testing beyond the 12 tests for manual review of medical necessity.

OO. Brachytherapy

Brachytherapy using multiple injections at the same site on a date of service is considered investigational and unproven. Brachytherapy as a multiple-injection service (i.e. code 19296) is not covered by Medicaid. Medicaid follows the Correct Coding Initiative; for example, codes 77786 and 77787 are incidental to code 77785. Codes in the range 77785 through 77787 are only reimbursed once on a date of service.

PP. Radiology

The technical portion of imaging procedures is payable to hospitals and independent radiology. Any equipment using radiation requires certification through the Department of Environmental Quality (i.e. 74150 through 74170). The technical portion of imaging (i.e. CT, ultrasounds) requires certification through the American College of Radiology that the facility (i.e. hospital, independent radiology/radiologist) has the credential indicating trained staff perform the procedure.

When MRI, CT, or PET imaging procedures are requested more than once a year, for the same anatomical area, medical record documentation must support the necessity of repeating the procedure.

1. Ultrasound and x-ray
A. Reimbursement for imaging studies for interpretation and report is limited to payment to the radiologist.

B. When an ultrasound or x-ray is completed in the physician office and the physician group owns the machine, medically necessary studies may be considered for payment. These studies are limited to obstetrical ultrasound and orthopedic x-rays when completed by the provider who specializes in that area of medicine.

C. Mobile ultrasound. Some ultrasound codes will be open to mobile ultrasound facilities (provider type 71) to provide ultrasounds for rural areas with limited access requiring long distance travel. Payment of transportation of equipment for this service is not covered. The requirements for becoming a provider type 71 include:

- Complete non-institutional provider application.
- Signed provider agreement.
- Statement from physician indicating a willingness to assume responsibility of providing general supervision of personnel and equipment for the ultrasound provider.
- Physician requirements:
  - Copy of current physician professional license from DOPL, or a copy from DOPL database, or telephone verification from DPL professional license.
  - Physician reading the professional component ultrasound to provide information describing their area of expertise to support reading and interpretation of the ultrasound (e.g. radiologist, obstetrician, cardiologist, urologist).
- Technician requirements:
  - Statement from the supervisor or diploma program director showing successful completion of 12 months of clinical ultrasound experience for the type(s) of ultrasound(s) performed.
  - Certificate showing successful completion of the certification examination as an ultrasound technician or ultrasound sonographer. (There is no licensure requirement in Utah).

2. PET/CT Scans:

To access criteria and/or coverage information, go to the secure website at: https://medicaid.utah.gov.

3. Radiation Therapy

- 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). Payment is limited to four plans (billed as units) per one anatomical site.

- When over four units are billed, the documentation of all the plans over the course of treatment must be submitted for manual review. Exact duplicates will be denied. Secondary or sub plans for the primary plan will be considered for additional payment. The TU modifier will be applied by Medicaid to indicate additional payment was made.

- 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. Payment is limited to 3 units per one anatomical site.

4. Intensity Modulated Radiation Therapy (IMRT)

IMRT requires manual review. The following information outlines the requirements.

A. Intensity Modulated Radiation Therapy (IMRT) Manual Review

- IMRT is covered for
  - Malignant unresectable neoplasms of the head and/or neck.
  - Stage III or IV nasopharyngeal or oropharyngeal cancer.

- IF one or more of the following critical structures may be spared using IMRT
  - Brain stem
  - Optic nerve (e.g. ethmoid sinus tumor)
  - Prevention sensorineural hearing loss-ototoxicity (e.g. parotid gland tumor, medulloblastoma)
  - Carotid artery
  - Mandible
  - Salivary glands (e.g. nasopharyngeal tumor, IMRT results in less xerostomia)
  - Parotid glands
  - Cervical spinal cord

B. For the Manual Review process, the physician must state in a summary document all of the following:

- The planned site for treatment is not a moving organ (e.g. heart, lung, intestine).

- The site of the malignant neoplasm is close to a critical tissue and stereotactic 3D-radiation will not be as effective as high precision IMRT in sparing specified essential surrounding tissue.

  - Provide supportive clinical evidence based literature if site is not one of critical sites listed in number 1.

- Document that at least one of the following applies. (Provide documentation for all that apply):
Important dose limited structures are adjacent to, but outside of planned treatment volume area defined by CT or MRI images.

- Include CT or MRI reports with submitted documentation.
- Images should be available upon request.

- Immediately adjacent areas have been irradiated and area must be targeted with high precision.

- Gross tumor are concave, convex, or irregular and in close proximity to critical structures.

- The prescription treatment plan (CPT code 77301) must address the specific dose need for the target site and constraints with surrounding normal tissue.

- When code 77301 is billed during a course of treatment to the same site, the standard plan 77300 is considered included within that service unless documentation supports the medical necessity.

QQ. Cranietomy and Craniotomy

The benefit of cranietomy or craniotomy decompression depends on the patient’s age, clinical signs and symptoms on admission, and the existence of major extra cranial injuries. The procedure is usually considered within the first 48 hours after the accident when, while monitoring the ICP and cerebral tissue oxygenation $p(t)O_2$, medical conservative interventions prove unsuccessful.

- Patients with primary fatal brain stem damage should not undergo decompression surgery, as indicated by:
  - An initial and persisting GS score of 3 despite conservative therapy.
  - With bilateral fixed/dilated pupils or other signs of herniation which include: progressive loss of consciousness, coma, irregular breathing, respiratory arrest, irregular pulse, cardiac arrest, loss of brainstem reflexes (blink, gag, pupillary reaction to light).

- Adult craniotomy is covered when despite medical treatment there is:
  - Sustained increase in intracranial pressure (ICP) > 20 mm Hg, but ICP has not exceeded 40 mm Hg.
  - Initial GSC score is 4 or has reached 4 on the 1st post traumatic day.
  - Pupils are dilating, not fixed and dilated.

- In children, decompression craniectomy should be preferably considered within the first 6 hours but up to 48 hours of a traumatic brain injury when all of the following are true:
No episodes of ICP > 40 mm Hg. NOTE: A UK study recommends cranial decompression be considered when the ICP reaches 25 mm Hg in children and the cerebral perfusion pressure reaches 50 mm Hg.

- GCS > 3 at some point subsequent to injury.
- Diffuse cerebral swelling on CT scan.
- Evolving cerebral herniation syndrome. Clinical signs of acute increased intracranial pressure include headache, vomiting, vision distortion, diminished sensorium, pupillary dysfunction, hypertension, bradycardia, flexor/extensor posturing.

RR. Frontal Orbital Advancement

Frontal orbital advancement is covered through one year of age. Requests for surgery beyond one year of age is a restricted service which requires prior authorization through the CHEC or UR committee.

SS. Cardiac Catheter Ablation

Cardiac catheter ablation is a therapeutic technique using an electrode catheter which generates a high level of direct current or radio frequency to destroy the arrhythmic area in the heart in order to eliminate conduction defects which cause tachycardia. The CPT codes which describe catheter ablation of cardiac arrhythmic focus include procedures 33250, 33251, 33261, 93650, 93651, and 93652.

1. Documentation must support the medical necessity of the catheter procedure based on chronic, symptomatic recurrent arrhythmia which is refractory to cardioversion and drug therapy or the drug therapy is contraindicated. The following arrhythmia’s are covered for catheter ablation:
   a. Supraventricular atrial or sinoatrial tachyarrhythmia’s (SVT) in patients resistant to drug therapy with symptomatic recurrent SVT.
   b. Atrioventricular nodal ablation carries less certainty of benefit but may be considered medically necessary in patients with a dual chamber pacemaker who have pacemaker-mediated tachycardia which cannot be treated effectively with drugs or by reprogramming the pacemaker.
   c. Tachycardia with syncope or Wolfe-Parkinson-White.
   d. Atrial tachycardia with rapid ventricular response or patients resuscitated from cardiac arrest due to atrial flutter or atrial fibrillation with rapid ventricular response in the absence of an accessory pathway.
   e. Patients with an identifiable focus for chronic or recurrent ventricular tachycardia (VT). The procedure may be medically necessary in cases of refractory atrial flutter or fibrillation in which the ventricular rate cannot be medically controlled by cardioversion and drug therapy.

2. The procedure may be recommended for trial flutter with paroxysmal atrial fibrillation when the tachycardia is drug intolerant or drug resistant. Catheter ablation is indicated for atrial fibrillation when the tachycardia is drug resistant and there is evidence of a localized site of origin.
3. Cardiac ablation procedures are non-covered under the following conditions:
   a. Patients with ventricular and atrial tachyarrhythmias who are responsive to drug therapy and/or cardioversion.
   b. The patient has unstable, rapid, multiple, or polymorphic VT that cannot be adequately localized with mapping techniques.
   c. The patient has multifocal atrial tachycardia (MAT)
   d. The patient has benign non-sustained VT that does not cause symptoms.
   e. Other uses of radio frequency catheter ablation are considered investigational procedure.

4. ICD-9 codes supporting medical necessity:

   426.7 Anomalous atrioventricular excitation (Wolfe-Parkinson-White syndrome)
   426.89 Other specified conduction disorders: atrioventricular, isorhythmic, nonparoxysmal AV nodal tachycardia
   427.0 Paroxysmal supraventricular tachycardia, paroxysmal tachycardia: atrial (PAT), atrioventricular (AV), junctional, nodal
   427.1 Paroxysmal ventricular tachycardia
   427.31 Atrial fibrillation
   427.32 Atrial flutter

TT. Fiber Optic Endoscopic Evaluation of Swallowing (FEES)

Fiber optic endoscopic evaluation of swallowing (FEES) is an alternative to modified barium swallow evaluation for patients at risk of aspiration (codes 92610, 92612, 92613).

1. Patients have one of the following conditions which have shown benefit from the procedure:
   a. Stroke or other central nervous system disorders which affect swallowing and speech.
   b. Patients without an obvious CNS disorder with difficulty in swallowing, a clinical history of aspiration, or a history of aspiration pneumonia.
   c. Presence of oral motor disorders with symptoms such as drooling for food or liquids placed in the mouth or oral food retention.
   d. Lack of coordination, sensation loss, (postural difficulties) or other neuromotor disturbances affecting the ability to close the buccal cavity, bite, chew, suck, shape or squeeze a food bolus into the upper esophagus while protecting the airway.
   e. To visualize the larynx directly for signs of trauma or neurologic damage and assess laryngeal competence post-surgery where the laryngeal nerve was vulnerable.

2. The diagnosis or clinical suspicion of aspiration currently must be present for the procedure to be considered medically necessary.

3. Medical record documentation must support the medical necessity and describe why the FEES procedure provides more information and benefit than barium swallow evaluation studies.
4. The results of FEES testing will impact the clinical decisions which affect the daily dietary management of the impaired patient and impact the evaluation and management of therapy programs.

5. Limitations and non-coverage:
   a. Services are limited to physicians. Incident to services cannot be billed.
   b. The procedure is not covered for routine screening, excessive frequency, or when performed in the absence of a specific sign or symptom supporting medical necessity.
   c. The clinical effectiveness and applicability of the addition of sensory testing to the FEES procedure have not been determined. Therefore, CPT codes 92614 through 92617 are non-covered services.

UU. Home Telemetry

Outpatient long-term cardiac (Holter) monitoring codes 93224, 93225, 93226, and 93227 will be placed on manual review with the following criteria:

- Outpatient long-term cardiac (Holter) monitoring must be ordered by a BC/BE neurologist.
- Client must have had a stroke or TIA with no identifiable cause.
- Client should have already had 24 hour monitoring done previously (either with outpatient long-term cardiac monitoring or as inpatient with telemetry).
- Client should not be currently anti-coagulated on Warfarin for any other reason.
- Client should not have a known contraindication for Warfarin.
- Outpatient long-term cardiac monitoring may only be authorized for the 30-day test.
- Data from the test must be reviewed and interpreted by a BC/BE cardiologist.

4 PRIOR AUTHORIZATION

When prior authorization is required for a Medicaid medical or surgical health care service, the physician must obtain approval from Medicaid BEFORE service is rendered to the patient. Medicaid can pay for services only if ALL conditions of coverage have been met, including but not limited to, the requirement for prior authorization. Generally, a physician must complete a Request for Prior Authorization form and submit it with any required documentation to the Division of Medicaid and Health Financing, Prior Authorization Unit. Before requesting PA, review the appropriate policy manual regarding what must be received in order to make a determination on the request. PA requests must be sent with complete documentation or the request will be returned with a letter indicating what is missing. The date in which a complete request, with all necessary supporting documentation, is received will be the date posted for the PA request.

The physician has the responsibility to obtain a prior authorization when one is required because the physician has basic responsibility for the patient, for establishing a diagnosis, and for outlining the medical necessity indications for the requested service. Current Procedural Terminology (CPT) codes are those which identify procedures requiring a prior authorization. The CPT codes are developed by the
American Medical Association for physicians to describe medical/surgical procedures for billing purposes. The Centers for Medicare and Medicaid Services (CMS) has adopted the CPT codes as part of the HCPCS/HIPAA coding system.

If a physician fails to obtain the required authorization, provides service anyway and then bills Medicaid, Medicaid must deny the claim. Because it was the physician’s responsibility to obtain authorization, all providers involved with the service are prohibited from subsequently billing the patient for the unpaid service. [References: Utah Medicaid Provider Manual, SECTION 1, Chapter 6, Provider Enrollment and Compliance, and Chapter 9 - 7, Retroactive Authorization.]

Refer to chapter 2, Covered Services, for information as to services which require prior authorization. For information on codes requiring prior authorization, manual review, or non-covered status, refer to the Coverage and Reimbursement Lookup Tool on the Medicaid website at https://medicaid.utah.gov.

These services include, but are not limited to:

A. Drugs identified on the attached Drug Criteria and Limits List or in Medicaid Information Bulletins.

B. Medical supplies identified on the attached Medical Supplies List, in SECTION 2 of the Utah Medicaid Provider Manual for Medical Suppliers, or in Medicaid Information Bulletins.

C. Admission to a general hospital for psychiatric care by a physician.

D. Procedures and surgical services identified on the attached Medical and Surgical Procedures List or the Hospital Surgical Procedures List as requiring prior authorization.

E. Organ transplant services.

F. Any other service identified in a Medicaid Information Bulletin.

4 - 1 Retroactive Authorization

There are limited circumstances under which a provider may request authorization after service is rendered. These limitations are described in SECTION 1 of this manual, 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. For services in which multiple providers may be eligible for reimbursement, either the provider or the facility may submit the retroactive authorization request. The medical record documentation must meet the 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 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 supporting the emergent 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 emergency nature of the condition or the surgical exception that occurred that required the procedure: (ALL)
   - Submit the admission history and physical examination, 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 test (i.e. CBC with differential, culture)
   - 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 the 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 meet Medicaid coverage requirements for prior authorization for consideration of retroactive authorization.

3. Medicaid may consider the request for retroactive authorization and payment when the conditions for a surgical exception are met (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 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, retroactive 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. 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 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 supporting the need for the procedure.

Utah Medicaid
Attn: Prior Authorization Unit
P.O. Box 143111
Salt Lake City, Utah 84114-3111
FAX: (801)536-0162

5 NON-COVERED SERVICES

Certain services have been identified by agency staff and medical review to be non-covered for the Medicaid program because medical necessity, appropriateness, and cost effectiveness cannot be readily identified or justified for the purposes of medical assistance under Title XIX of the federal Social Security Act and Title 42 of the Code of Federal Regulations (CFR).

1. General Exclusions

   a. Services rendered during a period the recipient was ineligible for Medicaid.

   b. Services medically unnecessary or unreasonable

   c. Services which fail to meet existing standards of professional practice, which are currently professionally unacceptable, or which are investigational or experimental in nature

   d. Services requiring prior authorization, but for which such authorization was not requested, was not obtained, or was denied

   e. Services, elective in nature, and requested or provided only because of the recipient’s personal preference.

   f. Services for which third party payers are primarily responsible, e.g., Medicare, private health insurance, liability insurance. Medicaid may make a partial payment up to the Medicaid maximum if limit has not been reached by third party

   g. Services fraudulently claimed

   h. Services which represent abuse or overuse

   i. Services rejected or disallowed by Medicare when the rejection was based on any of the reasons set forth above
j. When a procedure or service is not covered for any of the above reasons or because of specific policy exclusion, all related services and supplies, including institutional costs will be excluded for the standard post operative recovery period.

2. Specific, Non-Covered Services

Medicaid does not cover the services specified below. Services not on this list are subject to the general exclusions in item A.

a. Routine physical examinations for adults
b. Experimental or medically unproven physician services or procedures.
c. Cosmetic, reconstructive, or plastic surgery procedures which are elective or desired primarily for personal, psychological reasons or as a result of the aging process.
d. Panniculectomy and body sculpturing procedures
e. Chemical peeling or dermabrasion of the face
f. Revision of minor scars not related to major trauma
g. Removal of tattoos
h. Hair transplant
i. Electrolysis
j. Procedures related to transsexualism.
k. Surgical procedures to implant prosthetic testicles or provide penile implants.
l. Certain services are excluded as family planning services:
   (1) Surgical procedures for the reversal of previous elective sterilization, both male and female
   (2) Infertility studies
   (3) In-vitro fertilization
   (4) Artificial insemination
   (5) Surrogate motherhood, including all services, tests, and related charges
   (6) Abortion, except when the life of the mother would be endangered if the fetus were carried to term, or when pregnancy is the result of rape or incest
   (7) Prolonged educational and counseling services beyond and those in included within the initial evaluation and management service
m. Circumcision procedures for infants or adults, by clamp or surgical excision, are non-covered.

n. Certain services are excluded from coverage because medical necessity, appropriate utilization, and cost effectiveness of the service cannot be assured. A variety of lifestyle factors contribute to the “syndromes” associated with such services, and there is no specific therapy or treatment identified except for those that border on behavior modification, experimental or unproven practices. Services include:

(1) The facility with one registered polysomnography technician and a physician director may be considered for coverage only when the physician director has a collaborative relationship with a sleep medicine physician to read the study.

1. Pain clinics.

2. Eating disorders clinics.

o. Finger/heel/or ear sticks do not qualify for billing a specimen collection fee for an adult. Finger sticks used for blood reagent strip testing may not be billed as venipuncture.

p. Medications for appetite suppression (oral or inject table), experimental surgical procedure, experimental therapies, or education/nutritional/support programs for treatment of obesity or weight control are excluded from coverage.

q. Office visits only for administration of medication are excluded from coverage.

r. A surgeon cannot provide general anesthesia in addition to providing the principle surgical procedure. Some regional or local anesthesia procedures don’t require monitoring according to Medicare and may be completed by the surgeon. An example of this type of service is code 01995. Regional anesthesia provided by the surgeon is included within the global surgical fee and is not separately reimbursable. When monitoring is required during regional or local anesthesia, services are payable to the anesthesiologist.

s. The code 95920 Intraoperative Neurophysiological testing by definition requires monitoring per hour of surgery. As per Medicare guidelines, the procedure is not covered for the surgeon, assistant surgeon, or anesthesiologist. The service is covered only when a separate physician provides the monitoring.

t. Standby or monitoring by the anesthesiologist or nurse anesthetist during local anesthesia is not a covered Medicaid anesthesia service.

u. Treatment and evaluations of subluxation or flat feet. Treatment of flat foot is a condition in which one or more arches in the foot have flattened out. Surgical or nonsurgical treatments undertaken for the purpose of correcting a subluxated structure in the foot or devices directed toward care or correction of this condition, including prescription of supportive devices are not covered.
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